

Minutes
National Advisory Council on the National Health Service Corps
Meeting June 16, 2020

The National Advisory Council on the National Health Service Corps (NACNHSC) met on June 16, 2020 via webinar. NACNHSC is a group of healthcare providers and administrators who are experts in issues faced by communities with a shortage of primary care professionals. The Council serves as a key source of information to the 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 National Advisory Council on the National Health Service Corps was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2) which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D of Title III of the Public Health Service Act.

Welcome and Council Experiences with COVID-19

Ms. Fabiyi-King called the meeting to order at 9:34 a.m. She welcomed the Council and took roll call. All members were present. Dr. Billings welcomed the Council, Federal staff, and guests, and thanked them for their work in their communities. Dr. Billings also expressed gratitude toward employers who support members in their work for NACNHSC. Dr. Billings shared inspirational quotes: “If you’re walking down the right path and you’re willing to keep walking eventually you’ll make progress.” “The future rewards those who press on.” “Change will not come if we wait for some other person or some other time. We are the ones we’ve been waiting for. We are the change that we seek.” Dr. Billings then reviewed the meeting agenda and invited Council members to discuss the impact of COVID-19 on their clinical sites and communities.

Council Experiences with COVID-19

Dr. Billings said that he practices medicine in rural West Texas near the Mexico border. The community did not conduct much testing when the first pandemic began. Until a few days prior to the meeting, Dr. Billings’ community had not experienced any confirmed cases of COVID-19. At the time of the current NACNHSC meeting, the community had nine confirmed cases and had begun drive-up testing for patients who were concerned about having been exposed. The

Association of American Medical Colleges (AAMC) asked medical schools to return all students to home campuses; so students serving at Dr. Billings' site stopped serving on clinical rotations until 2 weeks ago, when restrictions were relaxed.

Dr. Schmitz serves as chair of a primary care and family medicine department in the rural upper Midwest. He said the COVID-19 pandemic has disrupted health profession education. It also has reduced the volume of patients presenting for routine primary care, which impacts providers financially and presents a challenge for funding residency programs.

Dr. Callins serves in Albany, Georgia, which is a COVID-19 hot spot. A nurse she works with has lost seven family members to the pandemic. Dr. Callins lost her brother's father-in-law to COVID-19. She said the chaos resulting from the pandemic has encouraged creative solutions. For example, she is collaborating with community members to ensure local secondary school students have adequate supplies of menstrual products through school lunch delivery mechanisms. The pandemic elucidates the value of community partnerships in achieving public health goals.

Ms. Witzel works at a Level 1 trauma center which consistently overflowed prior to the onset of COVID-19. The center was prepared for a large influx, but instead capacity reduced by nearly half as patients stopped presenting for other needs, such as myocardial infarction and transient ischemic attacks. The center has been open for a month and has returned to overflow capacity. She is concerned about the impact of people not seeking or receiving care during the pandemic. Ms. Witzel also noted that approaches to treating COVID-19 change almost daily and that care providers still have much to learn about how to respond to this type of virus.

Dr. Bockwoldt serves in a federally qualified health center (FQHC) in Chicago, which was an early COVID-19 hot spot. The center transitioned to providing telehealth services with the support of the Coronavirus Aid, Relief, and Economic Security (CARES) Act and HRSA flexibility, including allowing billing the same amount for virtual and face-to-face visits. Dr. Bockwoldt said the change has resulted in more patients presenting for care. Patients appreciate the option of virtual visits that comply with the Health Insurance Portability and Accountability Act (HIPAA). The center, with use of personal protective equipment and logging temperatures, is now open. It provides face-to-face visits and experiential training for medical students.

Ms. Stergar serves in rural Montana, which has had one of the lowest COVID-19 prevalence rates in the country. Priorities include obtaining personal protective equipment for direct service

providers as well as testing supplies. With lack of national leadership regarding COVID-19 response procedures, these efforts require coordination with state officials and learning to work with varying leadership styles. Results have indicated the importance of public health infrastructure, and the mutual impact of state policies and activities. Ms. Stergar emphasized that even states with low prevalence are not isolated and are impacted by contact with people from other states. Ms. Stergar said it is important to educate and retain a workforce that is prepared for public health emergencies.

