

Minutes

National Advisory Council on the National Health Service Corps

Meeting March 10-11, 2020

The National Advisory Council on the National Health Service Corps (NACNHSC) met on March 10-11, 2020 via webinar. NACNHSC is a group of healthcare providers and administrators who are experts in the issues faced by communities with a shortage of primary care professionals. The Council serves as a key source of information to the NHSC senior management, the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, the Administrator of the Health Resources and Services Administration. The National Advisory Council on the National Health Service Corps was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2) which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D of Title III of the Public Health Service Act.

Welcome and Approval of January Minutes

Ms. Fabiyi-King welcomed the council and took roll call. All members were present except for Ms. Witzel, who joined the meeting shortly after roll call. Dr. Billings welcomed the council and thanked members for their work. He invited members to introduce themselves and state their affiliations. Following introductions, Dr. Billings invited meeting participants to appreciate NHSC staff and patients, and others currently fighting the COVID 19 pandemic.

Dr. Billings asked the council to provide commentary on the minutes submitted for the meeting held on January 14-15, 2020. Ms. Stergar said the minutes were detailed and well done. She requested for minutes to include a summary of motions made during the meeting as well as an executive summary. Ms. Fabiyi-King said that the technical writer had produced a brief meeting summary for HRSA that she could distribute to the council. Ms. Fabiyi-King also supported the suggestion to add a summary of motions. Ms. Witzel said that the minutes reported that an example she had given about a rural scholar was about herself. This example was based on what

she has heard from other scholars, not herself. The minutes should be corrected to reflect this. Dr. Billings asked for a motion to accept the minutes with requested edits. Ms. Stergar made the motion; Ms. Witzel seconded. The motion passed unanimously.

Council Review of Committee Workgroups, Discussion to Finalize Letter to the Secretary

Ms. Fabiyi-King asked the council to review activities of work groups and to work toward finalizing its letter to the Secretary of Health and Human Services. Dr. Billings reviewed the meeting agenda.

Dr. Billings said that about half of NACNHSC had volunteered to write a letter to the Secretary. This group collaborated to produce a draft letter, then requested input from the technical writer. He read the current draft of the letter, “Dear Mr. Secretary, The US currently faces a critical healthcare provider shortage. The Health Resources and Services Administration’s most recent data identifies 7,023 Healthcare Provider Shortage Areas (HPSA), with a total of 80 million residents in need of 14,534 primary care medicine providers. HRSA identifies 6,285 HPSAs with 59 million residents in need of 10,387 dentists and 5,523 HPSAs with 117 million residents in need of 6,363 mental health care providers. A report for the Association of American Medical Colleges projects physician demand growing faster than supply, leading to a projected total physician shortfall of between 46,900 and 121,900 physicians by 2032. This shortfall includes 23,600 primary care physicians and 15,600 dentists needed by the year 2025. In addition to an overall shortage, providers are maldistributed, with HPSAs disproportionately affected.

The National Health Service Corps (NHSC) is the largest and most visible public program working to address the geographic maldistribution of the US health workforce. NHSC is administered by HRSA’s Bureau of Health Workforce (BHW), which supports the NHSC and other programs to improve distribution of providers to underserved areas. NHSC offers scholarship and loan repayment funding of clinicians in exchange for serving HPSAs across the US. Currently more than 13,000 NHSC members provide care including primary medicine and dentistry, behavioral health care, and substance use disorder treatment and pharmacy services to more than 13 million Americans.

Settings where NHSC participants serve include certified rural health clinics, school-based clinics, community mental health centers, critical access hospitals, substance abuse disorder treatment facilities and others. Recent evaluations of healthcare finance models consistently demonstrate that high quality primary medical and dental care and behavioral health care are major contributors to cost reduction.

The May 22nd, 2020, fiscal cliff threatens NHSC program stability and recruitment efforts for academic Year 2021. The current NHSC funding level supports 8,800 providers, which is a critical contribution to the health work force, but less than one-third of the projected shortfall.

Given the urgency of reducing healthcare provider shortages and the associated cost of inadequate access to healthcare services and the NHSC's 50-year history of success in recruiting and training a health workforce that serves the nation's most vulnerable populations, we request a commitment to support the NHSC and to increase the budget 300 percent. Based on our collective experience and expertise and on evidence about effective strategies for meeting the nation's healthcare needs, we believe this budget increase and commitment to the continuation of NHSC will save lives, reduce the burden of critical health issues such as the opioid epidemic, obesity, and chronic disease, and reduce cost of healthcare. Respectfully submitted."

Dr. Billings invited comments about the letter. Ms. Witzel recommended emphasizing key points with bullet points. Ms. Stergar said that the list of NHSC settings should include Federally Qualified Health Centers (FQHC), which train nearly half of NHSC trainees. Dr. Billings concurred. Ms. Stergar also recommended that COVID-19 be provided as an example of the type of urgent public health issue NHSC responds to. Dr. Billings agreed.

Dr. Billings said he appreciated the data that had been added to the letter to provide dramatic evidence about NHSC's impact. Dr. Billings said the evidence was clear that NHSC is a necessary public health resource that requires a budget increase. Dr. Billings said the letter conveyed both passion for NHSC and objective evidence for its value to the Nation.

Dr. Schmitz noted that the letter requested a 300 percent budget increase. He asked whether the council had information confirming that this was the amount needed to support the increase in NHSC trainee placements that the council recommends. Dr. Schmitz said it might be more accurate to submit a request for the funding necessary to triple placements of scholars and loan repayments, without trying to specify the amount of funding. Dr. Billings confirmed that the intent was to support filling all available placements for NHSC trainees. Dr. Schmitz asked if there were specific information regarding the funding amount needed to accomplish this. Ms. Fabiyi-King said she would work to obtain this information. Dr. Billings agreed with Dr. Schmitz's point. Dr. Schmitz recommended rewording the request to emphasize that the budget increase should support increasing the number of trainees supported by 300 percent, without specifying the amount of money required to support that increase. Ms. Stergar agreed. She said the Secretary would not expect the letter to include an exact funding amount. The main point is to emphasize that the current budget is not adequate to address the current primary care shortage. Dr. Billings agreed that it would be more appropriate for staff with budget expertise to determine the specific amount needed to support the Council's recommendation.

Dr. Callins recommended that the letter begin with a statement that it is from NACNHSC for the purpose of requesting a budget increase. This would be followed by a description of NHSC, then discussion of the Nation's shortage of primary healthcare providers. Dr. Callins also suggested using formatting features such as bolding to emphasize at the end of the letter that the purpose is to request a funding increase. Dr. Callins said this order of information could help to emphasize the letter's message.

Dr. Billings asked Ms. Fabiyi-King to explain the process for finalizing the letter. Ms. Fabiyi-King said the NACNHSC's technical writer would refer to feedback provided during the meeting to revise the letter, then submit a revised version to Ms. Fabiyi-King and the council for review and comment. Dr. Billings asked if the council, BHW staff, or technical writer had additional comments on the current draft of the letter to the Secretary. Ms. Stergar asked if the letter should refer only to the NHSC program as a whole, or if BHW staff preferred to describe programs within NHSC, such as Federal student loan repayment and Rural Communities Opioid Response Program (RCORP). Ms. Fabiyi-King said the letter could refer to NHSC as a whole, but that she would confirm the preference of HRSA's executive office.

