Meeting Minutes

National Advisory Council on the National Health Service Corps

June 25–26, 2024

Health Resources and Services Administration

5600 Fisher's Lane

Rockville, MD

Council Members

Charmaine Chan, DO, Chair

Aaron Anderson, DO

Sheri-Ann Daniels, EdD

Jihan Doss, DMD, MPH

Debbian Fletcher-Blake, APRN, FNP

Sandra Garbely-Kerkovich, DMD

Deborah Gracia, DO

Kareem Khozaim, MD, FACOG

LuVerda Martin, DNP, CNM, APNP

Shawn McMillen, MPA, ASUDC

Edward Sheen, MD, MPH, MBA

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

Abby Walenciak, MA, PHR, LPC, LADC

Health Resources and Services Administration Staff Present

Diane Fabiyi-King, Designated Federal Official

Keisha Robinson, Management Analyst, Bureau of Health Workforce

Janet Robinson, Management Analyst, Bureau of Health Workforce

Overview

The National Advisory Council on the National Health Service Corps (NACNHSC, or Council) met June 25–26, 2024, at the Health Resources and Services Administration (HRSA) headquarters in Rockville, MD. 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 HRSA Administrator. The NACNHSC was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2), which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D, of Title III of the Public Health Service Act.

DAY 1

Opening and Welcome Remarks

Designated Federal Official (DFO) Diane Fabiyi-King opened the meeting at 9:02 a.m., Eastern time, and called the roll.

Council Chair Charmaine Chan, DO, welcomed the participants and led them through a breathing exercise around centering. The goal of the meeting for the first day was to discuss and finalize the Council's recommendations and rationales for a white paper in development.

Michelle Yeboah, DrPH, Deputy Director of the Division of NHSC in the Bureau of Health Workforce (BHW) at HRSA, welcomed the Council. She thanked Dr. Chan for her outstanding leadership of the Council. Dr. Yeboah appreciated the insights that the Council provides to her and her colleagues, noting that input from the Council has informed her presentations and discussions.

Breakout Sessions

The Council members met in their respective workgroups to finalize the recommendations and rationales that each workgroup proposed in March. Members were also asked to review the entire draft document and provide input as needed.

Workgroup Reports

Site Recruitment and Retention Workgroup

Abby Walenciak, MA, PHR, LPC, LADC, said the workgroup clarified its initial recommendation to increase participation of sites in rural Health Professional Shortage Areas (HPSAs) in NHSC, which included a long list of bulleted items, beginning with a suggestion to provide technical assistance (TA). Feedback from HRSA staff indicated that the Division of Regional Operations already provides TA to sites. To streamline the recommendation and respond to the feedback, the workgroup simplified the bullets to describe the key areas in which HRSA should focus its efforts. In addition, the workgroup discussed concerns about how HPSA scores are calculated and ultimately decided to include the issue in its recommendation, which was revised as follows:

> ***Recommendation S-1:*** Increase participation of sites in rural HPSAs in NHSC by expanding methods of communication and engagement with potential sites, increasing the frequency of communication with existing sites, and improving the consistency of outreach. Examples include the following:
>
> - Enhance opportunities for TA.
> - Ensure consistent communication with sites.
> - Emphasize collaboration between NHSC and state loan repayment programs.
> - Create regional focus groups (perhaps led by regional HRSA staff) to improve outreach.
> - Consider how the calculation of HPSA scores contributes to sites dropping out of the NHSC despite their continued need for NHSC providers.

The workgroup members agreed to retain the recommendation asking that HRSA consider strategies for alleviating the obstacles presented by the requirement that NHSC sites use a sliding fee scale. However, they took out the reference to asset testing in the recommendation, rationale, and background, because it confused the issue. Workgroup members acknowledged that TA on the sliding fee scale would necessarily address the topic of asset testing. Debbian Fletcher-Blake, APRN, FNP, pointed out that the goal of the sliding fee scale is to ensure access to care, and it should not be a deterrent to site participation.

Discussion

Aaron Anderson, DO, appreciated the workgroup raising awareness about the challenges rural areas face in maintaining involvement in the NHSC. He also appreciated the attention to minimizing barriers to participation.

