Meeting Minutes

National Advisory Council on the National Health Service Corps

June 27–28, 2023

Council Members Present

Charmaine Chan, DO, Chair

Andrea Anderson, MD, M.Ed., FAAFP

Tara Brandner, DNP, FNP-C

Debbian Fletcher-Blake, APRN, FNP

Sandra Garbely-Kerkovich, DMD

Deborah Gracia, DO

Kareem Khozaim, MD, FACOG

Edward Sheen, MD, MPH, MBA

Elias Villarreal, Jr., MPAS, DMSc, PA-C, DFAAPA

Health Resources and Services Administration Staff Present

Diane Fabiyi-King, Designated Federal Official

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

Zuleika Bouzeid, Management Analyst, Advisory Council Office

Janet Robinson, Management Analyst, Advisory Council Office

Overview

The National Advisory Council on the National Health Service Corps (NACNHSC or Council) met June 27–28, 2023, via teleconference. The NACNHSC is a group of health care providers and administrators who are experts in the issues faced by communities with a shortage of primary care health professionals. The Council serves as a key source of information to the National Health Service Corps (NHSC) senior management, the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, the Administrator of the Health Resources and Services Administration (HRSA). The NACNHSC was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC

App.2), which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D, of Title III of the Public Health Service Act.

DAY 1

Opening and Welcome Remarks

Designated Federal Official (DFO) Diane Fabiyi-King opened the meeting at 9:02 a.m., Eastern time, and called the roll. HRSA staff member Janet Robinson provided instructions for meeting participation.

Council Chair Charmaine Chan, DO, welcomed the participants, and gave an overview of the agenda. She urged participants to keep in mind that the U.S. Supreme Court would be handing down a decision on affirmative action in higher education, which will affect diversity, equity, and inclusion efforts involving medical and graduate students, among others. Dr. Chan said research indicates that patients have better outcomes when treated by a physician of the same ethnicity. Additional encroachment of politics into the private clinical space between clinicians and their patients is happening on the state and federal levels, she added. As the country emerges from the COVID-19 pandemic, workforce shortages in all levels of health care continue to put a tremendous amount of pressure on many states, especially in rural areas where safety net hospitals are closing. Addiction, gun violence, and mental health issues continue to surface in the news and in policymaking. Maternal and child health continue to worsen, especially among Black and Latino populations. Dr. Chan challenged the NACNHSC to wrestle with these topics and consider how the NHSC can help smooth the way for scholars as they complete their training and start their careers.

Dr. Chan welcomed new Council members. Council members introduced themselves.

Presentation: NHSC Update

Israil Ali, MPA, Director, Division of NHSC

Sean Smith, Senior Policy Analyst, Division of Policy and Shortage Designation, Bureau of Health Workforce (BHW), HRSA, HHS

Israil Ali, MPA, welcomed new Council members on behalf of the BHW. The NHSC continues to focus on improving access to health care providers and addressing the maldistribution of the primary care workforce. Authorization for the program expires at the end of fiscal year (FY) 2023 (September 30, 2023). Following its March 2023 meeting, the Council wrote a letter to the Secretary making the case for continued authorization of the NHSC with increased funding.

The American Rescue Plan Act of 2021 provided the NHSC $800 million over 2 years, which was transformative, said Mr. Ali. As a result, the NHSC reached a peak in field strength; at present, about 20,000 NHSC members provide service to nearly 21 million people in the United States. However, the NHSC predicts a sharp decrease in field strength by the end of 2023, as health care professionals complete their service obligations. Mr. Ali anticipated that more than 6,000 health care professionals would leave the program. With the end of supplemental funding for COVID-19, NHSC will not have enough funding to replace those 6,000-plus people. President Biden's proposed budget requested mandatory and discretionary funding totaling $960 million for NHSC in FY 2024. Mr. Ali was optimistic that Congress would recognize NHSC's role in maintaining primary health care services.

Sean Smith appreciated the Council's letters, white papers, and other efforts to support the NHSC. He briefly described the role of the Division of Policy and Shortage Designation. Mr. Smith summarized recent testimony by HRSA Administrator Carole Johnson and Principal Deputy Administrator Diana Espinosa before Congress in support of NHSC reauthorization during several U.S. House of Representatives committee meetings.[1]

The NHSC has strong bipartisan support in both chambers of Congress, Mr. Smith stated. HRSA testimony focused on the role of Congress in sustaining the NHSC, the historic high number of NHSC providers reaching underserved and rural communities, and the NHSC's remarkable

[1] House Energy and Commerce Committee, Subcommittee on Health, April 19, 2023, "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care"; House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, April 16, 2023, "Oversight Hearing—Provider Relief Fund and Healthcare Workforce Shortages"; House Energy and Commerce Committee, Subcommittee on Health, June 21, 2023, "Responding to America's Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT [Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment] Act"

recruitment and retention rate. Mr. Smith said his team provides Congress with strong statistical data demonstrating the NHSC's achievements and directs congressional staff to the program's public databases, noting that NHSC data are getting better and stronger over time.