Dr. Billings asked if Ms. Fabiyi-King had a timeline to recommend for letter completion. Ms. Fabiyi-King explained that the council would set the timeline. Dr. Billings opened the floor to discuss the timeline. Ms. Witzel asked whether the fiscal cliff would occur on May 22. Ms. Stergar said that was the case. Ms. Witzel asked how much time Congress would need before a response could be reflected in the budget. Ms. Stergar said she did not think Congress could respond by May 22, especially with the attention required by COVID-19. Ms. Stergar said she thought it would be acceptable to review the revised letter at the council's next meeting, scheduled for June 2020. Dr. Etminan said it is important for the letter not to be ignored while the Secretary must respond to COVID-19. She asked if more experienced council members thought it would be better to wait until after the crisis was less pressing. Ms. Stergar said the letter was the council making a recommendation on the record to increase NHSC funding because of an urgent need for the program, which is currently seriously underfunded. Ms. Stergar said it is difficult to know how such letters affect policy makers. She asked BHW staff their opinions. Ms. Fabiyi-King said the letter would be part of Congressional budget justification documentation. It is difficult to predict its impact or whether it would be received in time to influence the next budget. She said the most important thing is for the council to communicate its point to the Secretary. Dr. Billings said the letter would be a documentation of the council as private sector advisors to the Federal Government offering some evidence regarding needs of underserved patients for NHSC services, and that policy makers would weigh the letter with other evidence when making decisions. He said the goal was to influence policy discussion over the long-term, not just to request a change in the next budget. Dr. Billings said that it is important to make the request this year, which is the 50th anniversary of the legislation that authorized NHSC. He said that the COVID-19 outbreak illustrates the importance of investing in public health infrastructure that can prevent and respond quickly to public health crises.

Dr. Callins asked whether the letter to the Secretary should mention that this is the 50th anniversary of the NHSC and that it is important to continue the long-term support for the program. Dr. Billings and Ms. Stergar supported this idea.

Dr. Billings said he thought it would be possible to finalize and submit the letter within a month. Dr. Callins agreed. She said that COVID-19 illustrates the need for strengthening the health

workforce and is not a reason to wait to submit the letter. Drs. Schmitz, Taylor-Desir, Sein, Brown, Piernot, Jones, and Etminan agreed. Dr. Billings asked if any council members dissented. None did. Dr. Billings asked Ms. Fabiyi-King to describe steps for finalizing the letter. Ms. Fabiyi-King said the technical writer would revise the letter and submit within approximately a week for council review. Following council approval, BHW will submit the letter to HRSA administration for review. Following HRSA approval, the letter will be submitted to the Secretary. Dr. Billings said the letter needed only minor revision and that it would be timely to submit it during the COVID-19 pandemic and the NHSC's 50th anniversary. He said the council is an important voice regarding funding for NHSC. Dr. Billings thanked the working group, especially Dr. Etminan who developed an initial draft, for their efforts developing the letter, and the council for its comments.

Council Review of Committee Workgroups: Review and Discuss Application Program Guidelines

Ms. Fabiyi-King shared the loan repayment application program guidance (APG) on the screen. She said that applications for support in 2020-21 would be accepted from March 10 9:00 a.m. through April 23 7:30 p.m. She said her presentation would discuss APGs for scholarship and loan repayment programs.

Ms. Fabiyi-King noted that the loan repayment APG was 53 pages long, and explained that she would review the table of contents to help the council identify priority areas rather than attempt to review the entire document. She explained that the introduction provides an overview of the program, including its initiation and implementation. APGs describe eligibility requirements and the award process, as well as service obligations. They describe tax implications of awards, and program requirements by area of discipline. APGs describe post-graduate service obligations, including time requirements. APGs also include instructions for applying. Ms. Fabiyi-King explained that some text in the APGs, such as award eligibility requirements, is required and cannot be revised in response to council comments. She said that the council could revise sections about program overview and benefits of NHSC.

Dr. Billings asked whether NHSC scholars could become commissioned officers of the Public Health Service Corps (PHSC) while they are students. Ms. Fabiyi-King said they could not. PHSC officers must have completed their education and post-graduate training.

Ms. Fabiyi-King explained that applications are scored with a rubric. External reviewers review applicants' essays. Ms. Fabiyi-King said that dentists do not typically complete post-graduate training and BHW is considering the implications of this for scoring applications. She said BHW is interested in input from council members who are dentists.

Ms. Fabiyi-King said APGs discuss requirements for transitioning from training to service at an approved service site. BHW's Division of Regional Operations (DRO) supports trainees in identifying potential service sites. The Health Workforce Connector, a HRSA online resource, also supports identifying potential sites by location and practice site.

APG description of service obligations discusses types of services that fulfill the obligation, requirements to report to HRSA, and half- and full-time obligations by professional discipline, as well as contract requirements. Ms. Fabiyi-King emphasized that BHW wants applicants to understand obligations before applying. She invited council members to consider which aspects of the APGs they would like to review. Dr. Billings thanked Ms. Fabiyi-King for her presentation and invited comments from the council.

Dr. Schmitz said he would like to review the section on academic performance criteria and discuss its implications. Dr. Callins said that, during its previous meeting, the council had discussed reviewing the APG definitions of full- and half-time service. She recalled that a council member had reported difficulties with fulfilling time obligations. Ms. Witzel said that APGs currently define full-time practice as 40 hours per week and that the council had discussed reducing this requirement to 36 hours per week. She said NHSC requires clinicians serving in critical access hospitals to serve 16 hours in the clinic, 8 of which can be teaching, and 24 hours in a critical access hospital, or Indian Health Services hospital-affiliated clinic or nursing home swing bed. Ms. Witzel said the nursing home is sometimes a separate facility in rural health clinics, not owned by the hospital, but which shares staff. She said she would like clarification regarding whether service in these facilities counted toward required service hours. Dr. Etminan said she understood that the 40-hour per week requirement allowed 4 to 8 hours per weeks for

teaching and administration. She asked if the suggestion to reduce the requirement for full-time to 36 hours included reducing the time allowed for teaching and administration. Dr. Etminan said, based on her experience in the loan repayer program, she thought 8 hours is an adequate amount of time for these tasks. Ms. Fabiyi-King invited the council to consider this issue.

Dr. Sein said NHSC should require participants to become board certified. Dr. Billings said the guidelines should reflect emerging changes in healthcare, such as virtual visits, an option being considered more often as a result of the COVID-19 outbreak. Dr. Taylor-Desir concurred and asked whether the current APGs discuss telemedicine. Ms. Fabiyi-King said that they do and showed this section on the screen. She said that NHSC encourages scholars who are performing telehealth to use HRSA's telehealth resource centers, which provide free technical assistance and training. NHSC accepts telehealth as eligible service when the locations of both patient and provider are in HPSAs and are NHSC-approved. If a self-employed clinician provides telehealth services in another State, the clinician must have a license to practice in that State. Dr. Piernot asked if telehealth services are counted in service obligation hours. Ms. Fabiyi-King said that they are.

Dr. Billings asked whether Ms. Fabiyi-King or other BHW staff considered any sections of the APG to be outdated or unclear. Ms. Fabiyi-King said NACNHSC should consider whether and how the guidance should be updated to reflect changing trends in healthcare. Dr. Billings said that since 1999, when he was an applicant, the APG has become longer and more flexible regarding practice settings and training opportunities.

Dr. Piernot said the telehealth section was well-written. She asked whether virtual visits to patients' homes would be considered telehealth or home visits. Ms. Fabiyi-King said the council could make a recommendation about policy regarding this issue with supporting evidence regarding benefits. Dr. Piernot said her practice is working to increase these types of visits and asked if that were also the case with other council members. Dr. Billings said the FQHC where he works is considering using telehealth to serve patients outside of regular hours, which would likely reduce use of emergency departments.

Dr. Taylor-Desir asked whether Federal prisons are still qualified NHSC service sites. Ms. Fabiyi-King said that they are. Dr. Taylor-Desir asked if APGs discuss this. Ms. Fabiyi-King

said she did not think so. Dr. Billings said Federal prison sites tend to have higher HPSA scores. Ms. Fabiyi-King said that NHSC encourages scholars to consider all options for service; and that APGs do not emphasize any particular type of service site.

Dr. Billings asked whether APGs discuss HPSA scoring. Ms. Fabiyi-King said that they do. APGs show sites' score histories.

