Meeting Minutes

National Advisory Council on the National Health Service Corps

November 14–15, 2023

Council Members

Charmaine Chan, DO, Chair

Aaron Anderson, DO

Andrea Anderson, MD, MEd, FAAFP

Tara Brandner, DNP, FNP-C

Sheri-Ann Daniels, EdD

Jihan Doss, DMD, MPH

Debbian Fletcher-Blake, APRN, FNP

Sandra Garbely-Kerkovich, DMD

Deborah Gracia, DO

Kareem Khozaim, MD, FACOG

Shawn McMillen, MPA, ASUDC

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

Kim Huffman, Director, Advisory Council Operations

Overview

The National Advisory Council on the National Health Service Corps (NACNHSC, or Council) met November 14–15, 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 10:02 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 pointed out that today's challenges around health care echo those described in a document from 1927. Dr. Chan encouraged participants to focus on action, saying, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has," a quotation attributed to anthropologist Margaret Mead.

Dr. Chan welcomed new Council members Aaron Anderson, DO; Sheri-Ann Daniels, EdD; Jihan Doss, DMD, MPH; and Shawn McMillen, MPA, ASUDC. Council members introduced themselves. Representatives of each of the Council's three workgroups briefly outlined their efforts. Ms. Fabiyi-King described the various vehicles the Council uses to communicate recommendations and insights to NHSC and HHS leadership. Dr. Chan reminded Council members that, as special government employees, they may take part in political advocacy as personal citizens but not as representatives of the NACNHSC.

Action Item

- HRSA staff will send the agency's ethics guidance to Council members via email.

Via chat, Dr. Aaron Anderson shared a recent article from *Medical Xpress*, "Efforts to Attract Physicians to Underserved Areas Aren't Working, Says Study," and a link to the source study, published in *Health Affairs*, "After 50 Years, Health Professional Shortage Areas Had No Significant Impact on Mortality or Physician Density." Via chat, Elias Villarreal, Jr., MPAS, DMSc, PA-C, DFAAPA, expressed concerns about the generalizability of the study results, but said the conclusions draw attention to some needed topics. He believed that some response to the findings is in order, specifically regarding physician demographics and more inclusive geographic locations.

Presentation: Bureau of Health Workforce Update

Sheila Pradia-Williams, RPh, MBA

Deputy Associate Administrator, Bureau of Health Workforce (BHW), HRSA, HHS

Sheila Pradia-Williams, RPh, MBA, welcomed new Council members on behalf of BHW. She outlined the President's proposed budget for fiscal year (FY) 2024, noting that Congress has not yet passed a budget for FY 2024. Funding and authorization for HRSA's mandatory programs are set to expire on November 17, 2023. Programs are operating under a continuing resolution, which provides funding at the same level as FY 2023. The President's proposed budget signals support for the NHSC and implementation of Maternity Care Target Area (MCTA) scores into HRSA award designations, among other topics. HRSA has requested a 3-year, $2.37-billion reauthorization of the NHSC, a crucial program for improving health equity in underserved communities.

The NHSC seeks to address the maldistribution and supply of health care providers by investing in recruitment and retention, supporting community-based training, and incentivizing providers to work in high-need areas. BHW published its updated projections of health workforce shortages through 2036, which anticipate that the number of primary care physicians, obstetrician-gynecologists (ob-gyns), dentists, and behavioral health care providers will be insufficient to meet demand in coming years. In some cases, BHW does not have good mechanisms to estimate unmet need, so its projections may overstate the supply. The projections highlight the need to strengthen the health workforce through education, training, and service.

In the 2021–2022 academic year, largely thanks to a bolus of funds from the American Rescue Plan Act, BHW training programs reached nearly 500,000 health care providers and contributed to a combined field strength of nearly 25,000 clinicians serving through the NHSC and Nurse Corps. With additional funding to boost provider resilience, BHW created workshops and materials for clinicians and sites on maintaining well-being and avoiding burnout, which reached nearly 53,000 trainees. Among the funding opportunities for FY 2024 is the NHSC Students to Service Loan Repayment Program (LRP), which offers up to $120,000 in loan repayment funds and an additional $40,000 for ob-gyns, family medicine physicians who practice obstetrics, and certified nurse midwives.

BHW has taken steps to enhance access to its publicly available data, used by researchers, policymakers, and others. Upcoming efforts include a new nursing workforce dashboard, updated health professional training program data, and updated area health resource files.

BHW reaches out to prospective trainees through virtual job fairs. An upcoming job fair features presentations from rural health care facilities. BHW is always seeking candidates interested in becoming HRSA grant reviewers. On behalf of BHW, Ms. Pradia-Williams expressed tremendous gratitude for the expertise, time, partnership, and support of Council members. She encouraged the members to share new funding opportunities with their communities.

Discussion

Dr. Aaron Anderson asked how BHW recruits candidates from within communities of high need. Ms. Pradia-Williams responded that BHW tackles the pipeline broadly—for example, via scholarships for disadvantaged students and workforce diversity programs. It supports career advancement by recruiting from among paraprofessionals (e.g., licensed practical nurses, certified medical assistants) and investing in apprenticeship programs. BHW also provides readiness programs and academic support to help individuals better compete for scholarships.

Sandra Garbely-Kerkovich, DMD, asked how the NHSC could fund allied health professionals, such as nutritionists, community health workers (CHWs), and health coaches, who help

clinicians link patients to services. Ms. Pradia-Williams said funding from Congress is key. American Rescue Plan funding enabled BHW to support CHWs and others, but that funding is ending. Statutes governing HRSA programs tend to be narrowly focused on certain professions, but sometimes the agency has flexibility in how it uses appropriations. Funding more paraprofessionals is one way to boost the allied health professions.

Dr. Garbely-Kerkovich asked whether BHW has considered funding for oral health specialists (e.g., oral surgeons, periodontists). Ms. Pradia-Williams said BHW recognizes the general shortage of oral health providers but focuses on initial dentistry training. If additional funding were available, BHW could push for more specialty dental training, she noted.

