

National Advisory Council on the National Health Service Corps (NACNHSC) Teleconference and Webinar Meeting Summary

May 15, 2018 – 2:00 p.m. EST

Health Resources and Services Administration (HRSA)

5600 Fishers Lane

Rockville, Maryland

Advisory Council Members Present:

Adrian N. Billings, MD, Ph.D., Chair

Jodi Adamson

Wilton Kennedy, D.H.Sc., MMSc, PA-C

Daryl S. Salvador, PsyD

Cindy J. Stergar, M.A.

Gwen L.R. Witzel, APRN, FNP, FAANP

Health Resources and Services Administration (HRSA) Staff Present:

Israil Ali, Director, Division of National Health Service Corps

Diane Fabiyi-King, (Acting) Designated Federal Official; Chief, Division of National Health Service Corps, Scholarship Branch

Kandi Barnes, Management Analyst, Advisory Council Operations

Monica-Tia Bullock, Management Analyst, Division of National Health Service Corps, Scholarship Branch

Kimberly Huffman, Director, Advisory Council Operations

CAPT Sheila Pradia-Williams, Acting Deputy Associate Administrator, BHW

Laura Ridder, Ethics Advisor, Office of Human Resources, HRSA

Opening Remarks

Ms. Diane Fabiyi-King convened the meeting of the National Advisory Council on the National Health Service Corps (NACNHSC or the Council) at 1:00 p.m. on May 15, 2018, at the headquarters of the Health Resources and Services Administration. The meeting was held by teleconference and webinar. Ms. Fabiyi-King conducted a roll call. She then noted that this formal NACNHSC meeting is subject to the provisions of the Federal Advisory Committee Act, and all communications associated with this meeting, including public comments, are being recorded. Ms. Fabiyi-King also noted that meeting minutes will be posted on the NACNHSC website after review and approval by the Council Chair.

Ms. Fabiyi-King turned the meeting over to Council Chair Dr. Adrian Billings who began by thanking Council members and federal staff for their time at the meeting. His overall goal is a productive meeting with good ideas to continue to improve the health of the underserved and vulnerable that NHSC shares and cares for. Dr. Billings reviewed the meeting agenda, and then asked Ms. Laura Ridder to begin her presentation.

Ethics and Serving on the Council

Ms. Ridder thanked Council members for submitting their ethics forms quickly, and noted upcoming distribution of new recusal notices and ethics guidance. She also noted the upcoming annual ethics presentation, to be available by web link. She then updated guidance on the Hatch Act as it applies to special government employees who work for the federal government fewer than 120 days a year, on the days they actually serve (e.g., meetings in person or by telephone).

The Hatch Act prohibits federal employees from political or partisan activity while on duty or in a federal room or building. Under the Act, political activity is defined as any activity directed toward the success or failure of a political party, a partisan political group, or a candidate for a partisan political office.

Council members likely have heard ethics information before. However, the Office of the Special Counsel within the Department of Justice updated its guidance since President Trump appointed a campaign manager in March for the 2020 campaign and that means his re-election campaign is in full swing, and the Hatch Act will apply to incumbent President Trump as a candidate for the new election. That means that while serving on the Council or while in a federal building members will not be allowed to engage partisan political activity toward the success or failure of President Trump as a candidate. The restriction covers displaying or distributing items with any slogan from either the 2016 or 2020 elections, and any display of nonofficial pictures of the President.

Ms. Ridder asked Council members to contact her if they have questions about compliance with the Hatch Act or other ethics considerations and forms, and she or a referral will offer guidance.

Ms. Stergar asked for clarification about being able to wear anything while not on duty as a Council member. Ms. Ridder confirmed that is the case, and reiterated the restriction applies to whenever a Council member is on federal property. She added the law was enacted to avoid politically-based coercion of federal employees in their place of work.

NHSC Update

Mr. Ali began by saying that while the Council has not met for a year or more, the timing now is optimal for NHSC's efforts to further address the nation's health workforce for healthy communities.