Mr. Smith summarized five proposed bills that address NHSC reauthorization, all of which have been referred to committees within their respective chambers:

- The Restoring America's Health Care Workforce and Readiness Act (S. 862) includes a 3-year reauthorization that would double the mandatory funding from $310 million to $625 million in FY 2024, increasing up to $825 million in FY 2026. It also authorizes a new NHSC Emergency Service Demonstration Project with a $50 million set-aside from mandatory funding.
- The Strengthening Community Care Act of 2023 (H.R. 2559) extends NHSC mandatory funding for 5 years (through FY 2028) with no funding level changes.
- The Resilience Investment, Support, and Expansion (RISE) from Trauma Act (S. 1426) extends NHSC mandatory funding for 5 years (through FY 2028) by $50 million each year, with a focus on school- and community-based settings.
- The Health Center Service Expansion and Provider Shortage Reduction Act (H.R. 3080) provides an additional $480 million per year to NHSC through FY 2028.
- The Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act of 2023 (H.R. 3561) extends NHSC funding (at $350 million per year) though the end of FY 2025.

Mr. Smith reminded the Council that proposed bills can be incorporated into other legislation, His office closely tracks the progress of all legislation related to the NHSC.

Discussion

Elias Villarreal, Jr., MPAS, DMSc, PA-C, DFAAPA, said he wrote to his congressional representatives to support NHSC reauthorization. He asked Mr. Smith's opinion on the level of support for the bills under consideration. Mr. Smith emphasized that contacting one's representatives is an excellent step, and representatives take their constituents' input seriously.

He said that the number of bills around reauthorization indicates clear interest in reauthorization; he reiterated that the NHSC has bipartisan support.

Mr. Smith clarified that some legislation focuses on authorization of programs, but separate legislation is needed to secure appropriations, and the two processes run on parallel tracks. HRSA is focusing on reauthorization by the end of this fiscal year. If the NHSC program is not reauthorized by the end of the fiscal year, Mr. Ali noted, NHSC can continue to operate beyond September 30, 2023, until it runs out of dollars, but no new funding would be awarded. Mr. Smith added that a new law incentivizes Congress to finalize appropriations bills by triggering automatic, across-the-board funding cuts if appropriations are not completed by the end of the calendar year.

Andrea Anderson, MD, M.Ed., FAAFP, said that the anticipated departure of 6,000 providers from the NHSC system would have a significant impact on the entire primary care workforce that would be magnified over time. Observing that the NHSC plays a permanent role in the overall health care workforce, Dr. Anderson asked whether the program could become permanent rather than continued to depend on reauthorization. Mr. Ali said HRSA is working to communicate the consequences of a funding lapse by speaking out and making data more transparent. Mr. Smith added that HRSA seeks to express that not reauthorizing the NHSC would affect not only scholars and loan repayors but also the recipients of care, particularly in communities of high need. He had not heard of any move to make the NHSC permanent, although he appreciated the rationale for doing so.

Ms. Fabiyi-King confirmed that the slides presented at this meeting are available to the public online and may be used by any individual to advocate for the NHSC. Mr. Smith suggested that Council members contact their congressional representatives to offer support and, if possible, provide compelling stories that show the decades-long impact of the NHSC.

Mr. Smith emphasized that all of the proposed bills seek the continuation of the NHSC. Council members can use their knowledge and expertise to advocate for whichever approach(es) seems to be most effective. Mr. Ali noted that reauthorization is needed to make NHSC awards for the

coming years; providers already in the system will continue to have support. He also indicated that the NHSC has enjoyed bipartisan support throughout its existence and across various administrations.

Dr. Chan asked HRSA to consider how it could provide NHSC scholars and alumni with information about the bills proposing reauthorization and encourage them to disseminate the information and advocate on behalf of the NHSC. Mr. Ali said the NHSC and HRSA's Division of External Affairs are constantly keeping an eye out for providers who would be willing to testify if Congress invites HRSA to do so, but HRSA does not ask individuals to advocate on its behalf. Discussion ensued about the role of the Council in advocating for the NHSC. Dr. Chan emphasized that at the very least, scholars and loan repayors should be reminded to check the NHSC website periodically for news and updates. Mr. Ali added that he works closely with the Association of Clinicians for the Underserved and the National Association of Community Health Centers, both of which advocate for the NHSC and amplify its messages.

Sherlandra Frink, HRSA Ethics Specialist, pointed out that the Council's work is public. If Council members contact their representatives, they should mention that they are NACNHSC members, for the sake of transparency.

Action Items

- Council staff will seek insights from HRSA experts on ethics and report back to the Council to indicate what steps the Council can take to advocate for the NHSC.
- Council staff will contact the HRSA official who oversees the agency's federal advisory councils to determine whether the Council can propose mechanisms for encouraging NHSC participants to advocate for the NHSC.

Dr. Chan asked for more detail about the proposed NHSC Emergency Service Demonstration Project. Mr. Smith said more information about legislation can be found at www.congress.gov.

