Meeting Minutes

National Advisory Council on the National Health Service Corps

June 28-29, 2022

The National Advisory Council on the National Health Service Corps (NACNHSC or Council) met on June 28-29, 2022, via webinar. The NACNHSC is a group of health care providers and administrators who are experts in the issues faced by communities with a shortage of primary care health professionals. The Council serves as a key source of information to the National Health Service Corps (NHSC) senior management, to the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, to 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 Remarks

Designated Federal Officer Ms. Diane Fabiyi-King convened the meeting at 9:03 a.m. Eastern Time. She introduced herself, welcomed the meeting participants, and conducted roll call. Ms. Zuleika Bouzeid provided instructions for meeting participation. Council Chair Dr. Keisha Callins thanked Ms. Fabiyi-King and HRSA staff for their work to set up the meeting. She also thanked the Council members for their attendance. Dr. Callins reviewed the meeting agenda.

Presentation: Addressing Health Worker Burnout: the U.S. Surgeon General's Advisory on Building a Thriving Health Workforce

Teeb Al-Samarrai, MD, MS

Director, Science and Policy, Office of the U.S. Surgeon General

Jeane Garcia Davis, MSN/MPH, RN

Associate Director, Science and Policy, Office of the U.S. Surgeon General

Dr. Teeb Al-Samarrai and Ms. Jeane Davis presented on the recently released publication tilted *Addressing Health Care Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce*. This Advisory sounds the alarm on the pandemic's unprecedented impacts on the well-being of our nation's health workers, including long-standing burnout, systemic challenges, and workforce shortages that existed prior to COVID-19. The publication lays out key recommendations for stakeholders from health care delivery organizations, government, payors, health tech and IT companies, training and academic institutions, accreditation bodies, communities, and other stakeholders.

Burnout is the result of chronic workplace stress due to an imbalance between job demands and resources. Even before the pandemic, health worker burnout was an issue of concern. In 2019, the National Academy of Medicine found burnout had reached "crisis" levels. Studies showed that up to 54 percent of nurses and physicians had experienced burnout, as well as up to 60 percent of medical students and residents. Negative consequences of health worker burnout can include insomnia, anxiety, depression, isolation, substance abuse, and exhaustion.

The pandemic had an unprecedented impact on health worker well-being. More than 50 percent of public health workers reported symptoms of at least one mental condition (e.g., anxiety, depression, PTSD, or suicidal ideation) during the first year of the pandemic. Health workers in rural and underserved urban areas were disproportionately impacted. Across 20 states, 76 percent reported feeling burnout from their work.

The Advisory contains recommendations from a variety of stakeholders including health care delivery organizations; federal, state, and local governments; tribal authorities; academic institutions; health workers; researchers; and the community. The Advisory recommended the following actions:

- Protect the health, safety, and well-being of all health workers
- Eliminate punitive policies for seeking mental health and substance use care
- Reduce administrative and other workplace burdens to help health workers make time for what matters

- Transform organizational cultures to prioritize health worker well-being and show all health workers that they are valued
- Recognize social connection and community as a core value of the health care system
- Invest in public health and our public health workforce

The presenters also informed the Council that on June 24th the National Academy of Medicine's Action Collaborative on Health Worker Well-Begin and Resilience presented their progress in the development of a National Plan for Health Workforce Well-Being.

Discussion

Dr. Michael Sein said that over time as a practicing physician he has seen various changes, such as organizational changes, policies, and other administrative system changes that have led to challenges in attending to patients. Ms. Davis replied that they continue to hear that it is the system changes and the additional burdens that are placed on health workers that impact the time needed to do what really matters when it comes to caring for patients. Dr. Al-Samarrai agreed and emphasized that a multi-prong approach will be needed to get at the root causes and develop long-term strategies.

Dr. David Schmitz asked the presenters if their group had addressed preparedness for serving, specifically in underserved environments. For example, educating those selected to do work on the NHSC on items such as cultural humility, mental health crises, opioid use disorders, medication-assisted treatment, and other aspects that could help prepare clinicians prior to placement.