Participant Recruitment and Retention Workgroup

Kareem Khozaim, MD, FACOG, said the workgroup made minor changes to wording but mostly retained the recommendations as proposed. The workgroup will add graphs, created using BHW's data dashboard, to underscore its recommendations to 1) look more closely at the data on existing NHSC participants to inform recruitment and retention efforts, and 2) consider financial incentives for long-term retention. The workgroup also revised language to reflect the fact that having shared experience or concordance with a community can be a factor in retention. It also clarified that if financial incentives are offered to increase long-term retention, sites may need guidance on how to distribute such money equitably. The workgroup incorporated comments from other Council members describing tools to increase housing availability for NHSC participants.

Discussion

Deborah Gracia, DO, appreciated the attention to salary parity and financial incentives, originally raised by Ms. Fletcher-Blake. She suggested that HRSA develop more TA materials on how sites can improve equity in general. Edward Sheen, MD, MPH, MBA, pointed out that the ultimate goal is not to provide one-time bonuses for retention but rather to increase salaries in a sustainable way, recognizing the issues around pay equity.

Council members discussed the recommendation that HRSA invest in increasing housing availability for NHSC participants. It was noted that, although NHSC is not expressly authorized by statute to fund housing, it could leverage existing programs that assist with housing. Shawn McMillen, MPA, ASUDC, pointed out that the U.S. Department of Housing and Urban Development has mechanisms (including tax credits) that rural communities could use to expand affordable housing options. Elias Villarreal, Jr., DMSc, MPAS, PA-C, DFAAPA, expressed that some sites funded by Area Health Education Centers offer housing. Dr. Khozaim highlighted

that the draft paper describes examples of innovative approaches to provide housing at NHSC sites that did not require any federal funding.

Ms. Fletcher-Blake suggested revising the recommendation to suggest that HRSA collaborate with the Department of Housing and Urban Development to offer TA on housing to NHSC sites. Dr. Chan added that the Division of Regional Operations could provide more information about how other sites have succeeded in meeting NHSC participants' housing needs. Ms. Fletcher-Blake hoped that any resources for housing for NHSC participants would be equitably distributed. Council members agreed on the fundamental need for more housing, particularly in rural areas, and that HRSA should increase collaboration and communication to support sites in developing housing solutions.

Expansion of Funding to Additional Specialties Workgroup

Dr. Gracia explained that the workgroup added more language describing *The White House National Strategy on Hunger, Nutrition, and Health* and its goals. It clarified that improving nutrition not only addresses obesity and diabetes but also chronic disease in general. The workgroup added language describing the need for clinicians to have more training about preventive medicine, holistic health care, and the team approach to interdisciplinary care.

The workgroup initially proposed that HRSA expand the current Uniform Data System measure on body mass index screening to include referring patients to nutrition services and following up on such referrals. Workgroup members discussed broadening the language to recommend that HRSA ensure that all sites have the capacity to gather data on diet and nutrition and their impact on health. It revised wording to acknowledge that not all NHSC sites use the Uniform Data System and focused on the importance of modernizing existing methods of data collection.

Discussion

Dr. Anderson asked how the workgroup decided to address the issue from the perspective of nutrition. Dr. Gracia explained that nutrition is a fundamental part of preventing and managing chronic disease, but clinicians receive little education on the topic. She emphasized that with more education about nutrition, primary care providers will be more comfortable working with

the other members of a patient's provider team to provide integrated, preventive care. Ideally, providers will refer patients for nutrition counseling before they develop diabetes or other chronic conditions. Dr. Gracia also pointed out that there is a lot of misinformation about nutrition and that the White House strategy signals a high-level federal focus on nutrition, opening a pathway to advance integrated, interdisciplinary care through the lens of nutrition. She agreed to review wording in the draft recommendation and rationale to ensure they do not appear to be limited to training for registered dietitians.

Regarding data collection, Dr. Sheen agreed that improving data collection systems would be a significant advance, as it increases the ability to gather data to support needed changes. Dr. Anderson agreed that gathering data should not be a meaningless chore but rather a tool for encouraging better care, such as making warm hand-offs that lead to patients following through with referrals.

Next Steps for the White Paper

The changes made at this meeting will be incorporated into a final draft for rapid review by the Council. The goal is to finalize the draft by mid-July so that HRSA staff can move it through the review and clearance process and into the Secretary's hands before the next fiscal year. Council members determined the specific dates and process for final review. Janet Robinson reminded the group that this meeting represents the Council's last opportunity for public deliberation on the paper; any further changes should not alter the substance of the content discussed.