Presentation: NHSC Update

Michelle Yeboah, DrPH

Deputy Director, Division of National Health Service Corps, BHW, HRSA, HHS

Michelle Yeboah, DrPH, explained that while HHS is operating under a continuing resolution, continuation awards will be supported, but new NHSC awards will likely be delayed. Over the past 2 years, the NHSC provided $266 million to licensed providers through LRPs and $65 million to licensed providers through scholarship programs. In FY 2023 alone, the NHSC supplied $100 million in grants to state LRPs (SLRPs) to support local health workforce development. SLRPs have grown in recent years to reach all 50 states.

BHW supports NHSC sites with targeted, regional workshops. In 2023, workshops focused on helping health centers develop workforce plans. Using BHW's data dashboard, health centers can pinpoint their workforce challenges and build capacity to train the next generation.

Also in 2023, in response to calls for more mentorship and dialogue among NHSC scholars, loan repayers, and clinicians on the front lines, the NHSC partnered with the Association of Clinicians for the Underserved and Abt Associates to create the Empowering Clinicians for Resiliency and Transformative Care initiative. It provides webinars, online materials, and other tools to promote clinician well-being, foster organizational and individual resiliency, address health inequity and

social determinants of health, and build bridges with the communities that the NHSC serves. The initiative plans to offer grand rounds and other mechanisms to share learning among peers.

For FY 2024, the NHSC continues to support improved maternal health care with a $10,000 per year enhancement to loan repayment awards for those pursuing maternal health training who agree to serve in high-need MCTAs. The NHSC is addressing provider readiness through the Empowering Clinicians initiative and other resources, including updated information for clinicians about the communities they will serve. Efforts are underway to create an internal mechanism to track BHW-funded postgraduate trainings completed through the NHSC pathway so that BHW can connect and support program alumni.

To optimize data use, BHW seeks to promote awareness of its dashboards. It also aims to combine NHSC data with other data, such as NHSC's behavioral health survey and BHW workforce projections, to learn more about health outcomes. In FY 2024, the NHSC will evaluate application data to learn more about applicants' funding needs and how to streamline the application process.

Discussion

Debbian Fletcher-Blake, APRN, FNP, asked how the NHSC gets feedback from sites. Dr. Yeboah responded that the Division of Regional Operations' (DRO's) hubs around the country gather input from sites during the site recertification process. Ms. Fletcher-Blake asked whether the NHSC would consider incentives for protected time for NHSC participants and site administrators to engage in trainings like those offered by the Empowering Clinicians initiative. Dr. Yeboah noted that the lack of time for training came up during webinars, so the Empowering Clinicians initiative created additional opportunities for clinicians and site administrators to talk, which have been helpful. She added that the NHSC also gets feedback from SLRPs, federally qualified health centers (FQHCs), and other sources.

Kareem Khozaim, MD, FACOG, pointed out that it is difficult for ob-gyns to practice in areas of high need, including MCTAs, that do not have hospitals with labor and delivery units. He asked how the NHSC can respond to the increasing number of hospital closures, which limits maternal

health services. Dr. Yeboah said the NHSC is aware that the requirements around its incentives for maternal health provider training may not be feasible. Dr. Aaron Anderson observed that the data are mixed on the impact of hospital closures on maternal mortality. Dr. Yeboah planned to bring the Council's concerns to BHW leadership. She said NHSC leadership meets regularly with HRSA's Office of Rural Health Policy about funding opportunities and how to better address the needs of rural communities, but she noted that the government works slowly.

In response to Dr. Garbely-Kerkovich, Dr. Yeboah clarified that an individual cannot receive loan repayment awards from both the NHSC and a SLRP. Dr. Garbely-Kerkovich pointed out that foreign-born people can study at U.S. dental professional schools, do residencies, and practice in the United States, yet some states limit them to provisional licenses. Those individuals are not eligible for NHSC funding or SLRPs, which limits health centers' access to qualified professionals who could work in underserved areas.

Via chat, Dr. Khozaim posted a press release from the office of Hawaii Governor Josh Green, MD, about Hawaii's $30-million SLRP for health care professionals.

Presentation: Uniform Data System

Jonjelyn Gamble

Data Production Team Lead, Bureau of Primary Health Care (BPHC), HRSA, HHS

Judy Van Alstyne, MPH

Public Health Specialist, BPHC, HRSA, HHS

Jonjelyn Gamble explained that the Uniform Data System (UDS) gathers data annually from HRSA-funded health centers on patient demographics, staffing, health care utilization, and quality of care, among other measures. HRSA uses the data to assess year-to-year changes and identify strengths and areas of improvement for its health care programs.

HRSA captures data that shed light on its statutory requirements, including characteristics of the population served, services rendered, process and outcome measures, costs and revenue, and other data elements that illustrate the changing landscape of care in health centers. BPHC aims to ensure that the UDS clinical quality measures (CQMs) promote data standardization and quality of care, minimize reporting burden, and support interoperability. The UDS CQMs align with the

Centers for Medicare & Medicaid Services' (CMS') electronic CQMs (eCQMs) to ensure consistency across HHS.

CQMs are used across patient populations and health care settings to advance the goals of high-quality, high-value, equitable care. Ms. Gamble pointed out that CQMs actually measure whether documentation of care aligns with the principles of high-quality care; if care is not well documented, then the CQM is not met. CQMs are defined by national stewards, not HRSA, and are detailed in the Electronic Clinical Quality Indicator Resource Center.

Annually, CMS publishes updates to its eCQMs and the UDS for public comment. The UDS Advisory Board reviews proposed changes to the UDS and makes recommendations, which are then published in the *Federal Register* for public comment. Recommendations for changes are guided by various factors:

- Responsiveness or relevance to a service mandated by statute
- Input from stakeholders, such as health care researchers or special interest groups
- Effect on interoperability and reporting burden
- Alignment with national and international standard measures, such as CMS' eCQMs or the demographic categories designated by the Office of Management and Budget
- Demonstration that a new measure is based in evidence
- Likelihood that the measure will provide generally valuable information to promote quality improvement in HRSA-funded programs

Discussion

Dr. Garbely-Kerkovich said her facility discourages oral health professionals from entering general health information into the electronic health record, and the only UDS measure of oral health is use of dental sealants. Oral health professionals can contribute to patient care by screening for body mass index (BMI) and referring patients for smoking cessation interventions, for example. Dr. Garbely-Kerkovich suggested that HRSA could help providers work together to achieve better patient health outcomes by adding UDS measures that encourage interdisciplinary care. Judy Van Alstyne, MPH, said BPHC is open to suggestions on how to better reflect such care, noting that behavioral and mental health providers have made some progress on that front.