Mr. Ali noted at the end of FY17 NHSC's field strength was 10,200 clinicians, including medical, dental, and behavioral health clinicians, who every day provide care to 10.7 million people. One-third of current clinicians work in mental and behavioral health and are helping to combat the nation's opioid crisis and serious mental health issues more broadly. One-third of NHSC clinicians serve in rural communities, and more than 90% of the diverse and dedicated NHSC providers continue to work in rural and underserved areas, even after their NHSC commitment is fulfilled.

Mr. Ali noted NHSC's three priority areas for FY 19: a workforce dedicated to substance abuse disorder; expanded telehealth; and value-based clinicians for the NHSC. He summarized each.

The substance abuse disorder workforce is the top priority. NHSC will dedicate \$105 million to support nationwide expansion of substance abuse treatment specifically in rural communities, in addition to planned 2019 funding. \$30 million will be for a partnership with HRSA's Office of Rural Health Policy, targeting communities identified by the Centers for Disease Control and Prevention (CDC) with a high rate of injection drug use. The other \$75 million will focus on expanding the nation's health workforce, including substance use counselors, a new discipline crucial to a substance abuse disorder workforce.

Expansion of NHSC telehealth is another priority, but will be challenged by barriers to providers leveraging telehealth to underserved communities per NHSC's mandate to improve access to providers. It will be necessary to evaluate and measure NHSC's impact as it relates to telehealth, and work with other groups interested in putting telehealth at the forefront of access to care.

The third priority is value-based NHSC clinicians, based on how those who train in community-based and underserved settings are more likely to practice in similar settings. NHSC will evaluate the characteristics that make clinicians likely to remain, to determine how to leverage their experience and predict who is providing transformative care. Also, loan repayment awards should be prioritized to clinicians with prior training in community-based settings. Another goal will be to establish linkages with the Bureau of Health Workforce Titles VII and VIII programs to make sure trainees matriculate into the NHSC to provide for vulnerable communities.

Discussion

Ms. Jodi Adamson asked for a recap of the professions trained under Titles VII and VIII programs, and acknowledged it likely is a wide range. She added that it is great for NHSC to work with BHW and those programs, especially for loan repayment. Mr. Ali said details of that are available from CAPT Sheila Pradia-Williams, but he mentioned a primary care training and enhancement fellowship program that is looking to support individuals known as 'primary care champions' to develop the competencies needed to be transformative in their communities. This effort is in collaboration with the Division of Medicine and Dentistry. Also, BHW is evaluating which trainings benefit NHSC, including ways to incentivize continued service in underserved communities.

Mr. Ali noted the list of professions is large, and he will share it with the Council sometime after this meeting, **ACTION ITEM**, and remain available for further discussion.

Dr. Adrian Billings asked about the timing and nature of expanded eligibility for substance use disorder counselors. Mr. Ali noted it is an FY19 investment, and work is ongoing with certification bodies and other stakeholders to understand what substance use counselors will be eligible for NHSC.

Dr. Billings asked for elaboration on telehealth expansion, and whether NHSC is looking at programs such as the Extended Community Health Outreach (ECHO) program begun in New Mexico, and now active nationally. He noted loneliness and isolation in rural frontier areas is due, in part, to no nearby specialists to help with specific needs. Virtual connection between

providers and patients would decrease isolation and loneliness that some experience routinely. Mr. Ali noted telehealth expansion and consultation about ECHO with the Office of Rural Health Policy. However, NHSC's legislation about actually serving a community could restrict telehealth expansion. He also noted questions exist about telehealth in a comprehensive care setting, since some telehealth is about in-home care. Mr. Ali also noted working with the Office of the General Council to look for flexibilities within NHSC's statutory requirement.

Bureau of Health Workforce Update

CAPT Pradia-Williams began by thanking Council members for their valuable work. She noted the Bureau has over 40 programs working to meet its tall vision and mission to support workforce education and training that will connect skilled health professionals with underserved communities and populations. She added much of the Bureau's programs address the pipeline of future health professionals. Pipeline efforts include scholarship and loan repayment programs, grants, centers of excellence in health profession schools, a health career opportunities program among community-based settings, undergraduate and community colleges, and scholarships for disadvantaged students already accepted to health profession schools. Also, a key Bureau goal is to target underrepresented minorities and disadvantaged populations to help increase health workforce diversity.