Dr. Sein serves in southwest Georgia, one of the areas hardest hit by COVID-19. Several of his patients have been infected. His wife, a family physician, contracted the virus and lost her sense of taste and smell. Though she has recovered from the infection, her sense of taste and smell has not returned. Dr. Sein tested negative for COVID-19, which, he said, illustrates the difficulty in understanding how the virus transmits. The clinic where Dr. Sein serves has not closed during the pandemic, and patient flow has remained similar to what it was prior to the outbreak.

Dr. Taylor-Desir works with an assertive community treatment team that serves people who are severely mentally ill. She said the opportunity to utilize telehealth has been helpful, but some people do not have Internet access, cell phones, or have cell phones that require payment by the minute. Care providers who continue to conduct home visits must use adequate personal protective equipment. Her group has been able to offer services continually.

Dr. Billings noted that care teams, including administrative and support staff, have demonstrated resilience and courage in fighting the pandemic. He said it is important to support provider and staff mental health and to guard against burnout and mood disorders. He encouraged council members to consider this for themselves, their staffs, colleagues, and families.

Bureau of Health Workforce (BHW) Update

Luis Padilla, MD

Associate Administrator, BHW

Dr. Billings welcomed Dr. Padilla. Dr. Padilla thanked Council members and HRSA staff for their time and effort, and praised NHSC leadership's work. He said that the current meeting was an opportunity to discuss the impact of COVID-19 on education, training, and programs. He thanked Council members for sharing their experiences and for their dedication to serving their communities. Dr. Padilla said such dedication is essential for effective emergency response.

Dr. Padilla said that NHSC site applications had been low during the middle of the current application cycle. Division of Regional Operations (DRO) staff conducted outreach to address this. DRO staff also conducted virtual site visits to ensure compliance with program requirements during the pandemic. HRSA has responded quickly and effectively to the pandemic and has sought advice from advisory councils and other stakeholders regarding what changes should occur in response, and which should remain in place after the pandemic. Education, training, and care delivery will change as a result of the current crisis. HRSA is focusing on accelerating telemedicine and distance learning. The Agency also is prioritizing protecting students and trainees as they return to school and clinical training sites. In addition, BHW is coordinating with stakeholders to identify gaps in emergency preparedness and to plan how to address those gaps, with a focus on how the Federal government can best support communities. BHW prioritizes supporting applicants, grantees, and partners affected by COVID-19.

The CARES Act allowed HRSA to award \$1.4 billion to nearly 1,400 health centers with the aim of preventing and addressing COVID-19 through measures such as maintaining and increasing capacity and staffing. Since the Act went into effect, health centers have been testing more than 100,000 patients weekly. Nearly 88 percent of health centers offer testing, and more than 65 percent offer walk-up or drive-up testing. HRSA awarded nearly \$165 million to more than 1,800 small hospitals and 1,400 telehealth resource centers across the Nation to combat COVID-19. Funding and technical assistance for telehealth has accelerated its expansion. HRSA awarded more than \$90 million to support 581 Ryan White HIV/AIDS programs in health departments, clinics, and AIDS Education and Training Centers across the Nation. COVID-19 has had devastating impacts on tribal communities. HRSA will support COVID-19 response efforts by 52 tribes and tribal organizations in 20 States. Dr. Padilla encouraged Council members to view

links to funding announcements on HRSA's website. Since April, HRSA has awarded \$46.5 million to increase telehealth capacity, including support for a website that offers assistance in locating telemedicine services anywhere in the U.S. The Department of Health and Human Services has charged HRSA with managing the \$75 billion Provider Relief Fund, which will reimburse healthcare providers for healthcare-related expenses and lost revenue attributed to COVID-19 in order to ensure providers test and treat people who do not have health insurance. This fund also supports launching the COVID-19 Uninsured Program Portal, through which providers can submit reimbursement claims for providing these services.