Ms. Davis thanked Dr. Schmitz for his comment and added that they have a section in the advisory that is specific to academic and training institutions and would welcome him to participate on the matter.

Dr. Bockwoldt said she was concerned because she felt the emphasis is on the worker and not the system, when it comes to burnout. She believes the emphasis must be off the worker. Ms. Davis said that, as a health worker, she agrees that most of the emphasis should not be on the health

worker. Systems need to change the policies and burdens that are often causing clinicians to feel overwhelmed.

Dr. Keisha Callins said that probably everyone in the Council has a story of how the system impacted their ability to take care of their patients and take care of themselves. One of the positive aspects about the pandemic is that it has catapulted this conversation to the forefront. These conversations will hopefully help raise the bar with respect to what is expected from the system.

Presentation: National Health Service Corps Updates
Israil Ali, MPA
Director, DNHSC, BHW, HRSA
Janelle McCutchen, PhD, MPH, CHES
Chief, Shortage Designation Branch
Division of Policy & Shortage Designation, BHW, HRSA

Mr. Israil Ali informed the Council that FY 22 NHSC applications have been closed for all of its six programs. Approximately $850 million have been allocated this year. Current NHSC priorities include: 1) NHSC State Loan Repayment Program; 2) Dedicated support to the NHSC pipeline; 3) Optimizing data utilization; and 4) Establishing outreach to health professional pathway and pipeline programs.

Dr. Janelle McCutchen said that the Improving Access to Maternity Care Act amended the Public Health Service Act to require HRSA to identify Maternal Care Target Areas (MCTAs), with the purpose of assigning maternity care and health care professionals to those areas. An MCTA is an area within a Primary Care HPSA that has a shortage of maternity health care professionals.

More specifically, the Improving Access to Maternity Care Act requires HRSA to: 1) Establish the criteria for MCTAs; 2) Identify shortage areas using the established MCTA criteria; 3)

Distribute maternity care health professionals using the newly-identified MCTAs; and 4) Collect and publish such data.

HRSA has developed the final criteria to identify MCTAs and develop a sub-score. The six criteria include: 1) The population to provider ratio; 2) A population with income at or below the 200 percent federal poverty level; 3) The travel time and distance to the nearest source of care; 4) Fertility rate; 5) Social vulnerability index; and 6) Preconception health index. Each of these criteria will be assigned a relative weight based on the significance of that criteria relative to all others.

Discussion

Dr. Schmitz said he was impressed as to how some of the recommendations made by the Council have been taken to heart and been incorporated into efforts to ensure that NHSC providers are well prepared to serve patients, especially in underserved areas. He asked Dr. McCutchen if family medicine physicians, some of which predominantly provide obstetrical care in some states, would be included in the calculations related to the MCTAs. Dr. McCutchen replied that family medicine physicians are not currently included in those calculations.

Dr. Callins asked how the Health Care Workforce Connector could be leveraged to help in terms of recruitment/retention and being able to connect existing scholars with new scholars. Dr. Ali said the possibilities are endless and that they have a team dedicated to looking at how one can allow those social connections to take place.

Dr. Andrea Anderson asked how family medicine physicians who practice obstetrics factor in the MCTA. Dr. McCutchen replied that family medicine physicians are not included in the population to provide a ratio for the benefits. There is a shortage of OB/GYNs and certified nurse-midwives in certain areas and the long-term goal is to have more of those professionals practice in those areas.

Dr. Schmitz said that family physicians can provide a wide breadth of services, including obstetrical and surgical obstetrical deliveries in a safe manner. Therefore, this could be an

important area of further study. Perhaps it is an area where HRSA could collaborate with the Rural Health Research Centers or other groups.

Dr. Bockwoldt asked if the recent Supreme Court ruling regarding Roe vs. Wade would impact the need or demand for maternity care services in states that no longer have pregnancy termination as an option. Dr. McCutchen said that, at a high level, there might be an uptake of returning-to-care services across the board.