Dr. Brown pointed out that there are at least five eligible specialties for physicians and physician assistants and only two for dentists. He asked why oral surgery is not an eligible discipline. Ms. Fabiyi-King said she would look into this and report back. Dr. Etminan said many community hospitals do not have divisions of dentistry and therefore have no staff who can credential and provide hospital privileges to oral surgeons. Oral surgery must be delivered in hospitals. Dr. Billings asked what actions could help to address this issue. Dr. Etminan said HRSA could offer grants to support hospitals to add divisions of dentistry. She said dental surgery generates less revenue than other surgeries, so hospitals do not have incentives to give oral surgeons time in operating rooms.

Dr. Billings asked council members to consider how to approach APG review and comment. Ms. Fabiyi-King said there are APGs for the scholarship and loan repayment programs. They overlap but differ, so members should review both. She reviewed the table of contents for the loan repayment APG, which has many of the same major sections as the scholar program APG as well as description of eligible and ineligible loans. Ms. Fabiyi-King said that scholars also can apply for loan repayment. She said that loan repayers can convert from full-time to half-time status, but cannot then return to full-time status. Ms. Fabiyi-King said that NHSC will help loan repayers who become unemployed while fulfilling their service obligations to serve at another approved site.

Dr. Billings thanked Ms. Fabiyi-King for her presentation. He asked her to clarify employment requirements for loan repayers. Ms. Fabiyi-King said loan repayers must be employed by July 18 following applications, and scholars have 6 months after graduation to begin service. Applications for loan repayment must include a letter verifying employment. Dr. Billings asked if employment must last for a minimum time prior to loan repayment. Ms. Fabiyi-King said NHSC only requires scholars to be employed by the specified time. Ms. Witzel said that the

current requirements do not allow sites to offer loan repayment as a recruitment incentive, because employment is a prerequisite for application, which NHSC may not approved. Dr. Etminan agreed that this is problematic. She asked how many applicants continue employment at service sites after their applications are declined. She said she has worked with several applicants who chose to stay after their applications were declined. Ms. Fabiyi-King said HRSA only tracks program participants. Dr. Etminan asked whether HRSA's clinician tracker tool tracks applicants who were declined. Ms. Fabiyi-King said she did not think this was the case.

Dr. Schmitz noted that a site's HPSA score could change during the application review process.

Dr. Billings said that it is challenging for uninsured and underinsured patients to get specialized treatment when they need it. He asked if loan repayment or other incentive programs could be implemented to encourage specialists to serve at NHSC sites, or to provide care for NHSC patients at other sites. He asked if the issue could be addressed through APG revision. Dr. Etminan agreed that this is an important issue, and said that her site has grappled with it. Specialists need specialized equipment, staff, and space, which have overhead costs and take space from primary care providers. Dr. Etminan said that, at her site, the waitlist to see a specialist is very long, partly because not all specialists accept payment from State public aid or managed care payers. She said it would be useful for HRSA to create incentives for hospitals and specialists that add to Medicaid reimbursement rates, which do not cover costs of specialty services. Dr. Etminan said it is best to deliver specialized care from the specialist's site, where the equipment, space, and staff are available. Ms. Stergar reminded the council that, while it can make recommendations to the Centers for Medicare and Medicaid Services (CMS), States make Medicaid rules and regulations. Therefore, for NHSC to increase access to specialized care, it would have to make specialists eligible for its loan repayment program, which may be beyond the council's purview.

Dr. Billings asked Ms. Fabiyi-King how the APG working group should proceed. Ms. Fabiyi-King said the group could make a recommendation or recommend changes to provide more nuance to the APGs, such as providing more detail about service sites. She said council members had discussed updates related to dentistry, and telehealth. Dr. Callins volunteered to join the APG workgroup. Dr. Billings encouraged the workgroup to begin discussing the work

among themselves after the current meeting. He reminded them that they could decide not to recommend any changes to the APGs. He encouraged them to consider barriers to care and how NHSC can help to overcome these barriers, and how NHSC can best support clinicians.

Dr. Piernot said that focusing on primary care is one of the best aspects of NHSC and that limited resources should not be expended to support specialized care, although she recognizes the need for specialists. Dr. Billings agreed with her point and noted that the council's current letter to the Secretary emphasizes current unmet need for primary care.

Ms. Fabiyi-King encouraged council members to use their lunch break to review areas of interest identified during their last meeting.

Overview of Regional Operations

Jeff Jordan

Director, Division of Regional Operations

Dr. Billings introduced Mr. Jordan. Mr. Jordan welcomed the council. He said that HRSA workforce programs aim to increase access to healthcare for underserved and vulnerable populations, promote equilibrium in workforce supply, improve workforce distribution, and develop a quality workforce that is trained in and implements evidence-based best practices. The division is considered BHW's "boots on the ground."

The Division of Regional Operations (DRO) is one of ten operating divisions within HRSA's BHW and is mostly based in HHS regional cities, with three staff members at HRSA headquarters. A regional supervisor or team lead serves in each office, with staff proportional to HRSA's presence in the region. Approximately 70 to 80 percent of DRO's work is related to NHSC. The remainder of DRO's work is managing Nurse Corps scholar placement and supporting new BHW initiatives such as the Opioid-Impacted Family Support Program, and Behavioral Health Workforce Education and Training Program.

DRO is responsible for determining whether sites comply with NHSC requirements by conducting site visits, and reviewing site applications and recertifications. Site visits are also an opportunity for DRO to provide technical assistance to NHSC sites. DRO coordinates with State Primary Care Offices (PCO), which also can review NHSC site applications, though DRO has final authority to approve or disapprove a site. Not all PCOs have enough staff to join site visits. DRO determines site visit priorities annually to align with HRSA and BHW priorities. FY 2020 priorities are: sites located in areas with current or emerging needs, sites with high HPSA scores but little or no NHSC program participation, sites for which there are compliance concerns, and program promotional activities. DRO is interested in why eligible sites do not participate in NHSC, and is exploring barriers during site visits. For the past 2 years, DRO has promoted substance use disorder programs. DRO's 44 analysts usually conduct between 800 and 1,000 NHSC site visits annually. Visits typically take half a day and no more than a day. Site visitors assess compliance using a one-and-a-half-page site agreement.

There are two site application cycles per year. The first, in late spring, is for new applicants; the second is for recertification. Sites are approved for 3 years, unless they qualify for automatic approval. Community health centers, FQHC look-alikes, tribal sites, Bureau of Prison sites, and Immigration and Customs Enforcement sites are automatically approved. Sites are given 6 to 8 weeks to submit applications. Site reference guidance describes site agreement and the application process.

Last year DRO reviewed about 1,800 new site applications and 3,200 recertifications. DRO also reviewed and approved 2,600 substance use disorder treatment sites- 154 opioid treatment programs, 1,042 medication-assisted treatment programs, and 1,121 general substance use disorder treatment sites- following Congressional approval of special funding for the Substance Use Disorder Workforce Loan Repayment Program. Currently, NHSC has just more than 5,000 substance use disorder treatment sites.

DRO supports NHSC participants by placing scholars and student service participants and by completing site verification requests. When scholars and students complete their training, a DRO regional advisor helps them find a site where they can complete their service obligation. The advisor provides guidance regarding the interview and placement processes, vets sites, provides resources and technical assistance, and coordinates site visits and relocations. Resources include assistance for visiting sites to assess whether they are good matches for participants, and relocation assistance. DRO helps ensure trainees understand their service obligations and HPSA requirements. Last year DRO supported placement of 268 NHSC scholars and Students to Service participants and 159 Nurse Corps scholars, and relocation of 215 NHSC scholars and Students to Service participants.

DRO is responsible for site verification, or answering questions about a site's status in NHSC. If a NHSC clinician becomes unemployed while fulfilling his or her service obligation, DRO helps to identify a new service site and verifies site eligibility. Last year DRO responded to slightly more than 2,600 site verification requests.