In addition, HRSA has prioritized oral health, and the dental sealant measure has strong support from the field. Ms. Van Alstyne said suggested changes or additions to the UDS should be supported by data that make the case for the potential impact of new measures.

If an intervention falls within the scope of the provider's practice and the health setting, Ms. Van Alstyne continued, it should be possible to record it in the UDS. Providers can also enter comments into the UDS that will help reviewers get a clearer picture of practice in the field. Ms. Van Alstyne pointed out that in FY 2023, the "medical visit only" filter was removed so that other providers could record evaluation and management codes, for example, with the intention of improving health centers' ability to document integrated primary care.

Shawn McMillen, MPA, ASUDC, asked whether BPHC captures housing stability and whether its data demonstrate better health care outcomes for people with permanent supportive housing. Ms. Van Alstyne clarified that the annual UDS report includes data on patients screened by health centers for social risk factors such as housing, so there are high-level data, but the denominator is limited to the number of patients screened. BPHC gathers aggregate data and cannot link individual patients with demographic characteristics or health outcomes. HRSA is moving toward deidentified reporting, which would allow the agency to look broadly at risk to identify where support is needed. In theory, Ms. Van Alstyne said, deidentified reporting, could show which patients received services under which programs and the patient outcomes.

Ms. Fletcher-Blake suggested that for diabetes management and process measures (e.g., smoking cessation, BMI), systems should move away from specifying the timing or number of visits at which such data are collected. To move the field toward integrated care, the medical encounter should not be seen as the definitive and only point of care. Dr. Chan appreciated Ms. Gamble's observation that the UDS captures measures of quality based on documentation, adding that health centers face a lot of limitations.

Public Comment

No public comments were offered.

Presentation: Travel Procedures

Janet Robinson

Advisory Council Operations, BHW, HRSA, HHS

In anticipation of an in-person Council meeting in June 2024, Janet Robinson described the procedures for members to reserve travel and receive reimbursement. HRSA staff will reach out to Council members about 3 months before that meeting. Meeting dates are being finalized, and travel will be discussed in more detail at the March 2024 virtual Council meeting.

Discussion

Ms. Fabiyi-King said the following Council meeting dates are tentatively scheduled for 2024, pending publication in the *Federal Register*:

- March 19–20, 2024 (virtual)
- June 25–26, 2024 (in person)
- November 19–20, 2024 (virtual)

NACNHSC Workgroup Updates

Scholar Recruitment and Retention Workgroup

This workgroup consists of Dr. Andrea Anderson, Dr. Khozaim, and Edward Sheen, MD, MPH, MBA. Dr. Khozaim said the group discussed possible barriers to recruitment, noting that in-person connections with NHSC participants or alumni have the most impact on potential applicants. Ideally, medical schools have alumni among their staff who can promote the NHSC. The workgroup reviewed current outreach mechanisms (primarily the NHSC web page and HRSA's YouTube channel) and concluded that the NHSC would benefit from a social media champion. In addition, the NHSC should explore partnering with other federal agencies, such as the U.S. Public Health Service Commissioned Corps and the HHS Office of Civil Rights, to promote the program. Dr. Sheen added that the NHSC recruitment process should highlight valuable opportunities for clinicians in training seeking a service-oriented career. He suggested the NHSC take a more strategic approach to marketing, use modern media to reach potential applicants, and simplify ways to learn about and apply for the NHSC. However, the workgroup also learned that the NHSC is receiving more applications than ever before, so recruitment does not appear to be a weakness of the NHSC.

At the second workgroup meeting, HRSA data analyst Carla Piwinsky explained how the NHSC calculates retention, which is at 83 percent overall. The workgroup observed that some NHSC participants may leave clinical practice but continue to further the mission of the NHSC—for example, through academic, public health, or administrative service—and thus should be included in the retention rate. Dr. Khozaim said the workgroup plans to address other issues raised by the Council, such as how to report concerns about sites without fear of retribution.

Discussion

Dr. Garbely-Kerkovich suggested looking at recruitment by discipline to determine whether it would be helpful for the NHSC to target its recruitment efforts.

Action Item

- HRSA staff will seek data on NHSC retention rates by discipline.

Dr. Aaron Anderson asked what constitutes successful retention and whether current measures take into account how medical practice has evolved. Dr. Sheen responded that HRSA measures retention of practitioners within communities designated as Health Professional Shortage Areas (HPSAs) but appears to be open to broader definitions of success. Dr. Khozaim pointed out that Luis Padilla, MD, BHW Associate Administrator, and Hawaii's Gov. Green are both NHSC alumni who no longer practice medicine but continue to contribute to the success of the NHSC.

Dr. Chan asked whether the NHSC is successfully recruiting candidates from underrepresented racial and ethnic groups (URGs). She also asked how to reconcile the success of the NHSC with the projected deficits in providers. Dr. Sheen said the NHSC should invest in targeted recruitment of URGs. Dr. Chan noted the difficulty of recruiting providers to rural areas.

Mr. McMillen noted that it is very difficult to attract behavioral health professionals to rural areas, even with LRPs, and once trained, many seek out private practice opportunities with higher pay. Notably, behavioral health providers who stay in underserved areas tend to be people from the community—such as people who completed a mandatory drug court program and

eventually entered the field of social work and behavioral health (a.k.a. the homegrown model). Mr. McMillen said people in rural areas often lack access to academic programs and need online education opportunities. However, licensing requirements are not well structured for people who receive their education primarily online.

Ms. Fletcher-Blake said that assessing the demographics around recruitment and retention is important, because the NHSC has a role to play in ensuring that the workforce reflects the people served. To address projected provider deficits, she suggested starting recruitment efforts earlier—for example, targeting students considering medical school, before they begin accruing debt. Jihan Doss, DMD, MPH, said some people from URGs avoid pursuing clinical training because of the substantial debt. She added that the NHSC should let participants know about state tax breaks for clinicians who work in rural areas. Also, despite NHSC funding to help with moving costs, housing remains a barrier for NHSC participants.