Public Comment

No public comments were offered.

Final Remarks

Dr. Chan said that day 2 of the meeting would feature presentations on school-based health centers (SBHCs), a topic she hoped the Council would pursue under the next Chair. The meeting recessed for the day at 3:32 p.m.

DAY 2

Opening and Charge of the Day

Ms. Fabiyi-King, DFO, opened the meeting at 9:00 a.m., Eastern time, and called the roll. Council Chair Dr. Chan offered a quotation from Anita Roddick, founder of The Body Shop: "To succeed, you have to believe in something with such passion that it becomes a reality." Dr. Chan said that the NHSC began with one person's passion to reach communities that lacked access to health care, and he pushed for legislation and funding that made the program a reality. She applauded all the Council members for their dedication to keep the NHSC moving forward. She invited the members who are completing their terms on the Council to reflect on their experiences.

Sandra Garbely-Kerkovich, DMD, said that throughout her tenure, she reminded the Council about the role of oral health as an integral part of overall health, and she hoped that the Council would continue to address oral health in all its deliberations. She encouraged new members to speak up and bring their ideas forward.

Dr. Khozaim said that the NHSC had given him so much that he felt obligated to give back by participating on the Council. He appreciated all of those who contribute to the program. He hoped that the NHSC would continue to expand, as it has been a lifesaver for so many people pursuing medical careers and has contributed to their recognition of the value of national service.

Panel: School-Based Health Care

Mental Health Education in Schools: New York State

Renee Rider, MEd, Director, School Mental Health Resource and Training Center, Mental Health Association in New York State

Susan Fisher, Assistant Director, School Mental Health Resource and Training Center, Mental Health Association in New York State

John Richter, Director of Public Policy, Mental Health Association in New York State

Ms. Rider explained that in 2016, New York State became the first state in the country to require schools to include mental health education in their curricula. The state also provided funding to create the School Mental Health Resource and Training Center to support schools in meeting the

requirement. Ms. Fisher noted that the Center does not provide specific curricula but helps schools develop their own by offering resources, guidance, and professional development. The Center also helps establish community partnerships, such as school-based mental health clinics, and engages families and caregivers around youth mental health.

Resources for school instruction include, for example, a starter kit of lesson plans on mental health that schools can adapt, information on adjusting the culture, and securing community buy-in around mental health efforts. The Center also works directly with schools to understand available resources, identify gaps, and determine how to fill them. The Center offers a lot of professional development, in person and virtually, guided and self-paced, to all those who work at schools. Monthly live webinars offer opportunities for teachers to discuss issues with experts in the field. For families and communities, a monthly webinar addresses topics of concern for parents, caregivers, and teachers, such as suicide, social media, and bullying.

Discussion

Dr. Anderson asked how schools link students to additional mental health services when needed and whether New York is considering banning students from having access to their phones during school hours, as Los Angeles recently did. Ms. Rider clarified that the Center focuses on ensuring that schools understand the basics of mental health wellness, and it focuses more on teachers than students. Ms. Fisher added that the Center promotes education for teachers or other adults in the school setting to recognize and address mental health issues that may arise among students.

Ms. Rider noted that, through professional development and other avenues, the Center encourages development of community partnerships to facilitate access to mental health services. New York State recently announced that it will provide funding for any school that wants to establish a school-based mental health clinic. Ms. Rider said New York Governor Kathy Hochul speaks frequently about the importance of mental health, and the state provides money for schools to link to community mental health partners.

Mr. Richter said that New York has not yet discussed banning phone use in schools, but it was the first state in the nation to legislate regulations around the algorithms that social media platforms employ to engage users to the point of addiction. Ms. Fisher pointed out that New York City sets its own rules and may be limiting phone access in schools.

Sheri-Ann Daniels, EdD, asked whether the Center's materials are translated into multiple languages and how cultural differences are integrated into materials. Ms. Rider said the Center recently launched a presentation on culturally responsive education that addresses topics such as the immigrant experience and cultural barriers, and it has been well received. Ms. Fisher said materials are offered in the most common languages spoken (English, Spanish, and Chinese), and users can translate the Center's website into multiple other languages. The Center is seeking multilingual presenters.