Panel: Exploring Resilience as a Pathway to Recruitment and Retention of Health Care Providers Serving In Rural and Underserved Communities
Tara Brandner, DNP, FNP-C
Moderator and Member, NACNHSC

Bernadette Melnyk, PhD, APRN-CNP, FAANP, FNAP, FAAN
Vice President for Health Promotion, University Chief Wellness Officer
Dean and Professor of Evidence-Based Practice, College of Nursing
Professor of Pediatrics and Psychiatry, College of Medicine
Ohio State University

Tim Cunningham, RN, DrPH, FAAN
Co-Chief Well-Being Officer, Woodruff Health Sciences Center
Vice President, Practice and Innovation, Emory Healthcare
Adjunct Associate Professor, School of Nursing
Emory University

Dr. Bernadette Melnyk, the Ohio State University's (OSU) Chief Wellness Officer, presented on a variety of wellness efforts carried out by the University to address burnout and provider well-being. When thinking of interventions and programs, one must think of both the individual and the organization. Effectiveness increases when individual and organizational interventions are combined. Addressing root causes requires large-scale organizational changes and commitment to resource reallocation.

In 2019, the Board of Trustees approved OSU's 2019-2024 Health and Wellness Strategic Plan. The plan was developed in part to place all of the institution's wellness efforts under one strategic umbrella. The plan includes the following four goals:

- Improve participation in evidence-based programming and interventions so that staff consistently engage in health behaviors and attain their highest level of well-being
- Implement evidence-based practices and continuous quality improvement to decrease chronic diseases and reduce population health risks
- Strengthen the wellness culture and environment, empowering leaders and managers with wellness resources, strategy, and evidence to act upon
- Position OSU as a national/international leader in university wellness through innovating and sharing best practices

The Strategic Plan includes a variety of metrics that can be used to assess each goal. The plan is a multi-component, evidence-based approach with a focus on culture and measurement outcomes. It involves individuals, management, leadership, and the system as a whole. OSU has a University Health and Wellness Council, where leaders from various departments meet once a month to discuss wellness efforts and other related issues.

One of the initiatives at OSU is Buckeye Paws. The initiative was launched in March 2020, with the mission of supporting the mental and emotional health of staff by using trained, certified therapy dog-handler teams. One individual remarked that a dog's presence can "calm people, brighten their mood, and allows them time to decompress, even if only for a quick moment."

Another OSU program is MINDBODYSTRONG. This is an evidence-based program to improve clinician well-being. The program consists of seven weekly sessions (35-45-minutes each) led by a trained facilitator. The aim of the program is to improve mental health and equip individuals with skills that have been shown to reduce stress, anxiety, and depressive symptoms as well as enhance healthy lifestyle behaviors. Backed by 20 studies, participants have demonstrated a significant reduction in stress, anxiety, depressive symptoms, and suicidal ideation after completion of the course.

Dr. Tim Cunningham spoke about the recently stablished Office of Well-Being, which he co-leads. The Office, launched on December 2021, will take the lead in designing and implementing well-being programs to address stressors among clinicians. It will also facilitate system-wide changes, centralize resources, and establish a well-being research foundation.

Emory's Office of Well-Being serves about 35,000 people in 11 hospitals, 250 clinics, and the Woodruff Health Sciences (e.g., Schools of nursing, medicine, and public health). Many of the clinics are HRSA-recognized as rural and underserved clinics. The Office is co-led by Dr. Cunningham and Dr. Chad Ritenour, a urologist and Chief Medical Officer at Emory University Hospital. Both Co-Chiefs report directly to the Executive Vice President of Health Affairs, who in turn reports directly to the University's President. The Office has an advisory Council made up of about 23 members from across the spectrum that will meet on a monthly basis. Council membership prioritizes diversity of profession, diversity of experience, and diversity of ethnicity, background, and culture.