The Bureau also works with area health education centers to support clinical rotations and training in community-based settings in underserved communities. The Bureau has a faculty loan repayment program, and training and education programs for specific aspects of healthcare, such as geriatrics, oral health, mental and behavioral health, and nursing. Also, the Bureau supports experiential longitudinal rotations based on strong evidence that people who train in certain types of areas are more likely to practice there or in similar settings. The evidence is that 95% percent of NHSC clinicians continue to practice in underserved areas up to two years after completion of service, and 43% of funded graduates across programs are employed in underserved areas after they graduate. Apparently, serving as an NHSC provider is a very good retention tool, and the goal is to link education and training to service.

Other Bureau programs include teaching health centers for graduate medical education and residencies for primary care residents who get familiar and become immersed in community-based primary care; and a children's hospital graduate medical education program, which trains a lot of pediatric residents, and sub-specialty fellowships.

CAPT Pradia-Williams noted the Bureau's national practitioner database that while not directly related to workforce development supports workforce and health quality in community health centers and hospitals. She also noted the National Center for Health Workforce Analysis (NCHWA) that collects and analyzes data to advance modern health care in general, and specifically support telehealth, team-based care, and integration of behavioral and mental health into primary care. The NCHWA look at needs, utilization, demand, and deficits for health professionals based on supply and demand models to optimize program direction, investment, and modernization (e.g., team-based care, integration, community-based academic partnerships, non-traditional community partnerships, and telehealth) within its current legislation. The Bureau also looks at provider distribution numbers and trends, in general and in light of

important developments (e.g., the opioid crisis).

CAPT Pradia-Williams noted a funding increase in FY18, and how in FY17 the Bureau's programs under Titles VII and Title VIII awarded more than \$1 billion and provided training for over 575,000 future and current health providers in 8,400 training sites, mostly rural and underserved communities.

CAPT Pradia-Williams concluded her presentation by noting her appreciation for how the Council's valuable expertise and insights will help BHW stay on target. She thanked Council members for their time commitment, involvement, and good work.

Discussion

Dr. Daryl Salvador asked what limits and barriers on telehealth were removed in FY18. Mr. Ali replied that the limit was 25%, or eight hours of direct patient care, but based on stakeholder input more flexibility was allowed and now with the FY18 competition providers are able to provide telehealth for up to 100 percent of their actual service time. However, a key barrier under review is whether telehealth as a modality of care meets the requirement to serve in an area with a HPSA score of 14 or higher.

Dr. Billings asked whether NHSC or BHW is working to resolve challenges with appropriate billing for telehealth, including with respect to potential loss of productivity or revenue for health centers. Mr. Ali noted that billing is among stakeholders' top concerns. Reimbursement for telehealth varies from state to state, and Medicaid's role is not clear. That makes it a challenge to establish policy for a national program. Further, the National Governor's Association has expressed concern over telehealth and reimbursement, including notice that despite a need for it, some states (e.g., Nevada) do not have telehealth programs due to lack of reimbursement. Therefore, NHSC and the Council should consider solutions since interest in telehealth exists among providers.

NACNHSC Future Priorities – General Discussion

Substance Use Disorder

Dr. Billings said states are interested in a substance use disorder workforce, and since NHSC is considering implementation of that in FY19 and FY20 the Council should address it. Ms. Cindy Stergar agreed that a substance use disorder workforce is an important topic being addressed in her state (Montana). However, definitions and licensing of relevant specialists varies across states, and in some cases various substance use disorder staff are not licensed. She would like the Council (or HRSA) to offer guidance on licensing for a substance use disorder workforce, including different levels.

Mr. Ali replied that it would relate specifically to substance abuse counselors or addiction counselors, and NHSC is considering Master's level counselors as outlined in the report language for the 2018 Consolidated Appropriation Act. He noted that a broader view would include providers doing medicated-assistant treatment (MAT) in various settings as part of NHSC's

addition of opioid treatment programs as evidence-based care. However, one challenge will be that some members of that care team (e.g., community health workers) will not be NHSC-eligible, though overall NHSC can play a huge role in that total care team.