Ms. Fletcher-Blake asked how the Center measures its impact. Ms. Rider said the Center routinely solicits survey evaluations of its webinars and presentations but acknowledged that it could work toward improving how it measures impact. Ms. Fisher explained that the Center has conducted three independent, statewide surveys of educators to analyze the reach of programs and demographics of participants. Feedback is generally positive. Ms. Fisher added that the Center aims to reach every community and school in the state, so it uses the information gathered to focus on that goal.

The Role of SBHCs

Seleena E. Moore, MPH, Vice President of Programs, School-Based Health Alliance

According to a national census by the School-Based Health Alliance, said Ms. Moore, the United States has more than 3,000 SBHCs, most of which operate within a traditional school model—that is, a fixed facility located on a school campus. Many use a variety of models, including mobile health units, telehealth services, and off-campus facilities, to reach beyond campus. SBHCs offer many benefits to students, their families, schools, and communities by promoting health through convenient, timely, accessible care. The Alliance's census found that 63 percent of SBHCs are sponsored by health centers (e.g., Federally Qualified Health Centers [FQHCs]), linking patients with physical and mental health care as well as safety net services.

Many SBHCs provide at least primary care, in person and through telehealth, and many offer behavioral health, health education, sexual and reproductive health, oral health, and vision care. Services are often provided by physicians or nurse practitioners. A number of sites are investing in youth development and gather insight from youth advisory councils to ensure that needs are met in a respectful way. Workforce recruitment and retention are a key consideration. The School-Based Health Alliance supports SBHCs, particularly around social determinants of health (SDoH), such as health insurance, food security, transportation, and housing. For example, the Alliance's Youth Safety Net Project has been working with support from the Bureau of Primary Health Care since 2008 to help community health centers meet the needs of children and adolescents in schools and communities. The Alliance also supports learning collaboratives and training to improve the focus on mental health and facilitates partnerships to address food insecurity and lack of housing, so that SBHCs can screen for SDoH and link students and families to services.

Along the same lines, the Alliance launched the School-Based Health Care Coordination initiative to streamline coordination of care. It is working with FQHCs in four cities and will bring care coordinators to 42 SBHCs, with the goal of building a sustainable, scalable, and translatable mechanism to support coordinated services. The initiative requires that programs be eligible to bill Medicaid for services, which will help pay for the coordinators. The Alliance also invests in youth development and introduces young people to careers in health through internships and other programs.

Behavioral Health in SBHCs: Georgia's Experience

Morgan Stinson, PhD, LMFT, CCTP, Behavioral Health Director, Community Health Care Systems, Georgia

Dr. Stinson described how SBHCs function in Georgia, with particular attention to behavioral health. Most of the state is facing a shortage of mental health providers, and the behavioral health workforce shortage is a challenge at every level of service. Community Health Care Systems operates 19 FQHCs and four SBHCs across the state. School-based behavioral health providers take part in health fairs and other events to increase visibility and reduce stigma around

behavioral health services. They also engage families and caregivers as vital links in the treatment process. From a behavioral health perspective, it is particularly important to work with school leaders to establish boundaries, such as confidentiality. School-based behavioral health should offer students a safe space, and mental health care should not be seen as a form of discipline or punishment, said Dr. Stinson. Planning should also establish protocols for emergencies, especially mental health emergencies. Each school has different resources and funding; Dr. Stinson emphasized that his organization's services can supplement but do not replace existing systems or providers, such as school counselors.

Among other critical steps to setting up effective school-based behavioral health programs are identifying the members of the team, fleshing out policies, and coordinating care. The goal is to move toward prevention as well as treatment. Family engagement can be challenging, especially in rural areas, but telehealth can help integrate families into care. It is particularly complicated to develop screening procedures for referring students to appropriate services. Dr. Stinson emphasized that collaborative relationships and communication are key.

The School Health Assessment and Performance Evaluation (SHAPE) System can help assess needs and track the performance of contractors. It also provides a framework for various tiers of mental health support, with a base level of promoting mental health in schools, a middle level of referral and coordination of care, and a top level of treatment, all adapted to the individual school and its resources. The system also addresses funding and sustainability of mental health services. Dr. Stinson added that data collection remains challenging because staff are overwhelmed. He pointed out that flexibility and adaptability are particularly important for success.