Dr. Villarreal pointed out that, in an attempt to boost the number of primary care providers, one state allows foreign medical school graduates to practice as physician assistants (PAs) without completing PA education. He argued that it would be better to invest in recruiting people from URGs into health care. Moreover, consideration should be given to loosening some restrictions so that it is easier to for people to pursue clinical education and licenses through homegrown models (such as those described by Mr. McMillen). Dr. Villarreal agreed with the workgroup that the NHSC would benefit from more champions and more appealing outreach approaches.

Via chat, Dr. Garbely-Kerkovich said some states have recruitment initiatives aimed at younger populations, such as Maryland's Pathways to Bright Futures. Dr. Villarreal added that the Pathways program, HRSA's Health Careers Opportunity Program, and HOSA–Future Health Professionals are active in many states. Dr. Villarreal noted that the through the University of California's Programs in Medical Education for health equity, the University of California, San Diego, School of Medicine successfully enrolled 20 Native students this year.

Expansion of Funding to Additional Specialties Workgroup

This workgroup consists of Tara Brandner, DNP, FNP-C, Dr. Garbely-Kerkovich, and Deborah Gracia, DO. Dr. Garbely-Kerkovich explained that although the NHSC is required by statute to focus on primary health care, it has expanded to incorporate disciplines that contribute to primary care, including oral and maternal health providers, as well as mental and behavioral health and vision health providers (some through separate HRSA programs). An integrated approach is needed. The workgroup discussed ways to better incorporate holistic and preventive care by promoting existing tools, such as programs and materials that address nutrition. The workgroup sought Council input on the following draft recommendations for the NHSC:

- Advance interdisciplinary and collaborative practice through funding set aside for NHSC participants to get additional training or certification on preventive care principles.
- Support integrated health care by funding pilot programs that bring nutritionists or other allied health providers to NHSC sites to address obesity, diabetes, and nutrition.
- Implement CQMs that promote interdisciplinary care and incentivize sites to improve collaboration among providers to enhance patient care.
- Gather data via the NHSC site application and recertification processes to assess the availability of nutrition support.

Discussion

Dr. Aaron Anderson described his own experience with a highly integrated health care system that allows provider teams to center their patients and link patients to other services and resources. Health care is moving toward team-based care, he noted, but it is not clear that the approach is well documented in electronic records. The more that providers can integrate care and document it, the more they will be able to demonstrate how it makes a difference.

Site Recruitment and Retention Workgroup

This workgroup consists of Dr. Chan, Ms. Fletcher-Blake, and Dr. Villarreal. Ms. Fletcher-Blake explained that, according to the minutes of the June 2023 Council meeting, the workgroup's goal was to identify how to improve site recruitment and retention by providing best practices for orienting new employees, create mentorships, expand education for administrators, and establish

school- and community-based health sites, among other mechanisms. The workgroup began by seeking data about best practices, gaps, and needs around site recruitment and retention. Maria Pestalardo, BHW DRO Senior Advisor, explained to the workgroup how HPSAs are determined; FQHCs, Indian Health Service sites, and correctional facilities are automatically designated as HPSAs, while all others must apply for HPSA status.

Notably, few rural sites apply to participate in the NHSC program; despite efforts to reach rural health centers, HRSA staff sometimes are unable even to establish contact. Moreover, some SLRPs compete with the NHSC rather than coordinate to make the best use of limited resources. At present, 70 percent of HPSA sites are in rural areas, but only 46 percent of NHSC sites are. To participate in the NHSC, sites must use a sliding fee scale. However, sites may not use asset testing to determine whether clients have alternative sources of income or assets that would disqualify them for free services, nor can they require clients to enroll in Medicaid as a condition of providing care. Ms. Fletcher-Blake said the workgroup is considering recommending that HRSA loosen restrictions to make it easier for sites to implement a sliding fee scale. Dr. Villarreal added that he appreciated that HRSA is looking closely at the factors that lead sites to drop out of the NHSC program. HRSA's new data collection process and year-end reporting will likely illuminate why a number of correctional facilities dropped out of the program recently.

Discussion

Dr. Chan observed that some correctional facilities lack sufficient staff to maintain safety, which deters clinical providers from accepting positions. Dr. Villarreal said the workgroup is looking at issues from the site perspective but recognizes the intersection between sites and scholars in terms of recruitment and retention.

Ms. Fletcher-Blake said it would be useful to know what would help HRSA get better data about rural health centers and improve communication with them. It is not clear whether rural health centers are aware of the potential impact that NHSC participation could have on their communities. Dr. Aaron Anderson added that many sites are understaffed and underfunded, so they may not respond to providers seeking more information before making a decision about where to work. Dr. Villarreal said that HRSA data did not identify staffing levels as a significant

factor in NHSC site participation, and it was not clear to the workgroup how or whether HRSA captures staffing data.

Dr. Doss asked whether sites get any training, support, or technical assistance on how to retain NHSC participants and whether that affects the site dropout rate. Ms. Fletcher-Blake said there is some training for sites, and the DRO staff visit sites periodically. Dr. Villarreal reiterated that the sliding fee scale remains the biggest barrier to site participation, according to HRSA.

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

Charmaine Chan, DO, Chair, NACNHSC

Dr. Chan asked the new Council members to consider which workgroups they would like to join. The Council should develop a timeline for a deliverable(s) that includes the recommendations from the workgroups. In addition, the Council recently adopted a practice of having individual members attend at least a portion of the meetings of other BHW advisory councils and then report back to the NACNHSC on items of potential overlap.

Dr. Chan briefly summarized the proceedings of day 1 and previewed the agenda for day 2. She asked members to think about potential topics or themes for the March 2024 meeting. The meeting recessed for the day at 3:41 p.m.

DAY 2

Opening and Charge of the Day

Ms. Fabiyi-King, DFO, opened the meeting at 10:07 a.m., Eastern time, and called the roll. in recognition of the upcoming Thanksgiving holiday, Council Chair Dr. Chan offered a reflection about giving and gratitude. She then summarized the agenda for the day.

Reports from BHW Council Meetings

Dr. Chan reiterated the Council's efforts to increase communication across HRSA's five BHW advisory groups:

- NACNHSC
- Advisory Committee on Interdisciplinary, Community-Based Linkages

- Advisory Committee on Training in Primary Care Medicine and Dentistry
- Council on Graduate Medical Education
- National Advisory Council on Nursing Education and Practice

Reports from Meetings

Ms. Fletcher-Blake attended a full day of a National Advisory Council on Nursing Education and Practice meeting, at which participants discussed paying for nurse practitioner (NP) preceptorship and residency programs, which could incentivize more NPs to train in public health settings. The use of artificial intelligence to supplement the nursing curriculum was also addressed.