Ms. Stergar asked whether consideration has been given to additional certification for primary care physicians to treat addictions, beyond granting waivers to allow MAT with buprenorphine, as part of team-based care. Mr. Ali replied that NHSC is looking at additional certification for physicians as addiction specialists. He noted a key internal task is to identify sources of addiction counselor certifications and providers who hold them. During the last application cycle the Corps gained a better understanding of that, and saw it included many nurse practitioners. Previous NHSC involvement has been constrained by the credentialing complexity and the Council should support efforts to move forward.

Dr. Billings noted his area has no dedicated substance abuse counselors with specific training on opioid dependence. He asked how much of the \$75 million Congressional funding is available for debuting this essentially new discipline at NHSC sites including the community health centers eligible for loan repayment. He also asked whether any of that money could be distributed to NHSC sites for recruitment, especially to pay for salaries or additional training, and to inform underserved communities and populations about this new type of service.

Mr. Ali replied that BHW's Division of External Affairs will promote the extension of services into substance use disorder. Those services will be evidence-based and funded through the \$75 million. Also, the Corps will continue to educate itself on treatment and certification, and will look to create better partnerships with certifying boards.

Ms. Stergar noted that while opioids have been identified as a national crisis, alcohol remains the number one killer in many rural locations. Therefore, a key challenge is an insufficient pipeline of Master's level clinicians trained to treat those dual threats, and it is good to target scholarships to those who can do so. She asked for thoughts about how to invest in the pipeline, especially for future Master's level providers in rural areas where currently they are few and far between. She added methods such as telehealth and team-based care will help, as will health coaches and peer support since the latter is probably a substantial piece of evidence-based care for substance abuse disorders.

Mr. Ali noted the Title VII Area Health Workforce Enhancement and Training Program and supplements dedicated to substance abuse counselors. This support will help bolster the pipeline of providers for substance use disorder. However, one of the challenges is that as people do fellowships and additional training they are not able to wait for an NHSC opening to work in an underserved area so they go to other types of communities. The Corps is looking at how to create linkages between NHSC and behavioral health workforce enhancement and training programs.

Dr. Billings said recruitment of substance use disorder professionals will be a challenge for both rural and urban underserved communities. Telehealth could help, though would not be an ideal solution. Ms. Stergar reiterated the barriers around telehealth, especially varying rules across states about what constitutes a visit and unclear billing. However, the opioid crisis could drive

telehealth forward as a way to meet demand for services to address the crisis, especially in rural and frontier areas. Mr. Ali agreed with Ms. Stergar and noted that telehealth billing differences across states is a barrier to care but telehealth could help address crises in substance abuse and other issues exacerbated by limited access to care. He added that solving billing issues will help remove the barrier to telehealth and optimize health delivery for vulnerable populations.

Ms. Joni Adamson noted in her state (Missouri) some providers are certified for substance use disorder but do not have sufficient training or credentials to bill Medicaid or private insurers for those services. This restriction applies to direct patient care or telehealth. While patients receive team-based care at patient centers the centers struggle to find ways to pay for some of the providers. Centers must be creative. Often they use licensed professional counselors or social workers who can bill in those settings, but if too much of the care is inpatient it can jeopardize NHSC eligibility. Overall, it gets very tricky with some of these counselors that do not have a certain amount of training. Mr. Ali noted that the Corps is looking at the types of settings, and as part of the \$105 million investment is considering a broader definition of comprehensive primary care to include substance use disorder. Those things are being discussed in hope of developing a solid plan.

Ms. Adamson asked for clarification on the \$30 million investment (out of the total \$105 million) for loan repayment for rural community opioid response. Mr. Ali replied that the \$30 million is for a partnership between NHSC and the Federal Office of Rural Health (ORH). It will be a loan repayment program that will allow ORH to look to NHSC for health workforce support. While details are still being ironed out, it will greatly bolster ORH investments with their grantees.

Dr. Billings asked that while much of the discussion has been about treatment of opioid dependence once it is an issue, could some of the money be used for prevention. As a family medicine physician he thinks a lot about prevention within vulnerable populations at all levels of their education (elementary/middle/high school, and college) and as adults. He also noted the importance of ensuring that clinicians are properly informed about diligent and responsible opioid prescribing in primary care, emergency medicine, and dentistry. He asked whether clinicians and members of the public (especially young people) are receiving sufficient education for their roles in preventing substance use disorders.