Discussion

LuVerda Martin, DNP, CNM, APNP, asked how school-based mental health providers manage a student's need for medications. Dr. Stinson responded that many FQHCs in his area use telehealth consultants to ensure access to medications. His system also has some psychiatric nurse practitioners, working under the guidance of a psychiatrist, who can prescribe some medications for students (e.g., antidepressant and antianxiety medications) and manage more complex medication needs (e.g., antipsychotics).

Jihan Doss, DMD, MPH, said that New Mexico requires students to have an annual medical and dental examination for school entry. She asked whether other states are moving in that direction. Ms. Moore said she would discuss the issue with colleagues and follow up with more information about legislation under consideration. The Alliance supports oral health care at SBHCs and just completed a 5-year program to provide such services in the five largest school districts in the country.

Dr. Sheen asked for more insight on how to initiate behavioral health services in schools and how to integrate them with other services effectively. Dr. Stinson noted that access to behavioral health services meets a need but can also mean that students are pulled out of class for appointments, which can be disruptive and challenging for students, especially if they are addressing abuse or trauma during appointments. Community Health Care Systems suggests that local providers meet regularly with schools to discuss how to provide care with less disruption of the school day. Ms. Moore added that telehealth has raised new challenges, and students need more opportunities to connect with providers. She said telehealth cannot address every issue; in-person, real-time access to professional providers is still needed.

SBHCs: The Ohio Experience

Kate Schroder, President and Chief Executive Officer, Interact for Health, Cincinnati, OH

Chelsie Hornsby, Senior Director of Business Development, HealthSource of Ohio

Angie Hartman, MPH, Senior Director of School-Based Health and Vision Services, The HealthCare Connection

Ms. Schroder said that as a result of many years of investment, the Greater Cincinnati region has 44 SBHCs that provide behavioral and mental health, and many also offer dental and vision care. She emphasized that SBHCs provide more comprehensive care than the school nurse model; SBHCs can diagnose, prescribe, and bill for services, and their work is part of the medical record. Making services available to the whole community through an SBHC contributes to financial sustainability.

A 2023 independent report on SBHCs in the Ohio region found that the number of sites and the patient population have grown dramatically over the past 10 years, with the greatest growth in vision, dental, and behavioral health services. The average consent rate is 67 percent, and higher in those with longstanding SBHCs. The report highlighted some keys to success:

- Promotion of universal access and targeted support for underserved communities
- Colocation of services when possible plus telehealth and mobile services
- Strong collaboration among school leaders, health providers, and the community
- Strong leadership and networks for communication
- Student and family engagement at all stages, including planning, design, marketing, and outreach
- Data collection to make the case for state support
- Investment in adequate staffing and capacity
- Investment in provider pipelines, e.g., through partnerships with higher education institutions

Ms. Hornsby explained that HealthSource of Ohio is the largest FQHC in the state, with 27 locations throughout rural southwestern Ohio. Its six SBHCs address community access to care by offering telehealth and transportation. Strong community support is crucial for success, including support from local health care providers. In addition, Ms. Hornsby said, it is important to build relationships with leaders at multiple levels to ensure continued support in the case of turnover.

HealthSource has been providing mobile dental and vision care for the past few years. From 2021 to 2022, the consent rate for mobile health skyrocketed as the convenience became clear. The organization is focusing on going beyond consent rates to increasing utilization of SBHCs. It is working with school-based nurses and others to link students to SBHCs when needed. It is also integrating behavioral health services where possible, although the region faces a huge shortage in providers, especially in rural areas. Ms. Hornsby added that keeping SBHCs open during the summer helps address some of the additional needs of the community.

The HealthCare Connection is also a longstanding FQHC, said Ms. Hartman, with three SBHCs and one school-linked location. In addition to medical, behavioral, and dental health services, the SBHCs offer health education and promotion. The HealthCare Connection recently launched an in-house pharmacy whose services extend to SBHCs, providing increased convenience for families and communities. Ms. Hartman said SBHCs facilitate health, well-being, and academic success by addressing access to care and services related to SDoH. She noted that 70 percent of young people who receive mental health services access those services at schools. In schools that already have mental health providers, the HealthCare Connection partners to provide behavioral health staff for short-term care. When ongoing care is needed, the organization facilitates a warm hand-off and serves as an interim resource during the time it takes to link to care. Providing mental health services in schools improves health and academic outcomes.