DRO works with partners and stakeholders to build partnerships and to promote training and residency programs at academic institutions. Last year DRO conducted program promotion activities at 98 health professional schools, and made presentations at 33 professional

conferences. Partners include Indian Health Services (IHS), and Substance Abuse and Mental Health Services Administration (SAMHSA). IHS sites have found it challenging to recruit and retain clinicians. SAMHSA regional offices are located in the same regional offices as DRO and have provided guidance regarding substance use disorder treatment. Last year DRO conducted outreach to more than 900 programs to promote substance use disorder treatment. DRO is working with the Federal Bureau of Prisons to identify sites for offering substance use disorder treatment.

DRO offers in-depth understanding of States and communities as well as day-to-day operations of NHSC sites. Staff include clinicians from multiple professions who have public health expertise. In addition to PCOs, partners include State primary care associations and Area Health Education Centers. Mr. Jordan said about 90 percent of NHSC sites meet or exceed requirements. It is important for DRO to monitor compliance and ensure participants do not take advantage of the program. Regional offices allow DRO to respond quickly and with understanding of the locale when urgent public health needs, such as the Zika outbreak, arise.

Discussion

Mr. Jordan invited questions. Dr. Callins asked what percentage of NHSC sites are automatically approved, and what qualifies them for that status. Mr. Jordan said 70 to 80 percent of sites are automatically approved. Currently, there are about 17,744 total NHSC sites. About 56 percent of these are FQHCs or FQHC lookalikes; 11 percent are community health centers; 8 percent are rural health clinics and critical access hospitals; the remainder are other site types. Page 8 of the Site Reference Guide discusses auto-approval requirements.

Dr. Callins said that, at the last meeting, the council had discussed the value of recruiting providers early in their education. She asked if BHW has initiatives to interest undergraduate college students. Mr. Jordan said BHW's Division of External Affairs leads promotional activities. Recruitment efforts generally focus on residency programs, medical schools, and training programs. They do not extend to undergraduate or high school students. BHW does work with AHECs, some of which offer programs for these students. Dr. Schmitz said that in the past 3 to 5 years, medical students have begun to consider loan repayment programs earlier in their careers. Some programs are recruiting residents earlier in their careers. He said it is

critically important for students to learn about options for reducing debt burden as early as possible.

Dr. Sein said that sites vary with regard to retaining scholars and loan repayers, which may affect HPSA scores. He asked if site evaluations consider this. Mr. Jordan said DRO is considering this issue but has not yet included retention in evaluation criteria. However, an NHSC statute gives DRO authority to disapprove a site for not making good use of NHSC clinicians. He said DRO has rarely invoked this authority. Instead, DRO provides technical assistance for retention and recruitment, and encourages sites to develop strategies and plans for retention and replacement. He said that disapproving sites in critical needs of resources is problematic.

Dr. Billings asked whether it is scholars or sites that initiate the process of applying for funds to travel to job interviews or to cover relocation expenses. Mr. Jordan said the scholar initiates this process by contacting the point of contact the site provides. Mr. Jordan said NHSC also pays for travel, including hotel and per diem expenses, to clinical rotations at NHSC-approved sites¹. These rotations provide scholars with an opportunity to learn what it is like to provide primary care in an underserved community.

Dr. Callins said that she is a former scholar. She interviewed with a site during her third year of residency. She appreciated receiving a stipend in between signing the service contract and starting work at the site. She said the relocation process was efficient. Dr. Callins said she had not known that NHSC pays for travel to clinical rotation. She said she would notify her students who are eligible for this support, and use it as a recruitment incentive, and that she would find where information about funding for travel to rotations is advertised. Dr. Billings said he also had been unaware of this benefit and would like more information about it. He agreed that it would be a valuable recruitment incentive.

Mr. Jordan said DRO is considering site visit priorities for 2021, with one possibility being assessing HPSAs with no NHSC presence. A workgroup will pilot test recruiting sites in these areas. Mr. Jordan said sites typically approach DRO for NHSC approval. DRO is interested in exploring promoting the program to communities that may not be aware of the program.

¹ Mr. Jordan later said that funds are no longer available to cover rotation travel expenses.

Dr. Billings thanked Mr. Jordan for his presentation. He encouraged council members to introduce themselves to and develop relationships with their BHW regional representatives². Dr. Callins said she had e-mailed her regional representative and would like to share information with the representative regarding areas where she knows a NHSC site would be useful. Dr. Billings said he expected that regional representatives could facilitate networking for trainees.

Dr. Bockwoldt asked for a description of NHSC scholar and loan repayer programs. Dr. Billings said the scholarship program supports medical, dental, and advanced practice clinicians while they are in professional school with tuition and a stipend in exchange for service in a HPSA for the length of time that they are supported. The Loan Repayment Program is open to more disciplines. Participants serve half- or full-time in HPSAs in exchange for \$30,000 to \$50,000 annual educational loan forgiveness. Dr. Bockwoldt asked if the benefits to NHSC sites are different for scholars versus loan repayers. Mr. Jordan said NHSC requires scholars to serve at sites with higher HPSA scores. He said benefits of hiring a scholar or loan repayer may depend on current staffing. Dr. Billings said the benefits to the site are about the same for recruiting scholars and loan repayers. He said that scholars owe only time. Loan repayers have the option to continue service in order to pay educational debt. Dr. Callins said scholars also can apply to the loan repayment program to reduce debt accrued as an undergraduate or at a graduate school other than the one for which they received a NHSC scholarship. She said that continuing service to reduce debt is an incentive for retention, which benefits communities served by NHSC. Dr. Billings said that he perceives scholars and repayers to be committed to serving underserved communities, and therefore to be the best applicants. These applicants tend to acclimate faster, be more satisfied with their choice to work in an underserved community, and more likely to stay, which is important to the community.

² Laura Ridder, HRSA Ethics Advisor, subsequently advised NACNHSC members that they have specific representational restrictions regarding interacting with the Federal government and that all communications with Federal staff on behalf of the Council should be mediated by the Designated Federal Officer.

Health Workforce Connector

Michael Dembik

Branch Chief, Division of Branch Operations

Dr. Billings introduced Mr. Dembik. Mr. Dembik reminded the council that he had presented the Clinician Dashboard at the last council meeting. The dashboard is now deployed and available to use via the HRSA data warehouse.

Mr. Dembik said he manages the Health Workforce Connector project. The Health Workforce Connector helps to connect clinicians to communities in need of their services. The development team is working to improve the online resource, which HRSA launched February 2017 to replace the NHSC Job Center. Since then the Health Workforce Connector has added Nurse Corps sites, new professional disciplines, a search option, and improved mobile experience. During the past year, 173,000 users viewed Health Workforce Connector pages 1.3 million times, with an average of 14,400 users and 48,000 unique searches per month.

DRO partners and Division of External Affairs staff have conducted outreach to encourage job seekers to create profiles, which points of contact at verified NHSC and Nurse Corps sites can search. Profiles include work experience, training, and work preferences. Points of contact can search using keywords, discipline, specialty, and location. There are currently more than 8,000 published profiles on the Health Workforce Connector, and about 16,000 total accounts. Nearly 1,800 opportunity seekers have connected to more than 12,000 available training and employment opportunities by indicating interest. Last month site points of contact conducted about 1,500 searches for opportunity seekers.

There are currently more than 26,000 NHSC and Nurse Corps sites; 60 percent have complete site profiles on the Health Workforce Connector. More than 2,200 sites have at least one open opportunity. There are between 3,000 and 5,000 postings at any given time. In addition to job opportunities, sites can post training opportunities. Currently, 349 sites have posted training opportunities. Grantees seeking partnerships with medical facilities can use site profiles.

The Health Workforce Connector has facilitated virtual job fairs approximately every two months. HRSA encourages sites to update their profiles and post opportunities in order to prepare

for virtual job fairs, and encourages job seekers to create and publish user profiles. The Health Workforce Connector team provides technical assistance to make virtual job fairs accessible and valuable. Mr. Dembik asked council members to participate in and promote virtual job fairs.