Dr. Andrea Anderson took part in a Council on Graduate Medical Education meeting, which focused on how to better support team-based care through interprofessional education, including educating residents about the role of CHWs.

Dr. Villarreal reviewed the minutes of the Advisory Committee on Training in Primary Care Medicine and Dentistry meeting, highlighting a program to train students and residents to provide high-quality primary care to people with limited English proficiency or physical, intellectual, or developmental disabilities.

Process Issues

Council members discussed ways to improve scheduling and notification about attending other BHW advisory council meetings:

- NACNHSC members would like to receive a calendar notification about meetings they agree to attend, as well as information about how to attend (e.g., links to connect virtually) and the minutes from the meeting afterward.
- NACNHSC members requested some time on other councils' agendas to report on NACNHSC efforts and raise topics of shared interest.

Action Items

- HRSA staff will send out a schedule of upcoming BHW advisory council meetings. Council members are encouraged to indicate which meetings they can attend and plan to report back to the NACNHSC. If it is not possible to attend a meeting, a Council member can opt to review and summarize key points from the meeting minutes.
- Once a NACNHSC member agrees to attend a meeting, HRSA staff will send a calendar notification, followed by participation information and a reminder via email shortly before the meeting. HRSA staff will send the minutes of the meeting as soon as they are available.

Panel Discussion: NHSC Site Executives

Moderator: ***Diane Fabiyi-King, DFO***

Panelists: ***Kavanaugh Chandler, MD, MBA, Chief Executive Officer (CEO), Coastal Community Health, Brunswick, GA***
Claude Jones, DO, MPH, MSc Law, President and CEO, Care Alliance Health Center, Cleveland, OH
Cindy Peavy, RN, CLSSGB, Executive Director, Arbor Family Health, Batchelor, LA

Ms. Fabiyi-King introduced the panelists, and each described their organization and the population it serves. Ms. Fabiyi-King posed questions for the panelists and invited comments and questions from the Council members.

What is helping you with recruitment and retention?

Kavanaugh Chandler, MD, MBA, said partnerships and communication are key. He works with area hospitals, schools, and teaching programs to find opportunities for collaboration and to raise concerns (e.g., housing constraints). As a trustee of a local college, he aims to ensure that health centers are part of the conversation around education. Dr. Chandler recommended being engaged with all the organizations in the community. Claude Jones, DO, MPH, MSc Law, agreed, adding that giving clinicians in training a chance to work at area hospitals, health centers, and clinics allows trainees to experience the communities and contributes to the workforce pipeline.

In terms of recruiting, Dr. Jones pointed out that in addition to location, salary, and benefits, candidates also consider the workplace culture and the community. His organization conducted a survey to better understand what candidates are looking for. Dr. Jones also follows up with new hires periodically over their first 3 months. Recognizing the competitive marketplace, Care Alliance used federal funding to provide retention bonuses.

Cindy Peavy, RN, CLSSGB, said the NHSC program is not a prominent part of her recruitment strategy but is crucial to retention. Because the LRP is conditional and has a long waiting list, it is not a reliable tool for recruitment, but Arbor Family Health encourages new hires to sign up for it. Ms. Peavy noted that once clinicians begin work, they get to know the organization's mission and the community's needs, which contributes to long-term retention. Developing relationships over time is critical to growing and keeping a mission-driven workforce, particularly for rural health centers competing with area hospitals for providers.

To address the competition for providers, Dr. Chandler suggested putting more effort into finding candidates who want to stay in the South. Dr. Jones agreed that it would be helpful to better understand NHSC candidates' career goals. Dr. Chandler added that building close relationships with would-be competitors can ensure access to health care for insured and uninsured people.

Are recruitment and retention challenges different in different states?

Dr. Jones responded that Cleveland's climate can be a deterrent to recruitment. The city has six large FQHCs and three major hospitals in the same catchment area. As a result, the public institutions bear more of the training costs, while the hospitals offer higher salaries and bonuses to trained providers. Dr. Jones said Care Alliance uses some innovative pay models to keep providers in its health centers.

How can the NHSC help sites improve workforce recruitment and retention and patient care?

Dr. Jones said in-person job fairs are an excellent opportunity for candidates to see and learn more about sites. Ms. Peavy said homegrown models have been her most successful approach.

By identifying local residents and providing assistance for training, Arbor Family Health has cultivated a workforce that understands the dynamics of the community and is invested in the community's future. Ms. Peavy suggested matching candidates to sites sooner. Alternatively, she suggested creating a mechanism through which sites support or encourage people to pursue training and then guarantee them a space in the NHSC program when they are ready to practice. HRSA could also provide other funding for health centers to invest in training local candidates (e.g., through stipends) as one long-term approach to grow the workforce.

Dr. Chandler proposed updating the NHSC's image to correct the perception that it serves only very poor people through free clinics. The NHSC should highlight that sites provide high-quality care and offer opportunities for career development and growth. Dr. Jones suggested emphasizing that NHSC service offers exposure to diverse clinical settings outside of a hospital, giving participants a broad view of a community and its needs. He recommended building relationships with providers seeking rewarding careers outside of hospitals. Ms. Peavy agreed, adding that more outreach is needed to educate clinicians in training about FQHCs and other public health settings.

Discussion

Dr. Aaron Anderson expressed support for the suggestion to better match candidates to sites and to make the case in support of the NHSC. As in any other business, NHSC sites are competing for the best talent, and salaries should reflect that.

Dr. Chandler pointed out that Mercer University will pay the costs of medical school for Georgia residents who agree to work in the state's underserved areas. To stand out, Coastal Community Health promotes itself as the best place to work, providing the highest quality of care and competitive salaries.

Dr. Villarreal described a lack of understanding about the roles and capacities of PAs, leading some NHSC sites to prioritize NPs over PAs. He asked the panelists whether they faced such challenges and how they address interdisciplinary recruitment for primary care providers. Ms. Peavy pointed to her state's restrictive regulations around supervision, collaboration, and backup

for advanced practice providers (APPs) and proposed funding that pays for such services as well as training on managing new APPs coming into the workplace.