Mr. Ali agreed that Dr. Billings makes a great point. He noted the Bureau is looking into prevention, in part to better leverage its investments in communities. However, NHSC-specific funding is restricted to providers who can serve underserved communities. Fortunately, funding for FY19 and FY20 includes a broader framework of who to consider in NHSC's investment and that could pave the way for partnerships to help communities, specifically with ORH. Such partnerships will help boost the necessary workforce even though it might include disciplines not eligible for NHSC.

Ms. Stergar suggested HRSA consider requiring teaching health centers to include training in MAT for family practice residents as part of the battle against the opioid crisis. Ms. Adamson asked whether that means potentially the teaching health centers requiring a waiver from within the funding request. Ms. Stergar said yes, perhaps teaching health centers could ensure that all

of their residents received training in MAT as part of compliance with GME and accreditation requirements. She added it could become a standard operating component of primary care since many physicians and other clinicians do not have it. She noted the American Society of Addiction Medicine will provide training in Montana to build a larger MAT cohort in the state, but other states are further along. This could help leverage NHSC funding to help build the pipeline through teaching health centers and GME to help address the crisis.

Mr. Ali agreed that is a great point. He noted that while teaching health centers are not under NHSC purview, the Corps works closely with the Division of Medicine and Dentistry who oversees the teaching health center investment. He added this can be an example of linkages within BHW where discussions are outside of NHSC but shared across other programs, and this is an opportunity for internal discussions about how that could happen. Ms. Stergar added this Council's recommendations will be important for this issue, and asked whether Council members are interested in pursuing it.

Dr. Billings said it is a great idea. Potential discussion partners include the American Council for Graduate Medical Education, the American Family Medicine Residency Director Association, the American Academy of Family Physicians, and the Director of the Teaching Health Center Program. The dialogue should be about whether to make substance use disorder treatment a required part of family medicine training since it is neither currently required nor a portion of most family medicine residency programs. Also, the effort should extend beyond physicians to include nurse practitioners, physician assistants, and others. Dr. Billings also said NHSC sites should be incentivized (the carrot) to provide substance abuse disorder treatment more than punished for not doing so (the stick).

Mr. Ali noted that incentivizing sites is always a consideration, especially since for the most part they are not under contract. The NHSC statute has opportunities to support sites, such as the allowance for recruitment. While it may be possible to loan them money, it is not clear whether sites would want to go into further debt to the federal government. The Corps should explore opportunities within the statute to leverage and incentivize more sites to provide substance abuse treatments and services in addition to the FQHCs already receiving funding to do so.

Ms. Stergar added integration and team-based care at FQHCs often includes behavioral health and substance abuse disorder, but FQHCs all over the United States are at different points on that continuum. It could be important to use the words "such as medication assisted treatment," to help strengthen understanding of approaches to care. This will in part help address the lengthy process centers face in determining how to do MAT, including the need for waived providers and team approaches. Plus they need discussions with emergency physicians. In addition, they need to work with dentists who do not treat substance abuse disorder but are involved per the American Dental Association (ADA) promotion of appropriate prescribing.

Mr. Ali said that while the ADA is a strong advocate for dentists the role of dentists and the ADA in substance abuse is not clear, especially for early detection and referrals. Part of the uncertainty stems from how dentists are not granted the same waivers as physicians, NPs, and PAs. The role of dentists is a frequently asked question, and perhaps the Council can offer some clarity, but if not that would be just another example of the roadblock he has encountered on this

issue. Dr. Billings replied that he is not aware of dentists being lookouts for the issue, but dental practice can change such as the recent addition of checking blood pressure prior to preventative cleaning or fillings. Therefore, perhaps the dental community could be recruited to look for substance use disorders and discuss it with patients or refer them to services, though may need some sort of incentive due to their already hectic schedules.

Ms. Stergar noted she sits on the ADA's Commission of Dental Accreditation. The body promotes appropriate prescribing, and inter-professional training. Also, FQHCs are fully integrating oral health and primary care to make screening for depression and substance use as common as testing blood pressure. In many cases dental staff, not just the dentists, engage screening. Also, some private, rural dentists are part of that inter-professional mix even though they are not co-located or a part of an FQHC or similar setting. Also teaching health centers and dental schools now have curricula around appropriate prescribing in light of the opioid epidemic. While these might be small steps, everyone should be moving in the same direction.