Mr. Dembik provided a live demonstration of the Health Workforce Connector. He said a new, easier to navigate, home page will be live in May. Mr. Dembik showed the search and advanced search features, and the “create an account” option. He showed how to use the Health Workforce Connector to link to the NHSC website and to information about HHS and HRSA priorities. He demonstrated the process of searching for an opportunity, and how to narrow a search by criteria such as profession, location, site type, opportunity type, and HPSA score. Mr. Dembik showed how to link from search results to site profiles, which show location, contact information, HPSA score, opportunities, points of contact, hours of operation, services provided, links to the site website or Facebook page, affiliated clinical sites, and what is nearby, such as schools and restaurants- a feature integrated with Google Maps. Users can click on tabs for specific opportunities, which will lead the Health Workforce Connector to send an e-mail notification to the opportunity point of contact, and link the point of contact to the seeker’s profile. If the seeker does not yet have a profile, the Health Workforce will encourage him or her to create one.

Mr. Dembik demonstrated how to create an opportunity seeker profile. Profiles include professional title, location, BHW program participation history, field of practice, discipline, specialty, language competencies, contact information, and National Provider Index (NPI) number. The Health Workforce Indicator integrates with the CMS NPI database, so users can link to the database to look up their NPI numbers. Profiles also include a personal statement and list of States where the individual has license to practice. Profiles include sections that summarize professional experience, education, training and certifications, and employment preferences. Users can make some profile sections private.

For site profiles, BHW enters data on HPSA score and whether a site is active. Site points of contact enter other site profile information. Mr. Dembik demonstrated how to create a site profile and an opportunity tab. Opportunity information includes date of availability, whether the opportunity is paid or unpaid, and which benefits the site offers. The Health Workforce

Connector provides information about how many users have connected to each opportunity. Site profiles can indicate that they typically offer training opportunities and for which disciplines. Site points of contact can link to a user manual. Mr. Dembik demonstrated how to search for candidates for site opportunities, and how to narrow a search.

Discussion

Mr. Dembik invited questions. Dr. Etminan asked whether sites can have multiple points of contact. Mr. Dembik said that they can and that HRSA actually requires sites to provide at least two points of contact. Dr. Etminan said this is an important feature because individual positions may be vacant, and sites may need different points of contact for different opportunities. Mr. Dembik demonstrated how to add a site point of contact.

Dr. Schmitz asked whether the Health Workforce Connector development team has considered analyzing users' behaviors, such as using the "what's nearby" feature, to obtain information about recruiting providers to rural and underserved areas. Dr. Schmitz said his own research has shown that community characteristics are related to recruitment and retention. He thinks analyzing Health Workforce Connector use could be valuable to BHW. Mr. Dembik said BHW does use Google Analytics to monitor users' behavior. He said the development team is enhancing the Health Workforce Connector, but hasn't discussed analyzing use of the "what's nearby" feature. The emphasis has been on locations of applicants, where they seek opportunities, and which opportunities, but not on how to use data to understand why applicants make the choices they do. Mr. Dembik said he would discuss Dr. Schmitz's comment with the development team. Dr. Schmitz said applicants' geographic location, educational background, and interests are linked to likelihood of serving rural and underserved communities. He offered to help provide input for developing the Health Workforce Connector to collect data relevant to recruitment and retention. Mr. Dembik said BHW Director, Dr. Padilla, prioritizes understanding the path from education to training to service, and what motivates clinicians to commit to service in areas where they are more needed. BHW values data that inform program decisions regarding recruitment and retention.

Dr. Billings said his site has used the Health Workforce Connector for several years. He said approximately two to four clinicians per month express interest in serving at his site. When he

responds to these applicants, only about half respond in return, sometimes indicating that they are not sure why he is contacting them. He expressed concern that applicants may use the Health Workforce Connector's easy process to apply to sites without learning about sites or being sure that they are interested in an opportunity. Mr. Dembik said the Health Workforce Connector is designed to make connections, not submit applications. The development team is working to make clearer the level of interest of a person responding to an opportunity posting. Dr. Billings said the current version resembles a dating app with an easy "swipe left, swipe right" feature. Mr. Dembik said others have expressed this concern. The team is working to make the Health Workforce Connector more similar to LinkedIn.

Dr. Billings asked how HRSA markets the Health Workforce Connector and which audience the connector is reaching. Mr. Dembik said the Division of External Affairs markets the Health Workforce Connector. Outreach focuses on NHSC and Nurse Corps applicants and participants. The Division encourages users to publish profiles. With 50,000 unique searches per month, there are more users than NHSC and Nurse Corps program participants; so many users are not participants in these programs. HRSA's Melissa LaCombe said many users probably are directed to the Health Workforce Connector through BHW virtual job fairs. The Division of External Affairs also pays for social media advertisement. Visitors to HRSA's home page can use a link to sign up for updates regarding NHSC programs and activities, including virtual job fairs. The site directs those who express interest to the Health Workforce Connector. Mr. Dembik said many sites with opportunities and opportunity seekers who participate in virtual job fairs do post profiles. Ms. LaCombe said sites often do not keep their profiles updated.

Ms. Fabiyi-King asked council members whether they use the Health Workforce Connector. Dr. Piernot said colleagues have told her that people seeking visa sponsorship use it. Dr. Billings said physicians and dentists seeking visa sponsorship have contacted his site via the Health Workforce Connector. Mr. Dembik asked Dr. Billings how he felt about this. Dr. Billings said his rural site is on the border between Texas and Mexico, where speaking Spanish is an important professional skill. Many applicants have not had that skill and became uninterested after learning that it is important for serving at the site. Mr. Dembik said the development team could modify the connector to discourage this kind of use. Dr. Billings said visa seekers are not a problem and that he likes the tool, which is increasing the number of people seeking

opportunities at his site. Dr. Callins said the tool is excellent and that the “what’s nearby” feature will help users to consider their interest in a site. Dr. Billings thanked Mr. Dembik for his presentation and his work. Mr. Dembik invited council members to contact him with any follow-up questions. He showed council members how to link to clinician dashboards, which are now live.

Public Comment

At 3:00, the operator opened lines and Ms. Fabiyi-King invited public comments. There were none.

Recap of Day 1 and Plan for Day 2

Dr. Billings summarized the day’s proceedings. The council determined how to finalize its letter to the Secretary within a month. The council gained a better understanding of current APGs and charged a workgroup with reviewing them and recommending updates if necessary. The council will discuss comments on APGs at the council’s meeting in June. Mr. Jordan provided an overview of DRO. Dr. Billings encouraged council members to develop relationships with their local DRO offices. (As noted above, a HRSA ethics advisor subsequently notified the Council that communication must be through the Designated Federal Officer). Mr. Dembik described the Health Workforce Connector and how to use it.

Mr. Jordan said that he had a correction regarding information he had presented: NHSC no longer provides reimbursement for clinical rotation travel costs.

Dr. Billings reviewed the agenda for Day 2 and invited comments. Ms. Fabiyi-King shared a document summarizing potential priorities that council members had discussed during the January meeting and asked them to review it before the Day 2 discussion. Dr. Billings thanked council members, BHW staff, and the technical writer for their work. Ms. Fabiyi-King adjourned the meeting at 3:35 p.m.

Day 2

Ms. Fabiyi-King welcomed the council and conducted roll call. All council members were present except Dr. Pinto-Garcia.

Charge of the Day

Dr. Billings welcomed the council and asked participants to keep the current COVID-19 public health crisis in their thoughts and prayers, and to do what they could to address the crisis. He reviewed the agenda for Day 2 and said he was pleased with work accomplished on Day 1.