One of the Office's first objectives over the next few months will be to start developing a strategic plan that is expected to be completed by the end of the year. There are various working groups or committees focusing on clinical areas as well as subgroups focusing on affinity groups such as physicians, nurses, clinical support staff, and non-clinical support staff. There is also an Innovation and Discovery Working Group which partners closely with researchers to understand aspects of the current research.

A recent policy change at Emory is the napping policy for nurses and nurse techs. The language has been changed and now states that if a nurse or nurse tech can find a safe place to take a nap during their unpaid 30-minute work break, they are encouraged to do so. The policy is based on that evidence shows the importance of sleep among clinicians.

Discussion

Dr. Schmitz said there has been some research examining the traits of grit vs. ambition in health care providers in rural settings. These may be some of the concepts to consider when preparing NHSC scholars to face challenges and build resilience.

Dr. Callins asked Dr. Melnyk if she could elaborate on the annual assessment of perceived wellness and how clinicians address any deficiencies, such as depression, found in the assessments. Dr. Melnyk said that, as a psychiatric nurse practitioner, she does workshops for nurse practitioners and physicians on how to better screen for and manage mental health issues in children and teens. The USPSTF recommends that clinicians begin to screen once systems are in place, so that they may be able to follow-up on any issues that come up during the assessment.

Presentation: Advancing Health Equity from the American Medical Association
Emily Cleveland Manchanda, MD, MPH
Assistant Professor of Emergency Medicine, Boston University
Director, Social Justice Education and Implementation
American Medical Association Center for Health Equity
American Medical Association

Dr. Emily Manchanda presented the American Medical Association's (AMA) efforts surrounding the advancement of health equity. The AMA launched its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. The three-year strategic plan features the following strategic approaches: 1) Embed racial and social justice throughout the AMA enterprise culture, systems, policies, and practices; 2) Build alliances and share power with historically marginalized and minoritized physicians and other stakeholders; 3) Push upstream to address all determinants of health and the root causes of inequities; 4) Ensure equitable structures and opportunities in innovation; and 5) Foster pathways for truth, racial healing, reconciliation and transformation for the AMA's past.

The In Full Health initiative was developed as a result of the above strategic plan. The Initiative seeks to provide a framework for shared understanding and a community for stakeholders committed to learning and action to center equity within their health innovation investment,

development, and purchasing efforts. The initiative offers a variety of resources to learn and take action.

The AMA also forms part of the National Health Equity Initiative. It is co-led by the Institute for Healthcare Improvement and AMA in collaboration with Race Forward, the Groundwater Institute, and the American Hospital Association. The Initiative is designed to: 1) Mobilize and equip individuals, health care organizations, and health care industry actors with concrete skills and tools to advance equity and racial justice within their systems and communities; 2) Sustainably change mindsets and narratives within health care around equity and racial justice; and 3) Influence and fundamentally change policy, payment, education, standards, and practices.

Along with collaborators, the AMA has developed a series of resources surrounding health equity, including:

- Racial and Health Equity: Concrete STEPS for Health Systems
- LGBTQ Health, Diversity, & Inclusion CME Course
- Prioritizing Equity: The Root Cause and Considerations for Health Care Professionals (Video)
- Prioritizing Equity: Getting to Justice in Education (Video)

The AMA is also supporting health equity in other areas including research and clinical practice.

Discussion

Dr. Callins informed the group that the AMA sponsors a Medical Justice in Advocacy Fellowship. She encouraged everyone to apply.

Dr. Callins said the Council has focused on topic areas of special interest, such as mental health and maternal health. She asked if there were disease- or condition-specific measures that address disparities that exist in health equity from that standpoint.

Dr. Emily Manchanda replied that the AMA's Improving Health Outcomes group has been supporting work specifically around blood pressure control. There are significant racial inequities in the management of hypertension, including hypertension in pregnancy, and the

group is helping support health systems that are interested in understanding how they can do better with respect to inequities. There is also a Maternal Health Working Group within the AMA that is specifically working on inequities.