Action Item

- Council staff will follow up with Mr. Smith for a synopsis of the proposed NHSC Emergency Service Demonstration Project.

Division of Regional Operations and the NHSC

Jeff Jordan, Director, Division of Regional Operations (DRO), BHW, HRSA

Jeff Jordan said that most of DRO's 66 full-time staff are based in HHS' 11 regional offices across the country. The bulk of DRO's work revolves around the NHSC; it includes reviewing new NHSC site applications and recertifying sites, assisting with NHSC and Nurse Corps job placement, visiting sites to ensure program integrity, and promoting NHSC programs. The DRO reviews new site applications in the spring and recertifications in the fall. It works closely with state primary care offices (which determine Health Professional Shortage Areas, or HPSAs) and takes state recommendations into consideration. Over the past few years, the DRO approved more than 200 emergency sites to manage demands for care during the peak of the COVID-19 pandemic. With the end of the declared public health emergency in May 2023, the DRO is encouraging those sites to apply for approval as new sites. Most of the approximately 21,000 NHSC sites take advantage of more than one of the BHW's loan repayment programs.

DRO staff visit approved sites to assess compliance and provide technical assistance. When the COVID-19 pandemic began, the DRO switched to virtual site visits. Now, in-person site visits are preferred, but virtual visits remain an option. The DRO conducted about 400 site visits in FY 2022 and hopes to increase that number for FY 2023 and beyond.

Much of the DRO's effort is devoted to NHSC scholar placement and ensuring that scholars' preferred sites meet requirements. The DRO provides funding for scholars to visit potential sites in person and pays relocation costs. To promote the NHSC and the BHW's other health workforce programs, DRO staff present at medical schools and professional conferences, working closely with the HRSA Division of External Affairs on all promotion activities. The DRO is conducting a rural outreach pilot program. Later this year, it will begin working on state and territorial strategic plans.

The DRO recently hired a senior advisor to analyze the substantial amount of data gathered from the NHSC and other BHW programs. The office just released its annual report and published NHSC site profiles. Mr. Jordan noted that the DRO cooperates with other federal agencies, such as the Bureau of Prisons, the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration, as well as states.

Discussion

Sandra Garbely-Kerkovich, DMD, asked how to make potential applicants aware of an organization's openings for NHSC participants. Mr. Jordan recommended that organizations ensure their profiles in the Health Workforce Connector are up to date, reach out to the DRO state lead in their region, and communicate with their local primary care association.

Debbian Fletcher-Blake, APRN, FNP, asked what percentage of site applications are approved and what criteria sites must meet. Mr. Jordan estimated that the approval rate is about 90 percent. Sites must offer services on a sliding fee scale and provide services regardless of the ability to pay; sites must have signage communicating both of these policies. All sites must be located in and serve a HPSA. Mr. Jordan explained that site visits seek to ensure continued compliance with these high-priority criteria. The DRO has about 50 staff members who conduct site visits, and each is required to travel to at least 15 sites per year. However, the program has 21,000 sites, so staff tend to prioritize sites that have never had a visit, particularly those with high HPSA scores and those where concerns or compliance issues have been raised.

Dr. Chan noted that Council members have discussed ways to promote NHSC participation through their own mentoring, teaching, and speaking engagements. She encouraged the DRO to consider how outreach efforts can leverage the enthusiasm and experience of NHSC alumni.

Action Item

- Council staff will follow up with Mr. Jordan, who will discuss with the Division of External Affairs the feasibility of sharing the template of key program information that DRO staff use for outreach or developing a new one for alumni who wish to promote the NHSC.

Mr. Jordan said that it is difficult to develop outcomes measures that show the impact of the DRO's outreach efforts. Mr. Ali said feedback indicates that many NHSC loan repayors learned about the program from employers who encouraged them to apply. Mr. Jordan noted that preferred methods of communication change over time; at present, most potential participants prefer text to email and do not like logging in to the Health Workforce Connector. Dr. Chan said such feedback can inform recruitment and outreach.

Action Item

- Council staff will work with Mr. Jordan on presenting information to the Council about the impact of the DRO's outreach and feedback from NHSC scholars and loan repayors at a future meeting.

Remarks from the Chair

Charmaine Chan, DO, Chair, NACNHSC

Dr. Chan explained that the afternoon's presentations would offer a more granular look at novel ways that sites connect communities with services. To set the stage, Kareem Khozaim, MD, FACOG, described his experience as an NHSC scholar in a health center in American Samoa that lacked the resources for gynecologic laparoscopic surgery. Over time, by buying used medical equipment, appropriating unused equipment sitting in storage, and finding creative, inexpensive solutions to obtain other resources needed, Dr. Khozaim set up a laparoscopic surgery service that is still being used, saving local patients hours of travel time and thousands of dollars in travel costs.