Dr. Schmitz asked for clarification about processes for workgroup communications and activities, and if staff support were available. Ms. Fabiyi-King said groups can determine their approach to tasks. The NACNHSC technical writer can join workgroup meetings and provide writing and research services. HRSA staff can provide conference call lines and participate in meetings on request. She said the letter writing workgroup had used Google Docs to facilitate communication. Dr. Schmitz asked if the chair would assign volunteers to manage workgroup activities. Ms. Fabiyi-King said workgroups determine their own approaches to management and organization. Dr. Billings said the letter writing working group had established e-mail communications; a member volunteered to write the first draft, then the group exchanged comments on the letter. The group requested information from BHW, then requested assistance from the technical writer. The process took approximately 6 weeks. Dr. Billings recommended that other working groups also begin with establishing e-mail communications and offered to facilitate this step. He recommended developing recommendations regarding the APGs for the council to consider at its June meeting.

National Advisory Council on Nurse Education and Practice (NACNEP)

Camillus Ezeike, Ph.D., J.D., LLM, RN, PMP

Designated Federal Officer for NACNEP, Senior Advisor,

Division of Nursing and Public Health

Dr. Billings introduced Dr. Ezeike. Dr. Billings said that NACNHSC was interested in learning about activities of other advisory councils, including NACNEP, and how councils could collaborate to be more effective. Dr. Ezeike asked council members to introduce themselves. After members had shared their names and affiliations, Dr. Ezeike said he would provide an overview of NACNEP and describe its programs.

NACNEP provides advice and recommendations on issues related to nurse workforce education and practice improvement to the HHS Secretary, the Senate Committee on Health, Education, Labor and Pensions, and the U.S. House of Representatives Committee on Energy and Commerce. NACNEP is authorized by Section 851 of the Public Health Service Act as amended by Public Law 105-292. The council is expected to offer recommendations that can be translated into policy actions. Authorizing legislation specifies NACNEP composition: two members from the general public, two full-time nursing students, two practicing professional nurses, at least nine leading authorities in nursing education, advanced practice nurses, and organizations that provide nursing services. NACNEP meets at least twice annually. The Designated Federal Officer calls the meetings, approves the agenda, and is present at these meetings, which are open to the public and always include time for public comment.

NACNEP makes recommendations regarding several HRSA programs: Nursing Workforce Diversity; Nurse Education, Practice, Quality, Retention; Veterans to Bachelor of Science in Nursing; Advanced Nursing Education; Nurse Anesthetist Traineeship; Nurse Faculty Loan Program, Nurse Corps Loan Repayment; Nurse Corps Scholarship Program; Comprehensive Geriatric Education Program; and Advanced Education Nursing Traineeship. The Veterans to Bachelor of Science Program supports primary care registered nurses who are veterans to practice to the full scope of their licenses in community-based primary care teams. The Nurse Education, Practice, Quality Retention Program's purpose is to prepare nurses to expand the role of registered nurses in primary care community-based settings. The Nursing Workforce

Diversity Program uses evidence-based strategies to increase nursing educational opportunities for people from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses. The Advanced Nursing Education nurse practitioner residency program is new. It supports nurse practitioner residency programs in preparing nurse practitioners for primary care practice in community-based settings, prioritizing service to rural and underserved populations. The Nurse Anesthetist Traineeship Program provides funding to schools that educate nurses to become certified nurse anesthetists who provide traineeships to students. The Nurse Faculty Loan Program offers as much as 85 percent loan repayment to full-time nurse faculty. The Nurse Corps Loan Repayment program provides loan repayment assistance to registered nurses, including advanced practice nurses, who work at eligible healthcare facilities with a critical shortage of nurses or who work as faculty at eligible schools of nursing. The Comprehensive Geriatric Education Program trains nursing personnel to provide geriatric care and also offers training for faculty.

NACNEP resources are available on the NACNEP website. Resources include the charter, authorizing legislation, member roster, meeting agendas, and reports with recommendations to Congress and the HHS Secretary published since 2001. NACNEP published two reports in 2019. The 15th report was *Promoting Nursing Leadership in the Transition to Value-Based Care*. The 16th report was *Integration of Social Determinants of Health in Nursing Education, Practice, and Research*. NACNEP currently is working on its 17th report, *The Impact of Nursing Faculty Shortage on Nursing Education and Practice*. The report discusses preceptorship for advanced practice registered nurses and for undergraduate and graduate nursing students.

Discussion

Dr. Billings asked if NACNEP is required to publish an annual report, and if NACNHSC is also required to do so. Dr. Ezeike said NACNEP is required by statute to publish recommendations to the Secretary and Congress annually. Ms. Fabiyi-King said NACNEP is required to publish a summary report or letters with recommendations annually.

Dr. Brown asked whether the council had initiated preceptorships for nursing students, or if these were already part of the programs NACNEP advises. Dr. Ezeike said the Nurse Faculty Loan

Program as of FY 2020 includes preceptors in the definition of faculty to address a shortage of preceptorships for advanced practice registered nurses.

Dr. Billings said his site is 160 miles away from the nearest nursing education and training program. There is a shortage of nurses in the area. Best care is delivered by multidisciplinary teams, of which nurses are an important part. He asked how to increase the number of nursing students who participate in preceptorships or rotations, which would give remote rural sites an opportunity to recruit them. Dr. Ezeike said that program participants are required to serve in rural and underserved areas. NACNEP supports HRSA in working to incentivize nurses to serve rural and underserved areas.

Dr. Bockwoldt said she is a family nurse practitioner who teaches at University of Illinois' nurse practitioner program. She said CMS documents are often physician-centric. CMS rules stated that medical students could enter electronic medical record data and a physician could sign the chart without reentering data. Because only medical students were specified, advanced practice nursing students were unable to enter electronic medical record data during clinical rotations at FQHCs. This meant preceptors had to duplicate charts, which was cumbersome. NACNEP sent a letter to CMS requesting a change in the rule. The change was implemented at the beginning of 2020. Dr. Bockwoldt said this was an example of how NACNEP impacts healthcare delivery.

Dr. Bockwoldt said she has wanted to participate in the Nurse Faculty Loan Repayment Program, but has not been able to because she is not from a disadvantaged background. She asked for comment on the rule. Dr. Ezeike said that the program does not require applicants to be from disadvantaged backgrounds. It requires applicants to be advanced nursing students who are willing to become nurse faculty. The Nursing Workforce Diversity Program is for undergraduate students from disadvantaged backgrounds. Dr. Bockwoldt said the application was for people who are already faculty and was available only to applicants from disadvantaged backgrounds. Dr. Ezeike said she was referring to the Nurse Corps Loan Repayment Program, which is different from the Nurse Faculty Loan Repayment Program.

Dr. Schmitz asked whether HRSA invests in preparing nurses, especially advanced practice nurses, to serve remote, underserved areas and if there are opportunities to train physicians and nurse practitioners to work together in these settings. Dr. Ezeike said that HRSA introduced an

Advanced Nursing Education program in 2019. The program prepares nurse practitioners for primary care practice in community-based settings, with priority for rural and underserved populations. The Advanced Nursing Education program prepares primary care advanced practice nursing students to practice in rural and underserved settings. Dr. Schmitz said it would be useful for higher education institutions to collaborate with rural communities to provide education. Dr. Ezeike said the Nurse Education, Practice, Quality, Retention Program integrates behavioral health practices into primary care through teams led by nurses.

Dr. Callins asked how nurses in the programs mentioned are connected to preceptors. Dr. Ezeike said HRSA supports interprofessional collaboration. States set requirements for nursing licensure, so programs vary in how they approach training. Dr. Callins asked how nurses can find NHSC physicians willing to serve as preceptors, and if a platform such as a website or directory were available to facilitate connecting nurses with preceptors. Dr. Ezeike said NACNEP is considering how to connect nurses with preceptors, and has discussed addressing this with BHW. Ms. Fabiyi-King said NACNHSC could recommend that NHSC consider how to facilitate connections between NHSC preceptors and nurses. She noted that sites can use the Health Workforce Connector to post clinical rotations, externships, and preceptorships. Dr. Callins said this was a good idea, and that she would discuss it with colleagues at her site. She said she would like the platform to make it easier for users to communicate availability to serve as a preceptor since advanced practice nurses often struggle to find preceptors. It is especially important to serve needs for women's healthcare in rural communities.