Ms. Hartman echoed that building strong relationships is key to success, along with raising awareness about services. Advisory councils that bring together school leaders, health providers, local partners, community members, students, and parents are an opportunity to learn what works and tackle issues upfront. Integrating the SBHCs with the school district and encouraging the staff to be part of the school community have helped build trust. The HealthCare Connection is currently focusing on expanding services through new partnerships.

Discussion

All three speakers noted that the NHSC loan repayment program is an effective recruitment tool for their sites. Ms. Hartman said her organization typically focuses on recruiting family nurse practitioners, behavioral health providers, and oral health providers.

Dr. Khozaim asked how to ensure that other providers in the area, particularly pediatricians, do not see an SBHC as competition and how SBHCs achieve sustainability in areas where other providers did not. Ms. Hornsby said that being part of an FQHC enables the SBHC to be sustainable. She also said that building connections is crucial; SBHCs can provide access to those who need it, and when appropriate and necessary, patients are referred to other providers for additional care. Ms. Hartman added that SBHCs seek to complement existing services, not replace them. For example, a student can take advantage of the SBHC while in school and then

transfer to their regular provider for continued care. From the outset, Ms. Hartman said, her organization talks with local providers about what the SBHC will and will not do.

Dr. Garbely-Kerkovich asked whether the organizations have considered expanding dental services to incorporate more advanced care. She also pointed to challenges SBHCs face around consent for dental treatment. Ms. Hartman said the HealthCare Connection provides advanced dental services and is expanding that capacity. She noted that the ideal opportunity to gain consent is at the beginning of the school year, in concert with all the other paperwork required for school entry. Her organization made a lot of headway by using an electronic portal for completing and signing all the school forms at once and by securing consent for treatment that remains valid for as long as a student remains in the same school district.

Ms. Walenciak asked about the makeup of advisory councils and trends in feedback from the councils. Ms. Hartman said her organization typically asks that the councils include a parent and a student representative and that the superintendent and other school leaders engage regularly as members. The councils add members as necessary to reflect their communities' needs. The councils offer advice but have no governing authority.

For mobile dental units, Ms. Fletcher-Blake asked how the SBHCs manage follow-up and financing. Ms. Hornsby said HealthSource treats most dental patients in its dental offices, following up and referring patients for additional care as needed. The costs are paid by insurance or by a foundation funded by grants and donations. HealthSource has care managers and also partners with health departments and community organizations for follow-up care and services. Ms. Hartman said the HealthCare Connection also treats most patients in house but refers some to local partners, including the Cincinnati Children's Hospital. She added that the organization responds to needs; for example, it partners with an organization that helps people with limited English proficiency complete paperwork for services.

Dr. Doss asked for more details on dental services, noting that only a small percentage of patients seen actually complete treatment. Ms. Hornsby pointed out various barriers to treatment

but said HealthSource is working to treat more often. It is also improving and refining how it follows up with patients, especially those seen in mobile dental units.

Council Discussion

The Council spent the remainder of the meeting in unstructured discussion with Israil Ali, MPA, Director of the Division of NHSC. Mr. Ali expressed his deep appreciation to the Council members for their contributions and congratulated Dr. Chan for her leadership. He noted that the NHSC program is changing as health care delivery changes. The statute on which the program is based is antiquated, so the staff continuously seeks innovative ways to improve the program within its legal authorities. Mr. Ali looked forward to exploring novel approaches, such as the recent award for linguistic competency.

Ms. Fletcher-Blake pointed out that the current method for determining HPSA scores prevents some health centers from taking part in the NHSC. Workforce challenges, gentrification of low-income neighborhoods, and the rise of for-profit health care funded by private equity firms all combine to put some health centers in an untenable position: they strive to meet the needs of underserved communities but do not have HPSA scores high enough to merit more federal intervention. Ms. Fletcher-Blake said one health center dropped from a HPSA score of 25 to 11 because of gentrification, and Mr. Ali agreed to follow up with Ms. Fletcher-Blake to learn more about that situation.