Shiprock–University of New Mexico Family Medicine Residency

Heather Kovich, MD, Department of Family Medicine, Medical Education Coordinator, Northern Navajo Medical Center, Shiprock, NM , NHSC Scholarship Program, Class of 2014

Dan Waldman, MD, Vice Chair of Education, Department of Family & Community Medicine, School of Medicine, University of New Mexico (UNM), Albuquerque, NM

Heather Kovich, MD, explained that the Northern Navajo Medical Center in Shiprock partnered with UNM to create a family medicine residency that prepares physicians to provide care in rural

communities. Residents spend 1 year at UNM and 2 years in Shiprock, located in the Navajo nation. The partnership represents the first residency program based within the IHS, and it is supported by a HRSA grant that covers start-up costs.

Dan Waldman, MD, recognized the need for more health care providers to train in rural areas, and added that there was a push to expand UNM's already large family medicine residency program. The partnership with Shiprock came about because so many residents who took part in rotations there reported having good experiences. Dr. Kovich pointed out that Shiprock has a long history of teaching medical students, residents, nurse practitioners, and physician assistants in various specialties at the medical center and its rural clinics. She added that she came to Shiprock in 2009 with the expectation of staying for 2 years as part of the NHSC loan repayment program but has yet to leave.

The HRSA grant requires the program to encourage NHSC participation, so that became part of the recruitment effort. Unique to the UNM–Shiprock family residency program is a Native health curriculum to help providers better understand the community they serve. It includes lectures on topics such as health disparities and trauma-informed care as well as hands-on learning. For example, residents spend time with a traditional Native healer and a local expert on ethnobotany.

To enhance the continuity of patients' relationship with their providers, residents are assigned to a community, where they conduct home visits and provide care in schools and outreach clinics. Residents are also assigned a panel of patients whom they see throughout their residency. Members of the community teach the residents about their local customs, and residents are required to take part in some community activities.

Dr. Kovich summarized the main challenges to initiating the rural residency:

- Sustainable funding: The HRSA grant covers 5 years of start-up costs. Most residents get some funding from the Centers for Medicare and Medicaid Services, and IHS provides some funding.
- Housing: The community has few rental spaces.

- Recruitment: Medical students are often reluctant to go to rural sites or new programs, as demonstrated by match data.

In closing, Dr. Kovich shared a video about the Shiprock community, its medical center, and the residency.

Discussion

Dr. Waldman pointed out that health care professionals are likely to work in the region where they train, but small, rural hospitals face challenges to training, including insufficient housing and lack of community support. Shiprock already had a strong educational program in place for training rotations and a dedicated faculty interested in teaching, so it was a natural fit.

Dr. Garbely-Kerkovich said it can be challenging for new residents to acclimate to a community and for the community to embrace trainees. Dr. Kovich responded that Shiprock's hospital has a robust community health department and many community health workers who link the hospital with local leaders. The remote communities welcomed the residents and requiring trainees to take part in local activities helps cement residents' connections with the community.

Dr. Anderson asked whether there are pathways to encourage local students to pursue health careers rather than recruiting entirely from outside. Dr. Kovich said UNM has a high population of Native students, and some of those pursuing health professions do rotations in Shiprock. There are also programs to mentor students interested in studying medicine. Dr. Kovich said there are some partnerships with local public schools, but she would like to see more. Dr. Waldman added that UNM requires residents to complete a community-based scholarly project; the university also hopes to encourage some of its Navajo medical students to study and practice at Shiprock.

Dr. Anderson pointed out that training rotations in rural areas can be transformative, especially for those who cannot commit to a 3-year residency in a rural location. Dr. Waldman said UNM includes rural care in its curriculum, but funding limits the amount of training in rural areas that UNM can support. Dr. Kovich added that the medical center's most effective recruitment tool is the word of mouth from those who have trained in Shiprock. She appreciated the fresh

perspective that rotating trainees provide, but the residency program allows physicians to see the same panel of patients over the course of 2 years, which benefits the community.

Choptank Community Health System Community Based-Program

Kim Fitzgerald, CRNP, Family Nurse Practitioner, Choptank Community Health System, Denton, MD

Kim Fitzgerald outlined the history of community health care on Maryland's Eastern Shore, beginning with the creation of a federally qualified health center that opened its doors in 1980. Choptank now has seven health centers providing medical and dental care. In 2000, Choptank started offering school-based care, which has since expanded to 32 sites in five counties. The health system is growing its integrative model to include behavioral health care. Behavioral health specialists are working in medical offices and in the school-based clinics. Choptank also provides dental care in the school-based clinics and through a mobile health unit. Choptank has a mobile health care unit that assists with migrant health clinics, serving workers in Eastern Maryland's agriculture sector.

Ms. Fitzgerald described the community needs in the region, pointing out, for example, that one of the counties Choptank serves has no hospital and no emergency care center. A substantial number of students qualify as economically disadvantaged and are eligible for free and reduced meal programs. The school-based clinics are staffed by nurse practitioners and physician assistants, and most sites have interpreters. The school-based clinics provide common medical services, including preventive and acute care. Some clinics have "health chats," during which providers meet one-on-one with students to establish relationships and address lifestyle and behavior choices, even if the student is not in need of health care. Ms. Fitzgerald said students who use their school-based clinics spend more time in class and less time out sick, perform better, and experience fewer disciplinary issues.