Dr. Bockwoldt said there are several online for-profit programs that offer training to become a nurse practitioner within 16 to 18 months. Students are responsible for finding their own preceptors. Programs do not have oversight and dilute the quality of the nursing workforce. Dr. Bockwoldt advised against having nurses identify their own preceptors. She recommended that connections be made through academic institutions in the same way that medical schools make these connections for medical students. Dr. Callins agreed and said that she would like to give preference to NHSC nursing students. She would like a mechanism to support that. Ms. Fabiyi-King supported this idea. Dr. Ezeike said it is a NACNEP priority to support nurses who have received HRSA support in transitioning to service at NHSC sites in order to maximize return on HRSA's investment and to serve areas most in need.

Dr. Billings agreed that it is important for nursing trainees to serve rural and underserved sites. He said there are no financial incentives for FQHCs to provide training outside of Teaching Health Centers, of which there are too few. He asked how to develop incentives, and suggested that NACNHSC and NACNEP could coordinate with a CMS council to develop recommendations on how to do so. Dr. Billings suggested considering giving higher grant proposal evaluation scores and additional funding to applicant sites that offer training. Dr. Ezeike supported this idea. He reminded the council that CMS is a different agency, where the council has no authority. However, NACNEP and NACNHSC could coordinate to make recommendations that could translate to policy change. Dr. Billings asked Ms. Fabiyi-King if she had comments regarding NACNHSC participating in a joint meeting with NACNEP and developing a joint statement to CMS regarding incentives to host trainees at FQHCs. Ms. Fabiyi-King confirmed that these activities are within NACNHSC's purview.

Dr. Ezeike shared contact information for Captain Sophia Russell, Director of the Division of Nursing and Public Health.

Council Member Discussion of Priorities

Dr. Billings asked council members for their thoughts regarding collaboration between NACNHSC and NACNEP. Dr. Taylor-Desir said the council had previously discussed prioritizing mentorship, and that Dr. Ezeike's discussion points had been relevant to that priority. She said she would support collaboration between the councils to draft a letter to CMS. She said preceptorship across disciplines is important for supporting interdisciplinary team practice. Dr. Taylor-Desir said it was important to document the recommendation as a first step toward implementation. Dr. Schmitz concurred. He said a limited number of rural communities have resources necessary for accreditation and other educational standards. The Accreditation Council for Graduate Medical Education (ACGME) recently announced that it will be accrediting training for service in rural and underserved communities. This could contribute to isolation between professional groups as residency programs are specifically for physicians or nurse practitioners. Dr. Schmitz expressed support for these communities sharing limited resources to educate people from multiple disciplines in integrated teams. He said NACNHSC should encourage this. Dr. Schmitz said this was one reason the council had invited COGME to discuss collaboration. He suggested the council also hold discussions with representatives of accrediting bodies, and discussions about how funding opportunities can support rural preparedness. Dr. Schmitz said technology is changing how healthcare is delivered and the way interprofessional teams function. It is important to train the workforce to work in integrated teams now so that they are integrated, rather than separate, as technological changes emerge. Otherwise, integration will require overcoming difficult technological barriers.

Dr. Callins thanked BHW staff for helping the council to understand HRSA's organization and structure so that council members can assess how to use these resources. She said that DRO may be able to provide information about how to connect nurses to preceptors. She added that it may be useful to conduct a pilot test of using and building on a regional platform for connections. Dr. Callins asked if the council could review examples of previous NACNHSC annual reports and suggested discussing the annual report objectives and content at a future meeting.

Ms. Witzel said that she had participated in a program, possibly called "Search," that paired nurse practitioner students with medical students for about 6 weeks to learn team-based care in a

rural community. The program provided an incentive to serve rural communities. She asked if there were data on how many participants in this program returned to practice in rural communities.

Ms. Witzel said she is writing a rural health curriculum for the University of North Dakota, as part of efforts to recruit nurse practitioners to serve in underserved and remote areas. It has been a challenge to find rural providers willing to serve as preceptors. There is not funding to support training, travel, or housing. Ms. Witzel said it is important for trainees to be immersed in rural communities they serve, which increases the likelihood of staying. She said it would increase the workforce in underserved and rural areas if all nursing and medical schools supported routine rural rotations. Ms. Witzel asked if the Search program is still operating. Ms. Fabiyi-King said the program was the Area Health Education Center (AHEC) program, which was very successful for several years. The program was a valuable resource for providing preceptors and residency experiences. Its funding period ended and HRSA has not renewed funding. The centers still work in their communities, independent of HRSA. Dr. Callins said she is a faculty member at Mercer University School of Medicine, which requires all medical students to do a 4-week community or rural health rotation in their first, second, and fourth years. The university coordinates with the AHEC and local communities to obtain student housing. She said the council should learn about existing resources such as these and consider how the resources can be used to achieve objectives. Dr. Taylor-Desir said that she had participated in an AHEC program as a medical student. The program taught her about what her practice and experience would be after she had fulfilled her NHSC service obligation. She said it is important for students to have rotations that expose them to areas of practice they may not have considered. Dr. Taylor-Desir said that it was a challenge to provide housing. She said that travel to rural sites can take hours, and residents should not drive hours after a long shift, so the medical school or training site should provide housing. Dr. Billings said the cost of housing can be a major burden on communities, clinics, and students. Dr. Callins asked whether the NHSC Ambassador Program is still in operation. Ms. Fabiyi-King said that it is not.

Dr. Billings asked for input regarding the council's June meeting, Dr. Ezeike's presentation, and whether the presentation affected priorities the council had identified. Dr. Callins said the presentation aligned with the council's priorities to provide education and training for physicians

and nurses in rural communities, to support mentorship, and for the council to collaborate with others. Dr. Billings said Dr. Ezeike's presentation had emphasized the importance of team-based care. He said the council should work with HRSA, BHW, NHSC, other advisory councils, and academic institutions to consider how best to serve underserved communities, including how to address financial barriers. Dr. Callins asked whether NACNHSC has collaborated with other organizations or councils in the past. Ms. Fabiyi-King said this has not been the case in recent years, but that the council has the option to collaborate. The council can invite organizations to speak. Ms. Fabiyi-King said the council should consider how work with other organizations will inform its work. Dr. Billings said he thought it would be useful to invite representatives from COGME, NACNEP, and CMS to the next NACNHSC meeting to discuss financial incentives for training in rural areas. He invited input from other council members. Ms. Fabiyi-King said the council already had extended an invitation for the Chair of COGME to participate in the next meeting. Dr. Callins asked if the COGME Chair knew the reason for the invitation. Ms. Fabiyi-King said the Chair had been told that NACNHSC wanted to learn about COGME's activities. Dr. Schmitz said that training and program accreditations are different for medical students and residents. COGME could provide valuable input regarding training residents, which ACGME governs.

Ms. Fabiyi-King asked whether the council were interested in inviting other speakers who could inform their recommendations. Dr. Callins asked whether the council could review examples of previous NACNHSC annual reports and suggested discussing the annual report objectives and content at a future meeting. Dr. Schmitz said he also would like to hear speakers from those organizations.

Dr. Callins said she would like to speak with Ms. Fabiyi-King about connecting advanced nurse practitioners who are NHSC scholars or loan repayers with physicians willing to help with their training. Dr. Callins said she would like to share that information with the council.

Dr. Taylor-Desir said she would like a workgroup to contact State DRO representatives to learn about their activities, then report to the council at the next meeting. (As noted above, a HRSA ethics advisor subsequently notified the Council that communication must be through the Designated Federal Officer). Drs. Callins and Billings supported this idea. Dr. Bockwoldt said

she would like to learn more about how to expand the health workforce through telehealth, and which regulations apply. Dr. Sein said he would be interested in hearing a representative of the Teaching Health Center program speak about residency training in rural and underserved communities. Dr. Schmitz said he would like a speaker from Indian Health Service to discuss opportunities it funds for graduate medical education through the Veterans Administration.