Dr. Garbely-Kerkovich said that Maryland's patient care organization counts providers in a way that vastly overrepresents the actual number, which negatively skews HPSA scores. Mr. Ali said the NHSC is required to use HPSA scores, but he acknowledged the need to ensure that the data collected accurately reflect community needs. He said he would bring concerns about Maryland's calculations to HRSA's shortage designation team. Mr. Ali also said that HRSA could do more to raise awareness about the different types of HPSA scores and how they work together.

Dr. Gracia suggested that NHSC scholars and loan repayers be required to take part in training on some critical topics, such as ethics, professionalism, SDoH, and interprofessional

collaboration. Mr. Ali said the Empowering Clinicians for Resiliency and Transformative Care initiative represents a sizable investment in NHSC scholars and loan repayers to address workplace readiness. The initiative is a direct response to focus groups of NHSC participants who said they did not feel adequately prepared for the dynamic nature of caring for people in underserved communities. Mr. Ali added that HRSA demonstrates its values by giving preference in loan repayment programs to those who have completed certain training through BHW-administered programs that advance interprofessional skills. He further pointed out that the Empowering Clinicians initiative is exploring how to reach more NHSC participants through webinars and other resources. Mr. Ali appreciated the suggestion from Dr. Gracia that HRSA offer continuing education credit for some of those offerings, which could act as an incentive.

Dr. Anderson asked whether NHSC is looking at mechanisms to recruit and retain providers in rural areas. Mr. Ali observed that more than 80 percent of NHSC participants remain in the community at least 2 years after the completion of their required service, and the figure is slightly higher in rural areas. Still, there is much attention to encouraging NHSC alumni to stay longer. Mr. Ali pointed out that the program supports future leaders, and not necessarily within the narrow space of clinical care provision. Raising awareness about the roles that alumni play in influencing how care is practiced and delivered broadly can be an incentive for participation. Mr. Ali added that HRSA has invested substantially in awards to recruit people who treat substance use disorders to rural programs, which has been successful.

Dr. Sheen pointed out that the Council's white paper in development will provide suggestions on how to achieve some of the goals stated by Mr. Ali, such as building a network to link NHSC alumni. Mr. Ali said the Empowering Clinicians initiative aims to generate networking opportunities. He supported the idea of an alumni network if it aligns with HRSA authority around the NHSC. Mr. Ali said there should be some way for the Empowering Clinicians initiative to facilitate networking, and he agreed to look into the matter.

Mr. Ali indicated that the NHSC has a team dedicated to marketing and outreach, which he hoped would increase awareness about the program. In its best years, NHSC only awards scholarships to about 11 percent of applicants—meaning that 89 percent are rejected. Only about

30–40 percent of loan repayment applicants are accepted, even though all applicants are working in a HPSA and are therefore eligible. Mr. Ali said both cases highlight missed opportunities. He hoped to better communicate to sites and communities the benefits of having an NHSC provider. He also would like to see more sites using HRSA's Health Workforce Connector to recruit providers. Ms. Fletcher-Blake suggested NHSC work more closely with state primary care associations, and Mr. Ali said he would look into whether there are additional opportunities to do so beyond current efforts.

Dr. Gracia expressed that HRSA site visits are an opportune time for HRSA to share information about all of the programs and resources from which sites could benefit, including the NHSC and the Health Workforce Connector. Mr. Ali agreed, saying that staff should consider how to prepare for site visits and should plan to at least leave information about the NHSC with the sites.

Dr. Garbely-Kerkovich explained that, in Maryland, foreign-trained dentists can provide full services but never receive full licensure. That population could be a target for NHSC recruitment. Mr. Ali responded that NHSC participants must have completed their education in an institution accredited by the U.S. Department of Education, so foreign-trained providers would not be eligible.

Public Comment

No comments were offered.

Closing Remarks and Next Steps

Charmaine Chan, DO, Chair, NACNHSC

Dr. Chan appreciated the Council members' engagement throughout the two days of meeting. She hoped the Council would continue to assess the potential role of SBHCs, saying that HRSA is highly focused on them. Dr. Chan encouraged Council members to take the initiative to present about the NHSC in their own communities, using materials that HRSA can provide. Dr. Chan thanked all of the HRSA support staff for their excellent work organizing and hosting the meeting and adjourned the meeting at approximately 2 p.m.