Choptank's school-based dental clinics provide oral hygiene and nutrition counseling. Students can be linked to behavioral specialists by the school-based clinic, a parent's request, or a primary care provider's referral. Choptank recently hired a registered dietitian to provide nutrition services in schools; the dietitian also takes part in community events to promote healthy,

affordable food choices. Through one partnership to highlight the availability of local produce, students received $20 vouchers to spend at their local farmers' market or on a farmers' market delivery service created during the COVID-19 pandemic.

Choptank's migrant health clinics reach workers in remote areas. Choptank purchased special equipment to ensure clinicians have internet access while on site, which helps streamline the flow of patient care. Mobile health units allow providers to bring more equipment to the sites so they can offer more services. Translators travel with the health care providers and are sometimes assisted by local community specialists.

Discussion

Edward Sheen, MD, MPH, MBA, appreciated the comprehensive approach to whole-person care in schools and migrant communities. He asked whether dental outreach programs have been able to integrate primary care. Dr. Garbely-Kerkovich, who practices in the Choptank system, said dentists do some screening and counseling around nutrition, weight, and blood pressure, for example. The system is currently revamping its electronic health system so that providers can more easily see patients' medical and dental health information. Through a collaboration to improve prenatal health, Choptank's dental providers taught medical providers how to conduct oral health screening among pregnant patients and when to refer them for urgent dental care.

Dr. Sheen pointed out that cultural differences can affect medication adherence. Although cost and access are recognized as barriers, some patients may also need to build trust in conventional Western medicine and health care providers.

Deborah Gracia, DO, described one novel approach to nutrition: working with the whole family as a group. For example, her organization's Family Fit Club relies on group visits, which expands access beyond one-on-one visits to a health care provider.

Managing Patients with Complex Conditions

Jeffrey Brenner, MD, Chief Executive Officer, The Jewish Board

Jeffrey Brenner, MD, a family doctor and researcher, offered some insights from his work in Camden, NJ, to improve the health of patients with complex conditions. Based on data from a regional health information exchange and a local hospital's billing department, Dr. Brenner hypothesized that comprehensive, coordinated care would reduce the number of admissions of people with complex conditions. He conducted a randomized, controlled trial of 3–6 months of coordinated care by a team that included a nurse, a social worker, and a community health worker. Few care initiatives are supported by randomized trials because they are expensive, time-consuming, and poorly funded. Ultimately, Dr. Brenner's comprehensive model of care coordination did not show a reduction in the cost or utilization of care.

Dr. Brenner concluded that the social and logistic problems that the participating subjects faced were so various and entrenched that even a comprehensive approach to care was not enough. The health care system and all of the systems that affect health—including housing, transportation, addiction, and mental health services—are built to serve the average person, not the outliers. Moreover, systems are often working at odds with each other; for example, a homeless individual may receive a voucher for a place in a shelter, yet be barred from the shelter because of a leg wound.

A fully integrated model of care would have providers who are cross-trained in medicine and behavioral care, work closely together, and collaborate with social services. These providers would also be trained in harm reduction, motivational interviewing, and trauma-informed care, for example. The Ryan White HIV/AIDS Program for people living with HIV is one model of comprehensive care built to serve people with complex conditions. Dr. Brenner proposed that health care systems create a separate track for caring for people with complex conditions, because integrating them into a system designed for average patients does a disservice to the system and its patients.

Discussion

Ms. Fletcher-Blake said her organization is moving toward an integrated model. However, she noted that other systems, like transportation, and social constructs, like poverty, get in the way. Dr. Brenner acknowledged the frustration and encouraged providers to recognize how much

progress has already been made, as evidenced by growing attention to trauma-informed care, harm reduction, and patient-centered care. He stated that as providers and others advance their understanding, systems of care will eventually improve. For people living in poverty, he noted, every system is dysfunctional. Health care providers can strive to offer care with compassion and give their patients a system that works.

If a system created a separate track for providing integrated care to selected patients with complex conditions, Dr. Garbely-Kerkovich asked, how would the system collect data to demonstrate effectiveness? Dr. Brenner acknowledged the challenge of conducting high-quality research for such an approach. Legacy organizations like The Jewish Board, which provides a broad range of health and social services, could be a proving ground for such models, he noted.

Dr. Gracia proposed more preventive care that addresses the family as a whole—for example, addressing childhood obesity in families with a history of hypertension, heart disease, and diabetes. She was skeptical that even a well-integrated system could have a substantial impact if it overlooked prevention. Dr. Brenner agreed and pointed to two promising models. As a result of major reform over 2 decades, New York City's foster care system uses evidence-based models to educate parents and families, which has resulted in a dramatic reduction in the number of children in foster care. Another program, the Nurse-Family Partnership, pairs nurses with women experiencing high-risk pregnancies to provide education and support through the baby's first year, demonstrably improving health and other outcomes for the babies and their families.