Next Steps

Dr. Billings said that next steps included the APG work group's review and comments by the June meeting. Other potential priorities include: considering how best to support NHSC trainees in fulfilling their service obligations through mentorship programs; contacting DRO representatives about connecting NHSC students and trainees with sites, especially rural sites (as noted above, a HRSA ethics advisor subsequently notified the Council that communication must be through the Designated Federal Officer); considering and making recommendations about how to leverage telehealth to improve reach to underserved communities; and inviting COGME, NACNEP, and CMS representatives to consider potential collaboration, such as joint letters of recommendation. He invited comments from the council. Drs. Taylor-Desir, Callins, and Billings volunteered to contact their State DRO representatives to learn how they work with NHSC students and sites, then compare findings. (As noted above, a HRSA ethics advisor subsequently notified the Council that communication must be through the Designated Federal Officer).

Dr. Callins invited council members to share comments about experiences they, their students, and colleagues had had with APGs. She reminded the council that the discussion that led to forming the workgroup included comments on requirements for service hours.

Dr. Billings and Ms. Fabiyi-King confirmed that the letter to the Secretary about increasing the NHSC budget would be sent to the full council for review during April and probably would be submitted to the Secretary before the June meeting.

Dr. Callins said that meeting with other councils would support developing recommendations regarding mentorship programs. Dr. Billings agreed.

Dr. Callins asked what action the council should take regarding interest in leveraging telehealth. Ms. Fabiyi-King said the APG workgroup could send recommendations about how the APGs can support optimizing use of telehealth. She said the council also could discuss telehealth in a report or white paper on telehealth as an emerging trend. Dr. Billings said he supported the APG workgroup focusing on considering how to update APGs to facilitate telehealth. He said that he would be interested in a CMS representative speaking at a future council meeting about CMS support for telehealth care and reimbursement. Ms. Stergar said she supported considering how telehealth can support NHSC. She said the council should seek input from telehealth experts from HRSA and from other committees. Dr. Billings said it would be useful to see CMS council recommendations on this issue.

Dr. Billings said he expected that the COGME representative at the June meeting would be able to discuss the Teaching Health Center program. He asked if the council also should invite a speaker involved with the program. Dr. Schmitz said he would like to hear from a speaker with detailed understanding of the program and its funding. Ms. Fabiyi-King said NHSC Director Israil Ali could discuss the program, and others could as well. Dr. Schmitz expressed interest in hearing a HRSA representative discuss the Rural Residency Program Development grant.

Ms. Stergar asked for an update on the HPSA Designation Modernization project and the status of the associated request for information. Ms. Fabiyi-King said she could invite Dr. Janelle McCutchen to provide an update. Dr. Billings supported this suggestion.

Dr. Sein said that retention is easier than recruitment. He said he was interested in developing recommendations for incentivizing retention. Dr. Callins said this could be a focus for mentorship programs and approaches to connecting mentors with students and trainees. Dr. Billings said that Dr. Brown's suggestion at the January meeting to recommend integrating primary medical and dental services at health centers was also relevant to the council's mentorship priority. Dr. Billings suggested that discussions with regional representatives could focus on the future of NHSC mentorship. Dr. Brown agreed.

Dr. Bockwoldt asked whether Ms. Fabiyi-King could recommend a speaker who could discuss HRSA telehealth goals and initiatives. Ms. Fabiyi-King said she would try to identify a speaker for one of the next two council meetings.

Dr. Callins suggested that the APG workgroup members should e-mail each other potential focus areas, compile a list, then meet weekly to discuss what they found in the APGs regarding these topics. Dr. Billings said this was a reasonable approach. He recommended trying to identify areas that would be easy to change quickly to achieve meaningful impact.

Dr. Taylor-Desir reminded the council that the Association of Clinicians for the Underserved (ACU) will host a 50th anniversary gala for NHSC on August 3, 2020 at the Mandarin Oriental Hotel in Washington, DC. ACU also will host a Congressional briefing on NHSC work on August 5 from 10:00-11:00 a.m. Dr. Billings added that ACU will host the gala at the end of its annual conference. He said the gala will celebrate the anniversary of enacting NHSC's authorizing legislation. The keynote speaker will be Eric Redmond, a legislative assistant who played an important role in enacting the legislation. Mr. Redmond will describe the history of gathering bipartisan support to pass the legislation.

Public Comment

Ms. Fabiyi-King invited public comment. There was none.

Closing Remarks

Dr. Billings thanked the council and staff for their contributions to the meeting. He said it is important to advocate for patients and clinicians and to work toward changes that improve population health. NHSC is a vital program for meeting the country's healthcare needs, and NACNHSC should support the program in expanding and improving.

Dr. Billings reminded the council that its next meeting will be in June, in-person. He asked all participants to take precautions to keep themselves, and their staff, family, and patients safe and healthy. Dr. Billings reminded council members to submit their professional headshots to post on the NACNHSC website.

Ms. Stergar and Dr. Taylor-Desir thanked staff and Dr. Billings for their work to facilitate and support the meeting. Ms. Fabiyi-King thanked the council for their work and she said she would send documents requested during the meeting. She invited council members to contact her or Dr. Billings with questions, comments, or requests.

Dr. Callins said that the council had discussed forming a workgroup related to recommendations from rural OB/GYNs. She asked for an update. Ms. Fabiyi-King invited Dr. Callins to send her an e-mail with an information request, which Ms. Fabiyi-King would address. Dr. Callins said she would review the January meeting minutes and send the e-mail to Ms. Fabiyi-King and Dr. Billings.

Dr. Billings asked whether there were any further comments. There were none. Ms. Fabiyi-King adjourned the meeting at 11:45 a.m.

Summary of Motions and Planned Actions

Motions

- Dr. Billings asked for a motion to accept the minutes with requested edits. Ms. Stergar made the motion; Ms. Witzel seconded. The motion passed unanimously.

Planned Actions

- The technical writer will revise the council's letter to the Secretary regarding increased support for NHSC and submit the letter to Ms. Fabiyi-King within approximately a week of the current meeting. Ms. Fabiyi-King will review and forward the letter to Dr. Billings to share with the council for review. Following council approval, BHW will submit the letter to HRSA administration for review. Following HRSA approval, the letter will be submitted to the Secretary.
- Council members will share comments with the APG workgroup about experiences they, their students, and colleagues have had with APGs.
- APG workgroup members will e-mail each other potential focus areas, compile a list, then meet weekly to discuss what they found in the APGs regarding these topics, then develop recommendations for updating or clarifying APGs for the council to consider at the June meeting.
- The APG work workgroup will consider whether and how to update APGs to maximize support for leveraging telehealth.

- Drs. Taylor-Desir, Callins, and Billings will contact their State DRO representatives to learn how they work with NHSC students and sites, then compare findings. (As noted above, a HRSA ethics advisor subsequently notified the Council that communication must be through the Designated Federal Officer).
- NACNHSC will discuss developing a joint statement with NACNEP and COGME to CMS regarding mentorships, and incentives for training in rural areas, including training at FQHCs.
- Council members will review examples of previous NACNHSC annual reports and discuss annual report objectives and content at a future meeting.
- Ms. Fabiyi-King will explore the possibility of inviting speakers from the Teaching Health Center program, Indian Health Services, and the National Advisory Committee on Rural Health as well as experts on telehealth, especially HRSA's telehealth initiative, and Janelle McCutchen to NACNHSC's next meeting.
- Dr. Callins will review the January meeting minutes and send Ms. Fabiyi-King and Dr. Billings a request for information about forming a workgroup related to recommendations from rural OB/GYNs.