Presentation: Division of Regional Operations (DRO) Updates and Initiatives
Anne Savage Venner, MA
Deputy Director, DRO, BHW, HRSA

Ms. Anne Venner said the Division of Regional Operations (DRO) is composed of 65 staff stationed across the country that cover all 10 HRSA regional offices. The DRO serves as the regional component of BHW, supporting cross-cutting initiatives and promoting BHW programs. A good portion of its work is focused on supporting the NHSC program. For example, the DRO provides yearly review and processing of NHSC site and recertification applications; management of both the NHSC and Nurse Corps scholar site search (as well as Students to Service participants); and ongoing coordination with state and regional level partners, stakeholders, and health professions schools in support of BHW programs and initiatives.

In FY 2021 alone, the DRO reviewed 4,286 NHSC site applications. Of these, nearly 50 percent were new applications (2154) while the rest were recertifications (2132). During the same year, the DRO conducted 850 virtual site visits, including 68 visits to substance use disorder sites, 149 visits to community health centers, and 122 visits to rural health clinics and critical access hospitals.

In 2021, the NHSC Site Reference Guide was developed. The guide is a technical assistance tool for NHSC-approved sites that are interested in effective recruitment and retention strategies and for new sites needing to establish a recruitment and retention plan. It also outlines ideas for building a resilient workforce.

Elements of the site recruitment and retention plan include: 1) Recruitment; 2) Retention; 3) Resiliency; and 4) Qualitative elements. For example, recruitment elements include outreach methods, onboarding, and site orientation. Retention includes outlining employee benefits,

developing retention goals, and tracking retention rates. Resiliency elements include describing actions that support resiliency and leadership buy-in for burnout prevention efforts. Finally, qualitative elements include having best practices, identifying organizational needs, and periodic evaluations. The DRO conducted a site review of 47 recruitment and retention plans across 9 site types. Results for the review are currently being developed and finalized.

Discussion

Dr. Sein asked if poor retention rates are a criterion for approval when it comes to recertification. Dr. Venner replied that poor retention rates are not included in the systematic review of applications. However, sites do need to have a recruitment plan in place. Also, there is language in the agreement that states that sites need to treat and use NHSC clinicians appropriately.

Dr. Schmitz said he has done work with 3RNET surrounding recruitment and retention. He added that he has published analytical research in the literature that examines assets and challenges related to recruitment and retention. He said he would be happy to share his expertise in the area.

Dr. Bockwoldt asked if there is a way to measure NHSC employee satisfaction and make results transparent. For example, "How many individuals stayed at the clinic once their service was completed? What is the staff retention at the clinic?" This would make clinics to be more competitive about their retention score. Dr. Venner replied that BHW has done some work on retention, but it is at the level of the specific HPSA, rather than at the clinic level.

Presentation: U.S. Department of Health and Human Services (HHS) Initiative to Strengthen Primary Health Care

Shannon McDevitt, MD, MPH

Federal Partner Lead, Initiative to Strengthen Primary Health Care

Immediate Office of the Assistant Secretary for Health (on detail from HRSA), HHS

Dr. Shannon McDevitt presented on a new initiative by the Office of the Assistant Secretary for Health (OASH)—the HHS Initiative to Strengthen Primary Health Care. The Initiative was

launched on September 2021 by the Office of the Assistant Secretary for Health. Its aim is to "Provide a federal foundation to strengthen primary health care for our nation that will ensure high quality primary health care for all, improve health outcomes, and advance health equity." The Initiative supports immediate HHS priorities.

The Initiative's first step will be to develop an initial HHS Plan to Strengthen Primary Health Care. This plan will be submitted to the Secretary in late summer 2022. The plan will recommend an HHS infrastructure for ongoing leadership, focus on ensuring high-quality primary health care for all, and include prioritized, initial actions to be taken by HHS and across HHS agencies. The Initiative has the support of HHS leaders at the highest levels, and includes meetings with the Assistant Secretary for Health, monthly updates for HHS agency administrators, and routine briefings for Secretary Becerra and the Secretary's counselors.