Dr. Sheen asked what payment models would best support an integrated approach to complex patient care. Dr. Brenner noted that measuring savings in such populations is "almost impossible," although he added that creating codes to track and pay for all the things providers can do to serve patients more efficiently—such as telephone calls to discuss test results and telehealth visits—could greatly improve current payment systems. Rather than looking at payment mechanisms, Dr. Brenner suggested focusing more on understanding what good care looks like, because it is clear now that lack of coordination of care is not the only barrier.

Dr. Brenner acknowledged that trauma-informed care does not fit neatly into large systems. He explained that a clinician who carves out, say, half a day per week to manage their most complex cases will quickly learn how to provide integrated care and which patients benefit the most. He reiterated that creating separate tracks would improve the entire system.

Dr. Chan asked how Dr. Brenner was able to obtain hospital data for his project in Camden. Dr. Brenner explained that the project started very small, and he had contacts within the hospital who supported his efforts. Getting data is about trust, he noted. Dr. Chan pointed out that building relationships in the community and earning trust are key lessons imparted to NHSC participants.

Public Comment

No public comments were offered.

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

Charmaine Chan, DO, Chair, NACNHSC

Dr. Chan briefly summarized the meeting so far and thanked the HRSA staff for their work in organizing the meeting. In preparation for upcoming deliberations, Dr. Chan asked Council members to consider the day's presentations and review the Council's list of potential topics to address, as depicted in the March 2023 Council meeting minutes.

Several Council members suggested addressing recruitment and retention, with specific attention to whether strategies should vary depending on the type of practitioner.

Mr. Villarreal asked what action has been taken in response to the Council's previous recommendations and calls to action. Dr. Chan proposed creating a spreadsheet to track the progress of Council recommendations.

Action Item

- Dr. Chan will discuss with Council staff how to create a tool to track the response to the Council's recommendations.

The meeting recessed for the day at 4:10 p.m.

DAY 2

Opening and Charge of the Day

Ms. Fabiyi-King, DFO, opened the meeting at 9:04 a.m., Eastern time, and called the roll. Council Chair Dr. Chan offered a reflection about the need for persistence to create change. She summarized the Council's charter.

The National Health Service Corps: Empowering Clinicians for Resiliency and Transformative Care

Diane Fabiyi-King, DFO, NACNHSC, Senior Public Health Advisor, Division of NHSC, BHW, HRSA, HHS

Ms. Fabiyi-King said that the team that developed the Empowering Clinicians for Resiliency and Transformative Care Initiative focused on what NHSC participants need when they are starting their service. Although participants are prepared with didactic and technical training on medical care, they also must understand community engagement, health literacy, cultural and linguistic differences, and a collaborative, multidisciplinary practice model, among many other factors. Through interviews with various stakeholders, the team learned that mentorship was a key factor in the NHSC's high retention rates, but so was a sense of belonging and connection with peers.

Over the course of a year, the team developed and edited documents and videos on the topics of most relevance to NHSC scholars and clinicians. In its first year, NHSC offered professional development opportunities in three series:

- Series 1: Clinician Well-Being and Self-Care (January–March 2023)
- Series 2: Fostering Resilience at the Organizational Level (April–July 2023)
- Series 3: Health Inequities and Social Determinants of Health (July–September 2023)

The NHSC: Empowering Clinicians for Resiliency and Transformative Care offers webinars and evidence-based resources on a broad range of issues under these three topics. NHSC scholars and loan repayors as well as NHSC site administrators can take advantage of all the available tools. The first webinars on burnout and resiliency were very well attended and well received.

Attendees particularly liked opportunities to learn coping strategies from peers and to hear case studies. To date, NHSC has presented five clinician well-being and self-care webinars, six presentations on fostering organizational resilience, covering topics such as understanding stress and leading during a crisis.

The Initiative's upcoming offerings on social determinants of health and health equity center around five tenets:

- Economic stability
- Educational access and quality
- Health care access and quality
- Neighborhood and built environment
- Social and community context

The team recognizes that clinicians are already very busy, so NHSC sought feedback from NHSC participants on what could help them better advocate for health equity in their communities. The team learned that engagement with NHSC is highly valued and sends a message to participants that they matter. The team also heard that participants struggle with the tension between the practice of medicine and the business of medicine. Ms. Fabiyi-King noted that having site administrators and NHSC participants together in webinars has been a good opportunity for both groups to learn from each other.

Discussion

Dr. Sheen asked whether the NHSC has any baseline data on burnout or other mental health challenges that can be used to measure the impact of the Initiative. Ms. Fabiyi-King responded that the team considered baseline data as it crafted this initiative. However, she was not sure how progress would be measured at this time until we have the collected feedback.

Action Items

- Council staff will determine whether the DRO collects data from NHSC participants or sites that could be used to assess the impact of the program.