Ms. Adamson noted that some dentists are involved in screening for substance abuse based on published literature about how patients with substance abuse disorders likely have more tooth decay and periodontal disease than "the general population." So, oftentimes, dental professionals can tell a history or a current use pattern based on the condition of the teeth. Further, health centers are reporting that people are presenting with oral health problems due to medicines or drugs, legal and illegal.

HPSA Designation

Ms. Stergar asked for clarification on rural HPSA designations in light of FQHC concerns that automatic HPSAs were going to be based on U.S. Census data versus more local-specific data, and that there would be a huge shift for many historically high-need areas. She added the issue has long been a topic of discussion. Ms. Diane Fabiyi-King replied that Ms. Stergar should follow up with her about that question, and it could potentially be on the agenda for the Council's next meeting if the Council feels it would be of interest. Dr. Billings said it is an important issue because of how the change will affect the workforce. Ms. Fabiyi-King agreed to add the issue to the Council's agenda. **ACTION ITEM.**

Partnerships, Linkages, etc.

Dr. Billings discussed great success between academic health centers and providers in sparsely populated west Texas despite great physical distances. Academic ties and collaboration have helped providers stay smarter and improve patient care due to the inclusion of trainees. It is a two-way street for education between providers, trainees, and leadership. This has enabled establishment of a rural training track, including residency, for family medicine. Further, several providers returned to the area after education and residency elsewhere. Academic ties for education, service, and research are important for underserved areas and clinics, though a key question is how to get schools for NHSC-supported disciplines into clinics for training. Other key questions are how to improve and expand the Teaching Health Center program, and how can community health centers be convinced that education is as important as providing patient care.

Dr. Billings added that isolation is as much a concern in urban areas (e.g., Bronx, NY) as rural (e.g., Alpine, TX) and ties between trainees and academic centers, and colleagues in and beyond one's community, foster collaboration. He would like to see more of an academic tie with the NHSC and training institutions, though it is not clear what that would look like. While not everybody is an educator and not everybody wants such ties, there are many benefits to having trainees at a clinic site.

Mr. Ali said Dr. Billings' points resonate with BHW's mission since the Bureau is looking at academic partnerships and linkages, and service through a lot of the Title VII and VIII programs. It goes a step further with NHSC when considering how it can support continued education for providers who are under service contracts. A question is what that would look like. While the Scholarship Program has some opportunities to support continued fellowship after residency and other post-graduate training, the Corps could do better with support for continued education for loan re-payers while they are in service. He welcomed additional ideas from the Council.

Ms. Stergar agreed with the importance of the tie in, and noted confusion over stumbling blocks in her state (Montana) regarding affiliations and connectivity with GME requirements and hospitals in rural and frontier areas. She would like this to be a topic of Council discussions, since it would be important to see formal connections between critical access hospitals and medical school residencies, and it will be important to discuss solutions to problems around GME requirements and the connections. Mr. Ali suggested contacting the Division of Medicine and Dentistry to work on this issue with the GME program and teaching health centers, including to hear the challenges and discuss more linkages across the program.

Ms. Gwen Witzel asked about the status of the former NHSC program called SEARCH that combined medical and NP students in a learning program in support of rural health. She said her personal experience was that it was a very valuable way to get providers and students into rural communities to deliver team-based care.

Ms. Fabiyi-King replied that while SEARCH no longer exists, tenets of the program are still resonating in states where it existed. Approximately 23 states had adopted SEARCH supported by NHSC and they are identified on the Corps website though it is not necessarily an NHSC program. People often ask about SEARCH, including at NHSC virtual job fairs. While the program itself is not likely to be resurrected, the Council can discuss ways to replicate some of its efforts for curricula and training. Dr. Billings agreed and said it is important to get people into underserved clinics, urban or rural, as soon as possible in hope of their starting a lifelong career in underserved primary care. Ms. Fabiyi-King said the topic will be put on the Council's discussion list. **ACTION ITEM.**

Criteria for Loan Repayment Awards

Ms. Adamson noted the vetting of loan repayment applicants is not as stringent as it is for the Scholarship and Students to Service (S2S) Loan Repayment Programs in terms of demonstrating long-term commitment to underserved communities. This is not referring to the scholars and S2S participants who enter the loan repayment program to help with debts after their initial service obligation. She would like to see just a little more vetting of loan repayment candidates.