More than 80 stakeholders are involved and they include advocates for patients, professional societies, academia, foundations, provider organizations, payers, and other parties. These stakeholders have been involved in the process through listening sessions to hear about the work they are doing regarding primary care, training, innovative practice designs, and other efforts.

One of the resources being used to guide the process is the 2021 report by the National Academies of Science, Engineering, and Medicine, *Implementing High-Quality Primary Care*. The Initiative will use, as guidance, several of the recommendations from this report. Some of the recommendations listed in the report include the following:

- Primary care practices should move toward a community-oriented model of primary care
- Health care organizations and local, state, and federal government agencies should expand and diversify the primary care workforce, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the workforce with the communities they serve
- The Centers for Medicare and Medicaid Services, the Veteran's Administration, HRSA, and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments
- The Secretary's Council on Primary Care should be informed through regular guidance

and recommendations provided by a Primary Care Advisory Committee that includes members from national organizations that represent significant primary care stakeholder groups, such as patients, certifying boards, professional organizations, health care worker organizations, payers, and employers

Discussion

Dr. Callins asked how the initiative will incorporate strategy to care for the caregivers. Dr. McDevitt replied that they are looking at some models that place the caregiver as part of the health care team. Also, there are digital tools and technology, like telemedicine, that may help reduce the burden on caregivers.

Dr. Charmaine Chan said that grants for primary health care research are usually awarded to large health systems, which makes it difficult for smaller systems or hospitals to participate. Is there a way to help smaller systems participate in this type of research? Dr. McDevitt said they are thinking of how to expand and support practice research networks, including the practice-based research networks previously funded by the Agency for Healthcare Research and Quality.

Presentation: Resilience, Healing, and Wellness for Health Care Professionals

Ann Berger, MD, MSN
Chief, Pain and Palliative Care Service
Co-Chair, Clinical Center Wellness Initiative
Senior Clinical Researcher and Full Professor
National Institutes of Health Clinical Center
National Institutes of Health

Dr. Ann Berger said that, according to the National Academy of Medicine's report *Taking Action Against Clinical Burnout*, about 35-45 percent of nurses and physicians experience substantial symptoms of burnout. In addition, 45-65 percent of medical students and residents experience these symptoms. The report states that there are various factors that affect physician well-being. In the model presented in the report, only two of the eight factors presented are within the physician's purview. The other factors are structural/environmental—these include

organizational factors, health care responsibilities, environment, rules/regulations, and society and culture.

Dr. Berger presented various requirements for wellness programs as well as the design principles for healing environments, including the Healing Environment Design Guidelines developed by the U.S. Department of Veterans Affairs. In addition, she presented two lines of research related to Pain and Palliative Care at NIH: NIH HEALS and the Enhancement of Well-Being for Health Care Providers.

NIH Healing Experience of All Life's Stressors (NIH-HEALS) is a 35-item questionnaire that helps identify factors that contribute to or detract from the positive transformation known as "healing." It is a psycho-social-spiritual measure of healing that assesses positive transformation in response to challenging life events for patients, families, health care providers. The questionnaire was developed by the observation that some patients with life-threatening and/or severe chronic illness report positive psychological, social, and spiritual changes during the diagnosis or treatment of their illness, even in the face of an unfavorable prognosis.

The questionnaire went through confirmatory factor analysis and validation to assess its validity and reliability. In the study, 200 patients with severe and/or life-threatening disease were recruited at NIH's Clinical Center. Results showed excellent internal consistency and split-half reliability (Cronbach's α=0.89). Other studies have shown differences in psycho-social-spiritual healing among men and women based on the NIH-HEALS. Results showed that men and women differed in the Reflection/Introspection factor, with women reporting increased enjoyment of mind-body practices, compassion, gratitude, and a desire to be more positive compared with men. These sex differences should be considered in the development of treatment strategies.