Dr. Garbely-Kerkovich described the effect of the pandemic on patients and providers. Now that the health care system is no longer in survival mode, she said, more guidance is needed on how to revamp the system post-crisis to address the lingering effects of burnout and mental health challenges. Leadership training is especially needed, she added.

Dr. Khozaim suggested the program should support more targeted, personalized approaches to improve wellness. For example, his employer offers monthly opportunities for its four obstetrician-gynecologists to gather with a facilitator and talk about issues other than medicine, such as work-related challenges and successes. Ms. Fabiyi-King said the program hosts frequent webinars, which include virtual discussion opportunities. The Initiative also offers tools for sites to lead discussions and share best practices.

Ms. Fletcher-Blake asked whether the program could incorporate implicit bias training. Ms. Fabiyi-King said the upcoming series on health equity offers a platform for discussing implicit bias, but there is no webinar planned on the topic. Much focus has been on suggesting coping mechanisms for individuals in sites that lack any such resources. However, Ms. Fabiyi-King said, the program is open to adding new topics and courses. Ideally, Ms. Fletcher-Blake said, implicit bias training is provided for everyone in an organization, but even if it is provided only to clinicians, they will carry that learning forward and raise awareness throughout the organization.

Dr. Gracia noted that providers are often good at advocating for patients but not for themselves, and some feel that voicing their opinions can sound to administrators like complaining. Also, managing expectations—of providers and administrators—is an important part of an effective workplace.

Dr. Gracia suggested that the NHSC disseminate information that clearly demonstrates the benefits of loan repayment, especially over time. Several Council members agreed that new clinicians often look only at salary and not benefits, and they often do not understand how much money they could save in loan interest over the long term by taking a position that offers loan repayment but with a slightly lower salary. Ms. Fabiyi-King agreed that the program could offer

more education about the financial matters that clinicians should consider, particularly those just starting their careers. Such information could also help site administrators and others recruit clinicians.

Action Item

- Council staff will propose that the NHSC create an amortization table that illustrates interest saved over time with participation in a loan repayment program.

Ms. Fabiyi-King explained that the NHSC partners with the Association of Clinicians for the Underserved and others to promote the program. She encouraged Council members to spread the word.

Reports from BHW Council Meetings

NACNHSC Members

Dr. Chan reminded the group of the proposal by previous Councils to increase communication across HRSA's five BHW advisory groups:

- NACNHSC
- Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL)
- Advisory Committee on Training in Primary Care Medicine and Dentistry
- Council on Graduate Medical Education (COGME)
- National Advisory Council on Nursing Education and Practice

At the March 2023 Council meeting, members agreed to attend other advisory group meetings and report back on areas of particular interest to the NACNHSC. Council staff created a template to assist reporting. Dr. Chan said she listened in on a National Advisory Council on Nursing Education and Practice meeting for about an hour and learned that their information about the NHSC was out of date.

Dr. Garbely-Kerkovich summarized the April 17 ACICBL meeting, which included a presentation on the priorities of all of the advisory groups. In brainstorming about topics for its next report, the ACICBL raised issues in three general categories: positioning the public health

system to better anticipate future health care needs, reversing negative trends in workforce recruitment and retention, and incentivizing equity in the health care system—all areas of interest to the NACNHSC. Dr. Garbely-Kerkovich identified some potential topics for discussion between the ACICBL and NACNHSC:

- Development of a simplified NHSC scholarship or loan repayment program to support providers in community-based health care settings
- Inclusion of ancillary care providers, such as dietitians, in loan repayment programs
- Reevaluating the process for loan repayment program reporting (which is burdensome for those working in community-based sites outside of the NHSC site)

Dr. Garbely-Kerkovich also proposed some areas for collaboration between the ACICBL and the NACNHSC:

- Breaking down barriers to recruitment and retention (e.g., limits on the practice of foreign-born clinicians)
- Providing bonuses or incentives to retain clinicians, especially in rural, underserved areas
- Simplifying navigation of virtual job fairs by offering profession-specific tracks

Discussion

Dr. Chan praised Dr. Garbely-Kerkovich's report for exemplifying how attending other advisory group meetings can inform the Council's discussions and strategic planning. The Council reviewed a schedule of BHW advisory group meetings for the rest of 2023, and members volunteered to take part, either by attending some or all of the meeting or reviewing meeting minutes.

Action Items

- Council staff will send calendar reminders to Council members about the upcoming 2023 BHW advisory group meetings that they volunteered to attend.

Public Comment

No public comments were offered.