She suggested looking for experience with various programs under Title VII or VIII, AHECs, the ORH, or states as indicators of commitment to underserved areas and therefore criteria to include in awards. She added that doing so would help with retention. To her knowledge, nothing like that is built into loan repayment at this time, except for being from a disadvantaged background.

Mr. Ali agreed that it is important to leverage Title VII and VIII programs and provider training to frame the characteristics of those likely to remain in an underserved area. The Corps is evaluating how to do that and looking to ensure loan repayment awards go to people that are not just happy to receive \$50,000 but who will make transformative change in a community. The Corps wants to support ideal candidates for the specific types of communities served, including with appropriate cultural competency. It is not an easy task, and the Corps is working on logic models and is working with the National Center for Health Workforce Analysis on a framework and defining language. Perhaps the Council can help ensure the Corps stays on track with that issue. Ms. Adamson added that it is good that many programs have the same definitions for things like underserved since that will help remove barriers to more effective award criteria.

Telehealth Revisited

Dr. Billings reminded everyone that issues with telehealth billing occur in care both related and not related to the opioid crisis.

Summary of the Day

Dr. Billings noted being enthusiastic and eager to do more work and practice what he tells medical students and residents practicing medicine outside the exam room. This meeting was a great example of what is important in terms of providing a daily impact on patients, for serving as advocates for their health care in venues such as this, and to being clinicians and leaders in communities, counties, states, and nationally. Dr. Billings said he is enthused from hearing Council member thoughts and the presentations, and he thanked everybody again for their time, thoughts, and intellect.

Dr. Billings noted he learned a lot from this meeting. He cited the great presentation and guidance from Ms. Ridder and the important updates from Mr. Ali and CAPT Pradia-Williams. He also thanked all of the federal staff for their leadership, insight, and efforts that truly are helping take care of patients in the field, even though it may be difficult from Rockville to feel that impact.

Dr. Billings reiterated the Council discerned four priority areas:

- a substance use disorder workforce, including funding for it;
- academic partnerships, especially to combat loneliness and isolation among providers in underserved areas, and a rekindling of SEARCH Program components to get student trainees into underserved sites early in their training to help grow a culturally competent and enthusiastic workforce for underserved areas;
- stronger vetting for loan repayment applicants to fund clinicians willing and able to provide a transformative experience for their clinic and their communities, and improve retention;

- address barriers to telehealth, especially billing and reimbursement.

Ms. Fabiyi-King said her staff will put together the list of identified topics and likely send it to Council members for a vote to perhaps narrow it to two specific topics for deeper discussion, including possibly via small workgroups across the year in preparation of larger discussions at a meeting of the full Council. She will ensure the information is distributed for vote. **ACTION ITEM.** She also asked Council members to look for future electronic meeting announcements and RSVP requests (e.g., the Doodle System).

Closing

Mr. Ali said everything was covered in the summary, and NHSC is eager to align its programs with the need of the community. He thanked Dr. Billings for his leadership at the meeting and said he did an excellent job as Chair in terms of making sure the meeting stayed on track. Mr. Ali thanked the Council members for their valuable and informative insights, and noted that he learned a lot at the meeting and its content will give him and his staff things to think about and address as they try to make informed decisions on next steps.

Dr. Billings said attendees at this meeting are part of a team, and no one is any more important than any other worker. The group is stronger as a team than as individuals, and certainly more is accomplished together than can be done apart. He encouraged everybody to keep fighting the good fight for patients, and thanked everyone for their time.

Dr. Billings reported that there are no public comments and therefore the meeting can adjourn. He again thanked everyone for their time, intellect, efforts, and insight. He will look forward to reconvening either via teleconference or in person. Ms. Fabiyi-King thanked Dr. Billings and Council members. She said she hopes to see everyone in a face-to-face meeting next time, and will send information about that. **ACTION ITEM.** She thanked everyone again for their insight and presence at the meeting.

The meeting adjourned.