Dr. Jones said organizations should evaluate their needs broadly to understand where they most need clinicians and how services contribute to revenue. Organizations should consider cost-effective models of collaborative care and take into account that patients want providers who reflect the demographics of the community. Dr. Chandler suggested that the NHSC and other programs do more to promote the role that PAs play. FQHCs and other nearby health centers could share the costs of supervisory or backup providers for their APPs. Ms. Peavy concurred that partnering with other health centers is key to cost-effectiveness and sustainability.

Mr. McMillen described tensions between FQHCs and some regional health authorities and noted a continued shortage of mental and behavioral health providers. He asked whether health centers could provide more supervision services to assist the professional advancement of such providers new to field. Dr. Chandler said Coastal Community Health created a psychiatric services partnership with local university funding; it has also considered collaborating with universities offering social work licensing programs to provide students with real-world experiences, which helps with recruitment. Finally, developing a collegial approach with the area primary care associations around psychiatric services has been helpful.

Dr. Jones said Care Alliance contracted with an outside group for psychiatric services. It also recruits NPs and PAs in training to fulfill their field requirements for psychiatric certification by working at Care Alliance sites under supervision. Dr. Jones said Arbor Family Health has used alternatives, such as telehealth for mental health services. She recommended adjusting the workflow to match the available workforce.

Where should the NHSC expand in terms of the disciplines it supports?

Dr. Chandler proposed offering LRPs for people pursuing quality assessment and data management. Ms. Peavy suggested investing in other types of providers, including CHWs and others involved in outreach, as well as supporting people who want to advance to the next level of education or training.

Dr. Jones recommended that the NHSC work with the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or others to offer short rotations (e.g., 1 or 2 months) at NHSC sites so trainees can gain experience in FQHCs and health centers.

Ms. Peavy requested that HRSA educate state authorities about how HPSA scores are determined and the appropriate use of HPSA scores as criteria for state programs. She said that despite high need, HPSA status, and rural location, Arbor Family Health does not qualify for Louisiana's special program to provide teledentistry for rural areas.

Discussion

Dr. Doss appreciated the concept of an FQHC rotation, noting that moving from dental school into practice, especially in a rural area, can pose a steep learning curve. A mentorship or residency program for dentists would be helpful, especially for those starting practice in a rural location where they may face clinical situations not covered in school. Dr. Aaron Anderson noted that an FQHC dental residency in his area provides great training and has high provider retention rates, and he strongly supported the concept.

How does the sliding fee schedule affect your site, and what financial factors contribute to the success of your NHSC sites?

Ms. Peavy said some organizations that have a mix of private and public payers might struggle with the sliding fee schedule. Arbor Family Health uses contracts to provide the highest quality care at the lowest cost. Hospitals and rural health centers that use models focused on volume of care are not sustainable over time.

Dr. Chandler said Coastal Community Health focuses on pinpointing needs, determining where it can diversify, and providing high-quality care. By doing so, it has increased the number of insured patients served, which offsets the costs of caring for uninsured patients. The biggest barrier around the sliding fee schedule is the paperwork.

Dr. Jones said Care Alliance is always trying to increase access without adding facilities. It assists clients with transportation and offers mobile health care and dental units. Key to Care Alliance's success is providing high-quality, patient-centered care.

Discussion

Given that hiring APPs is complicated by regulations around supervision and backup services, Dr. Villarreal asked the Site Recruitment and Retention Workgroup to consider the topic. For example, the workgroup could propose that the NHSC work with state APP organizations to advocate for regulatory changes to alleviate barriers around collaboration and supervision of APPs. Dr. Villarreal suggested the Council members review the American Academy of Physician Assistants' paper, The Six Key Elements of a Modern PA Practice Act.

Public Comment

Annabelle Bradford, MD, a psychiatrist, submitted a written comment asking the NACNHSC to review and update its policies on the use of telehealth for behavioral health. The letter described the rapid rise in telehealth for medical and behavioral health even before the COVID-19 pandemic. As the pandemic has waned, telehealth services continue to make up the vast proportion of outpatient psychiatric visits. Telehealth for behavioral services can substantially increase access to care while mitigating provider burnout. The Substance Abuse and Mental Health Services Administration recognizes telehealth as a priority for reaching people with mental illness or substance use disorders. However, Dr. Bradford maintained, the NHSC's policies reflect long-outdated norms and standards and inappropriately limits the use of telehealth to provide behavioral health care. (See the appendix for the full written comment.)

Presentation: HRSA Communications Strategy

Angela Hirsch

Director, Division of External Affairs (DEA), BHW, HRSA, HHS

Susan Schulken

Branch Chief for Media, Web, and Public Affairs, DEA, BHW, HRSA, HHS

To enhance communication about the NHSC program, Angela Hirsch explained, the DEA partners with other divisions that gather data and input from NHSC applicants,

participants, and sites. The barriers to NHSC recruitment change from year to year; the DEA talks with leadership, participants, and sites to identify urgent needs and adjust its strategies around the timing and targets of outreach accordingly. The DEA also strives to assess the mix of disciplines represented, the competitiveness and quality of applicants, and the effectiveness of efforts to place NHSC participants in areas of high need (particularly rural areas). The DEA seeks to communicate more information in advance about NHSC programs, policies, and deadlines so that people have more time to prepare (while also conveying that some factors are beyond HRSA's control). The DEA aims to use BHW data to learn more about the characteristics of applicants.

Over the past year, the DEA has brought in more staff with expertise in health communications, social media, and analytics. It also engages contractors to assist with social media placements, communication research, and up-to-date, targeted messaging.

Susan Schulken emphasized that the DEA recently implemented a new social media management system, new web analytics tools, and a new web page-level survey to capture comments from website visitors. The DEA relies on the NHSC web page as the basis for building awareness, followed by NHSC social media sites (YouTube, Facebook, and X [formerly Twitter]), paid social media and search advertising, and email marketing. Search engine optimization that drives online searchers to the NHSC website is the most effective NHSC marketing tool.

So far in 2023, the NHSC web page has had nearly 1 million visitors, including:

- 74,768 visits to the BHW customer service portal,
- 26,532 visits to the Health Workforce Connector, and
- 18,327 subscriptions to NHSC email updates.