Council Discussion: Recommendations, Papers, and Workgroups

Dr. Chan observed that the following topics addressed by the Council in recommendations and papers since 2019 have or are being addressed (fully or in part) by the NHSC through policies and programs like the Empowering Clinicians for Resiliency and Transformative Care Initiative:

- Telehealth
- Leadership training
- Mentorship
- Recognition of NHSC's 50th anniversary
- Workforce support and training (preventing burnout, building resilience, telehealth training, and interdisciplinary, team-based care)
- Addressing the need for comprehensive health care services
- Cultural competency training
- Equitable maternal care
- Promoting engagement between NHSC and community partners around social determinants of health
- Modernizing and validating HPSA and Maternity Care Health Professional Target Areas designations
- Promoting recruitment and retention by supporting clinician resiliency
- Improving readiness to provide care in HPSAs

Dr. Chan highlighted some ideas that have been partially addressed, but for which the Council may want to provide additional recommendations:

- Mentorship
- Recruitment and retention
- Collection and analysis of participant readiness data (to inform education and training)
- Development of measures of participant readiness
- Data-driven modernization to improve supply and distribution of the workforce trained in mental health and maternal health care

In addition, Dr. Chan said that HRSA asked for the Council's recommendations on school-based health centers. Council members raised other areas to explore:

- Trauma-informed care
- Addiction and harm reduction strategies
- Expanding the loan repayment program to include nutritionists and other ancillary health care providers
- Environmental medicine (the impact of the environment on health care)
- Integrative medicine and whole-person care
- Best practices for interdisciplinary, team-based care
- Best practices for orienting new clinicians to a site (e.g., developing site-specific materials describing policies, practices, and resources; designating an individual on site as the point of contact for NHSC participants; creating an orientation toolkit or checklists for sites to use in orienting new NHSC participants)
- Impact of Medicaid expansion and the end of pandemic-related Medicaid eligibility
- Behavioral health and navigating confrontation or violence in the workplace
- NHSC reauthorization
- Importance of diversity in the NHSC
- Support for specialty services in rural areas
- Best practices for recruitment and retention in rural areas
- School-based health centers
- Effect of NHSC scholars and loan repayors on a community's health outcomes

Council members discussed the role of the DRO in ensuring that sites are functioning effectively and providing NHSC participants with the tools they need to succeed.

Action Item

- Council staff will ask the DRO to provide more detailed information on the following:
    - The NHSC site application process

- The DRO's initial approval and recertification of sites
- Assessment of sites' ongoing efforts to recruit and retain NHSC participants
- Mechanisms for responding to a scholar's request for support while at a site

Dr. Gracia suggested that the NHSC create a mechanism for participants to learn about federal public health initiatives, such as those around housing, nutrition, environment, harm reduction, and addiction treatment.

Dr. Chan encouraged the Council members to consider how to prioritize topics of interest, with the goal of developing one or two products—such as recommendations or white papers—over the next few months. Once the Council identifies its priorities, it can direct Council staff to seek specific information or conduct a literature review, which will inform the Council's next steps.

Dr. Sheen reiterated the importance of focus and prioritization. He also noted that it would be helpful to assess the scope of problems and determine which are unique to the NHSC, possibly using input from sites and historical data. Ms. Fabiyi-King said feedback from NHSC webinars could provide some insights, and HRSA offices also have data. Dr. Chan proposed gathering data from HRSA's workforce database.

Dr. Garbely-Kerkovich reminded the group of the opportunities to collaborate with other BHW advisory groups. She pointed out that COGME is developing a recommendation about providing specialty services (e.g., oral surgeons; ear, nose, and throat specialists) to patients in rural areas using the NHSC model. The Council could endorse COGME's recommendation.

Action Items

- Council staff will assess how the NACNHSC can collaborate with other BHW advisory groups on recommendations.
- Council staff will determine how many NHSC sites currently offer school-based health clinics.
- Council staff will seek data from the HRSA Office of Rural Health Policy on best practices for recruitment and retention in rural areas.

- Council staff will discuss with HRSA policy experts the options for recommending the inclusion of other health care professionals in the NHSC.

Ultimately, the Council formed three workgroups with the following goals, and those Council members who were still in attendance indicated their preferences for participation:

- **Improving site recruitment and retention** by providing best practices for orienting new employees, creating mentorships, expanding education for administrators, and establishing school- and community-based health sites, among other mechanisms. (Ms. Fletcher-Blake, Dr. Sheen, Dr. Chan)
- **Enhancing scholar recruitment and retention** by supporting scholars and loan repayment program participants through education and guidance on social and behavioral health issues not covered in the medical education curriculum and creating anonymous methods for reporting concerns about a site, for example.
- **Enhancing cooperation with other health care professionals** (e.g., nutritionists); raising awareness of initiatives like the White House National Strategy on Hunger, Nutrition, and Health; and encouraging NHSC sites to expand school- and community-based health care, among other approaches to provide comprehensive, holistic health care. (Dr. Gracia, Dr. Garbely-Kerkovich)

Action Item

- Council staff will reach out to all Council members to determine the makeup of the workgroups. Each workgroup will be asked to identify a lead who acts as the point of contact.

Closing Remarks and Next Steps

Charmaine Chan, DO, Chair, NACNHSC

Dr. Chan said the conversation was invigorating, and she appreciated the substantial input of the Council members throughout the day. She thanked HRSA staff for their work behind the scenes. The meeting adjourned at 2:13 p.m.