In the area of Enhancement of Well-Being for Health Care Providers, a study examined the effect of a brief mindfulness course on the stress levels of health care workers. The study involved 78 workers who received 5 weekly mindfulness practice sessions lasting 1.5 hours. They were compared to health care workers who did not receive the intervention. The primary

outcome showed the perceived level of stress (assessed with the Perceived Stress Scale) was lower after 13 weeks compared with the initial measurement. The study also showed reduced anxiety, improved positive affect, and improved mindfulness. Another study is ongoing and is assessing the effect of a combined nature adventure and mindfulness program on reducing stress and enhancing well-being among providers who cared for COVID-19 patients.

Discussion

Dr. Callins said that a lot of the work being done is at the clinician level. She asked if there was any work being done at both the clinician and leadership level. Also, how can this be applied to the rural and underserved environments?

Dr. Berger agreed that programs should involve everyone in the hospital, including administrators, and not just providers.

Discussion and Recap

Keisha Callins MD, MPH

Chair, NACNHSC

Dr. Callins asked about the availability of a slide deck regarding the NHSC. Ms. Fabiyi-King said that some NHSC presentations and fact sheets are available on the HRSA website. She added that videos of various NHSC members are available in YouTube. Council members discussed the day's takeaways.

DAY 2

Welcome and Roll Call

Ms. Fabiyi-King convened the meeting and conducted roll call.

Charge of the Day

Keisha Callins MD, MPH

Chair, NACNHSC

Dr. Callins began by thanking all those at HRSA, including Ms. Fabiyi-King, who worked to plan and implement the logistics for the meeting. She asked each Council member to share something that they were grateful for.

Accessing Area Health Resources Files Dashboards

Yahtyng Sheu, PhD

Epidemiologist

Workforce Analysis Branch, NCHWA, BHW, HRSA

Steven Wilber, PhD

Economist

Workforce Analysis Branch, NCHWA, BHW, HRSA

The National Center for Health Workforce Analysis (NCHWA), within HRSA, collects data, conducts research, and generates information about the U.S. health care workforce to inform and support public- and private-sector decision making. NCHWA provides the public with extensive and easy-to-access data on Health Workforce programs.

Drs. Yahtyng Sheu and Steven Wilber presented on the Area Health Resource Files (AHRF). Established in 1975, the files contain aggregated information on health professions, facilities, and utilization, as well as environmental and socio-demographic topics. It is a health resource information database used by researchers, planners, and policy makers.

AHRF contains a comprehensive number of variables—nearly 8000—from more than 50 data sources. AHRF also contains aggregated data on various major domains, including: health care professions, health professions training, health facilities, hospital utilization and expenditures, and other data. These data can be used to evaluate geographic distribution and trend analysis for the health care system.

Every year, NCHWA releases county-level and state/national-level data files. County-level data are obtained from health professional organizations, government surveys, and administrative data. State/national-level data are for the most part derived from the American Community Survey.

The speakers walked participants through the AHRF Clinician Data Dashboard and the AHRF Clinician Diversity Dashboard. The Diversity Dashboard, which has been recently released, contains data from 2015-2019. Additional data will be added in future. The dashboard provides demographic data for 37 different health care professions, and the data can be used to assess how diverse a given profession is in terms of race/ethnicity, age, and sex. The data are provided for each of the 50 states, the District of Columbia, and for the nation as a whole.

Discussion

Dr. Sandra Garbely-Kerkovich asked if the dataset identifies the provider's primary language or the fact that they may be bilingual. Dr. Wilber said he would have to go back and check on the data availability for the language spoken.

Dr. Schmitz said it would be helpful to add the limitations of each dataset, that way researchers will not draw conclusions that may have unintended consequences. This may be especially important for research with small sample sizes or limited-resource environments, such as rural health care.