The NHSC website was the first BHW site to implement a short user survey. As a result of user feedback, the link to log in to the BHW portal now appears at the top of every page, and visits to the portal have since increased fivefold. On the basis of insights from the DRO, the website now

includes a section that walks NHSC participants through the transition from school to work. That section was so popular that a similar one was created for the Nurse Corps program.

Ms. Schulken presented metrics indicating that NHSC's social media posts focusing on scholarship drive significant traffic to the NHSC website, with social media impressions, engagement, and link clicks all substantially higher in 2023 than 2022. She attributed the gains to the DEA's new social media management platform, new social media leadership, new guidelines consistent with best practices, and a new analytics partner. The DEA is employing innovative approaches to expand reach, such as a new video targeting maternity care providers as well as other lighthearted posts that capture users' interest. Ms. Schulken recognized that some of the NHSC material on the HRSA YouTube channel is outdated, and her office is looking at ways to refresh videos based on lessons learned about engagement and response. The DEA also pays to amplify its content on some platforms.

The NHSC maintains an email subscription list; these emails are the second highest source of visitors to the NHSC website. Emails can be targeted to reach specific subsets of subscribers. For example, email reminders about imminent deadlines sent to people in the process of applying are highly likely to be read.

Google searches are the top driver of web page visits; the DEA pays for search engine optimization and has access to search engine analytics. Through data analysis, the DEA learned that a surge of web page visits in mid-July was linked to media reports about NHSC reauthorization. Ms. Schulken said the DEA intends to dive deeper into the analytics data in the coming year.

Ms. Hirsch emphasized that the DEA uses digital media, internal and external newsletters, in-person and virtual events, presentations, speaking engagements, and webinars to spread the word about the NHSC. The DEA is always gathering insights and working to act on that information as quickly as possible. It is currently seeking ways to better engage with tribal leaders and their communities about NHSC opportunities.

Discussion

Ms. Fletcher-Blake asked whether the DEA has considered reaching out to students before they enter medical school to let them know about the NHSC. Ms. Hirsch noted that HRSA's Area Health Centers Education programs and Centers of Excellence have deeper links to the undergraduate population than the NHSC. One challenge is that there is no way to measure whether promoting the NHSC and pipeline programs early on has a meaningful effect. Ms. Hirsch acknowledged that students need to see that a career in health care is within reach. Ms. Schulken added that social media is ideal for reaching younger people. Although young people do not use Facebook heavily, their parents do, so the DEA is considering outreach that targets parents of potential applicants as well as high school guidance counselors. The DEA is open to establishing an Instagram account if the Council recommends it.

Ms. Fletcher-Blake asked how many of the nearly 1 million website visitors eventually apply to the NHSC. Ms. Schulken responded that the DEA is currently setting up the capacity to assess that metric. It is problematic to track individual users through analytics, but BHW can identify trends and gather insights from user feedback.

Ms. Fletcher-Blake asked whether the DEA has considered creating a podcast, which might be one mechanism for reaching tribal and rural leaders. Ms. Hirsch said the DEA has proposed some podcast ideas, but podcasting is challenging. At present, it advertises on some podcasts and pitches stories about the NHSC to existing podcasts.

Dr. Aaron Anderson asked whether the NHSC program still conducts in-person meetings with new participants as they decide where they want to do their service. He also asked how the NHSC connects participants with mentors and other support. Ms. Hirsch said in-person meetings were popular, but the NHSC moved to virtual sessions even before the COVID-19 pandemic. She recognized that networking is difficult to achieve in virtual meetings. Ms. Hirsch added that BHW has a lot of work underway to address provider resiliency and burnout, much of which was initiated thanks to American Rescue Plan funding. She noted that BHW engages alumni and others to champion the NHSC, providing them with information and asking them to use their

social media or other avenues to promote the NHSC. There may be opportunities to build community via social media by connecting NHSC participants with each other.

Dr. Aaron Anderson suggested hosting an annual virtual convening for NHSC participants, and Ms. Hirsch said the DEA would consider it. Dr. Sheen added that sharing stories with other participants and recent alumni is a powerful experience that is key to recruitment and retention. Dr. Andrea Anderson proposed hosting regional virtual meetings among NHSC participants, possibly organized around themes (e.g., specific challenges faced by participants at various sites). She said opportunities to connect could boost morale and influence recruitment.

Dr. Sheen asked how many of the NHSC applicants are well qualified for the program and how many NHSC slots remain open. He observed that participation is tied to the program's capacity. Ms. Hirsch said other BHW divisions may be able to answer those questions.

Action Item

- HRSA staff will seek data on the proportion of recent NHSC applicants who are well qualified for the program and how many NHSC slots remain open.

Dr. Sheen suggested that the DEA make more content available at the local level so that alumni and current participants can share it among their peers and potential applicants. He also advised refreshing social media content more frequently to prevent it from appearing dated. Ms. Schulken said the DEA is considering how to better disseminate the NHSC's powerful case studies. Ms. Hirsch added that the DEA is planning to condense some material into very short videos showing, for example, a slice of life for a current NHSC participant. It is important that people be able to visualize themselves as part of the program, she observed.

Dr. Khozaim asked whether the DEA has organized communication efforts around current social issues to gain the attention of potential applicants. Ms. Hirsch recognized that social justice and service are strong motivators among NHSC applicants. While the DEA avoids partisan and divisive issues, messaging does focus on the broader concepts of social justice, serving the community, and helping people most in need.

Dr. Chan thanked the presenters and looked forward to learning more about the DEA's 2024 strategic communication plan.

Council Discussion: Recommendations, Papers, and Workgroups

In response to Dr. Chan's request for feedback on the structure of the meeting, Dr. Khozaim appreciated the presentations from the workgroups, which will inform the discussion as the workgroups move toward a deliverable. Dr. Aaron Anderson asked for clarification about how the Council and workgroups function and where the sister BHW councils fit in. Dr. Chan said that when she became Chair, Dr. Padilla charged the Council with producing a deliverable in support of NHSC funding (see the May 2023 letter to the Secretary). He also suggested gathering data to support direct recruitment, which workgroups are addressing. Dr. Padilla expressed interest in telehealth, particularly in underresourced areas. He proposed convening a meeting of all the BHW Council Chairs to foster discussion around mutual interests, such as addressing substance use from the perspectives of different specialties and sites.

Dr. Chan continued that the NHSC is considering including school-based health centers to better address child and adolescent health issues. These centers are not usually located in areas with high HPSA scores, so the NHSC is seeking alternative ways for the program to incentivize participation of such sites. Finally, BHW is clearly interested in forecasting and welcomes suggestions on how to capitalize on data to better understand who is applying to the NHSC. Dr. Chan encouraged the workgroups to incorporate these priority topics into their deliberations.

Dr. Chan proposed that each workgroup aim to provide preliminary recommendations and insights for discussion at the March 2024 Council meeting, with the goal of combining the materials into a draft document(s) for consideration by the Council at its in-person meeting in June 2024. She encouraged workgroups to take advantage of the Council's technical writer, Dana Trevas, who offers research and writing assistance for the Council and its workgroups.

Action Item

- HRSA staff will send new Council members the notes from the 2023 workgroup meetings to assist new members in selecting a workgroup to join for 2024.

Ms. Fletcher-Blake appreciated the panel featuring NHSC site executives, which brought forth information about issues of interest to the workgroups from the perspectives of people around the country. Dr. Doss agreed, saying the panel offered good ideas and helpful insights.

Closing Remarks and Next Steps

Charmaine Chan, DO, Chair, NACNHSC

Dr. Chan appreciated the Council members' engagement throughout the two days of meeting. She thanked all of the HRSA support staff for their excellent work organizing and hosting the meeting and adjourned the meeting at 2:33 p.m.

Appendix: Public Comments

Dear National Advisory Council Members:

I am reaching out to you as a psychiatrist and National Health Service Corps Scholar deeply committed to work with the underserved. I am specifically writing to urge you to review and update NHSC telebehavioral health policies to help meet significant unmet behavioral health needs in underserved communities.

Both telehealth practices and patient and site expectations around telebehavioral health have undergone significant change in the last decade. Use of telehealth had been steadily increasing well before the COVID-19 pandemic. Telehealth use doubled from 14% to 28% between 2016 and 2019 (American Medical Association 2019), and telebehavioral health visits for Medicare beneficiaries increased by 425% between 2010 and 2017 (Patel et al 2020). Individuals from underserved communities and rural patients living with schizophrenia and bipolar disorder were noted to have benefitted most significantly from the prepandemic increase in telebehavioral health use (Patel et al 2020; Uscher-Pines et al 2020).

The use of telebehavioral health accelerated even more dramatically during the COVID-19 pandemic--further altering norms for healthcare delivery and access. Telebehavioral health visits increased by 556% between March 11 and April 22, 2020 (Connolly et al 2021), and by the period between March and August 2021, 36% of outpatient services for mental health and substance use disorders in one study were being delivered by telehealth (Kaiser Family Foundation 2023). Research has found telebehavioral health to be noninferior to in-person mental healthcare delivery (Gehrman et al, 2021; Moreland et al 2015) and to be associated with increased healthcare quality via stronger adherence to measurement-based care practices (Weinfeld et al 2023). Though specific studies differ on the extent of telebehavioral health use, it is clear that telebehavioral health remains a substantial part of behavioral health today and that telebehavioral health has maintained an outsized portion of of COVID-related gains as compared with use of telehealth in other specialities, even as the pandemic has waned. One study, for example, indicated that outpatient psychiatric visits occurred via telehealth 75%, 85%, and 85% of the time in May 2020, May 2021, and May 2022, as compared with 42%, 13%, and 17% of the time for primary care visits at the same intervals (Zocdoc 2022).

With the current addiction and overdose epidemics, increasing rates of suicide and physician burnout, and heart-breaking tragedies like the mass shooting that occurred earlier this month in my state, the importance of facilitating use of telebehavioral health for patients with serious mental illness and substance use disorders is clear. Telebehavioral health can substantially increase access to much-needed care, while addressing provider burnout through supporting

increased flexibility, more manageable schedules, and decreased commute time (mHealthIntelligence 2020; iSalus Healthcare 2019; Sorenson 2018). The Substance Abuse and Mental Health Services Administration has indicated that increasing access to telehealth services for individuals struggling with serious mental illness and/or substance use disorders represents a priority topic (SAMHSA 2021).

Unfortunately, telebehavioral health guidelines for NHSC Scholars currently in part-time or full-time service reflect norms and standards from as early as 2016, prior to the dramatic changes in the service delivery landscape discussed above. Lack of clarity on what past NHSC telebehavioral health guidelines mean or should mean has unfortunately led to inconsistencies and midcourse shifts in NHSC guidance that have had significant negative impacts on individual scholars, their families, and the communities they are called to serve. NHSC restrictions in the use of telehealth have also created substantial challenges for NHSC scholars in finding allowable employment. Interpretations of NHSC guidelines for 2019, for example, stipulate that no more than a maximum of 25% of patient behavioral health visits can be conducted via telehealth. This limit appears well below the current market standard for behavioral health.

Beyond the imperative to examine and retroactively update prior NHSC telebehavioral health guidelines, it is critical to review and update the NHSC's current approach to telebehavioral health. The NHSC currently limits use of telebehavioral healthcare to arrangements where the "distant site" (location of the NHSC Scholar) is itself situated in an underserved location. This limit on the use of telebehavioral health has the unforunate result of incentivizing NHSC Scholars to find employment in the less severely underserved locations most easily reachable by commute from the areas where they live -- effectively curtailing the potential for telebehavioral health to meet behavioral health needs that could be addressed if Scholars were able to serve our most profoundly underserved patients from the communities where the Scholars themselves live.

As one example, while the Indian Health Service has long made use of telebehavioral health, it has had considerable difficulty filling behavioral health and telebehavioral health positions in severely underserved locations like the Pine Ridge Reservation, one of the most impoverished areas in the nation. By restricting use of telebehavioral health to what can be delivered from an underserved location, the NHSC's "distant site" telebehavioral health regulations unfortunately prevent this high-needs, underserved community from accessing NHSC resources to address its behavioral health needs.

Without a clear review of telebehavioral health guidelines and input from the National Advisory Council on the National Health Service Corps, I am concerned that these issues will remain unaddressed, hampering the ability of the NSHC to meet its underlying mission to address the health needs of communities with limited healthcare access via appropriate support to the health professionals dedicated to serving them.

I would be more than happy to discuss this topic further and urge you to undertake this project.

Respectfully,

Annabel Bradford, MD

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