Dr. Chan said that Guam and Saipan, two U.S. territories, participate in NHSC recruitment. She asked if data is available on these and other territories as they are severely underserved and have the most difficulty recruiting clinicians. Dr. Wilber said the American Community Survey does not include data from Guam, although the Clinician Dashboard does include some limited data on Guam.

Dr. Callins asked if there was a way to identify if the health professional also participates in the NHSC or the State Loan Repayment Program (SLRP). Dr. Sheu said she believed this

information is not in the AHRF data set. Ms. Fabiyi-King said some of those data are available through the BHW Data Hub.

50th Anniversary Paper Workgroups

NACNHSC Members

Dr. Callins and other Council members discussed the titles, development process, and topics to be covered in the 50th Anniversary paper. The paper will be developed through three working groups, each with 4 or 5 members. Details on the working groups, topics, and process are presented below.

Working Groups (WG)

- Accomplishments – Dr. Callins (*Lead*), Dr. Anderson, Dr. Bockwoldt, Dr. Jones
- Adaptations – Dr. Chan (*Lead*), Dr. Brandner, Dr. Khozaim, Dr. Piernot, Dr. Taylor-Desir
- Aspirations – Dr. Garbely-Kerkovich (*Lead*), Dr. Schmitz, Dr. Sein, Dr. Villareal

Impact Paper Topics

- Accomplishments –Historical/Policy
    - NHSC builds healthy communities by supporting qualified health care providers dedicated to working in areas of the U.S. with limited access to care
    - Include a statement about the overall impact of the products; potentially include how many initiatives/policies were created and their result
    - Include reference citations for each area covered
    - Mention that the mission has stayed consistent and has obtained enduring support through multiple administrations
    - There have been significant outcomes as a result of public funding investments (mention that the Council prepared a letter recommending additional funding)
    - In general, review the 2000 NHSC report
- Adaptations–Program Expansion/Policy

    - Growth (disciplines added), telehealth, tele-behavioral health
    - Ability to adapt to various crises that impact care: 911, Zika, Katrina, Opioids, COVID
    - Include MCTA and reference prior 2022 paper on Recommendations
    - Provide citations, links, or show program impact through documentary evidence
- Aspirations –Projections/Policy
    - Impacting interdisciplinary care and the inclusion of dental care and behavioral health care
    - Collaborations
    - Incorporate telehealth and hybrid models (reference the joint letter developed by the Councils)
    - Reference health profession education (e.g., readiness to practice)
    - Mentorship/pipeline expansion
    - Capture the "hearts and minds" of those coming up; consider adding the commitment and benefits of NHSC
    - Community development and community engagement
    - Add a closing paragraph on past recommendations
    - What we would like to see in the future: Seamless communication of documents and information among providers (i.e., coordination of care); list topic areas of future work for the Council from today to the next 50 years (i.e., show the vision)

Potential Working Titles

- Celebrating Commitment, Compassion, and Community
- Celebrating Our Past, Our Present, and Our Future
- Celebrating What We Learned, What We Know, and What We Do

Paper Development Process

- Use a collaborative working platform (e.g., Google Docs)

- Determine a lead that will work with the Chair and working groups

Public Comment

Ms. Fabiyi-King invited public comment. Jasmine Ryans, a family nurse practitioner student from Emory University, thanked the Council for the opportunity to listen and learn.

Discussion, Closing Remarks, and Next Steps

NACNHSC Members

Dr. Callins said that a running theme for the day was that burnout is a systems issue, rather than solely a clinician issue. Each member discussed how the Council could address the issue of burnout. Members were asked to forward any suggestions for topics and speakers for future meetings. Some of the topics offered included: geriatric care, training, mentorship, leadership training, resources for burnout (individual and institutional), the impact of the recent Roe v. Wade decision in access to health care by underserved populations, impact of burnout in the NHSC population, and the use of validated instruments to research burnout and well-being.

Adjourn

Dr. Callins adjourned the meeting.