BHW prioritizes continuing support for grantees, loan repayors, and scholars during the pandemic. BHW supports the National Practitioner Data Bank, which supports healthcare institutes in identifying qualified healthcare providers. Users have indicated the resource is invaluable. Until May 31, 2020 BHW waived fees for querying this data bank in order to support efficient responses to surges in need for healthcare. The Bureau is exploring options for extending the fee waiver.

BHW's response to COVID-19 has focused on program flexibility. The Bureau developed mechanisms to support NHSC participants in meeting contract requirements and service obligations. BHW extended the deadlines for NHSC loan repayment and scholarship program applications so that school closures and clinical rotation changes would not negatively impact potential applicants. Where States allow, NHSC is permitting nursing school students and graduates to practice with provisional licenses during the emergency. NHSC implemented a process for emergency site approval that allows unemployed NHSC clinicians to earn service credit at COVID-19 care sites.

Dr. Padilla said that the decrease in patients seeking primary medical and dental care has caused significant financial damage. A majority of NHSC's unemployed providers were dentists. This demonstrates a need to consider how to deliver care with minimal contact, including remote services.

BHW awarded \$15 million to 159 organizations in five programs: aging, geriatrics, center of excellence, nursing, and registered nursing. Funding is to support acceleration of telehealth for clinical training, behavioral health, and primary care. The Bureau anticipates supplemental funding that also will be used to support telehealth.

Dr. Padilla asked the Council for input on how BHW can accelerate training, improve clinical

education, and support the returning healthcare workforce. He asked for input on how to return clinicians to face-to-face service safely, and noted the importance of patients seeking important primary care services. Dr. Padilla asked for input regarding what should change as primary care providers return to in-person practice. One possibility is providing home visits. Dr. Padilla also requested input on how best to prepare for public health emergencies.

Discussion

Dr. Billings thanked Dr. Padilla for his presentation and for BHW's work. Dr. Billings said the pandemic has required innovation. Dr. Piernot said HRSA's Bureau of Primary Health Care's (BPHC) response to the pandemic has helped the FQHC where she works, and thanked Dr. Padilla. Dr. Padilla said he would relay her message to the BPHC Bureau Chief. Ms. Witzel said BHW's efforts have facilitated access to healthcare. She said she hoped changes that have increased access to care, such as increased telehealth, will remain in place after the COVID-19 pandemic. Dr. Padilla said maintaining changes will require advocacy. He said the pandemic has disrupted the business model of primary care and healthcare delivery. With telehealth becoming an important delivery mechanism, digital literacy is a high priority. Some patients are challenged to access virtual visits. Providers need training in delivering culturally competent care through digital platforms. Dr. Schmitz said it is important to consider which services cannot be provided through telemedicine, and how to support providers who deliver these services.

Ms. Stergar also thanked BHW for its support and for its commitment to addressing disparities. She noted that tribal communities in her home state of Montana have been affected by isolation and food insecurity as a result of the pandemic. She said addressing disparities should be a priority of workforce training and education. Dr. Padilla agreed that the Nation is experiencing a medical and social emergency. He said disparities are also the reason for current political protests. Dr. Padilla agreed that addressing social determinants of health is critical, and that health equity is the core of HRSA's mission. He said the public health emergency presents an opportunity to demonstrate the importance of this mission and to advocate for change. Dr. Bockwoldt concurred. She noted that some pharmacies closed during civil unrest and suggested considering developing plans for delivering medications during emergencies. Dr. Bockwoldt said supplemental emergency funding provided by HRSA supported her organization in reaching patients and maintaining productivity.

Dr. Padilla noted the burden of healthcare demands on the workforce. It is traumatic for providers to lose patients and colleagues to COVID-19. Suicide and mood disorders are increasing among health professionals. BHW is committed to supporting the workforce's mental health and to doing this more effectively based on lessons learned during the current crisis.

Dr. Billings noted that the pandemic is disproportionately affecting people of color and those with difficulty accessing healthcare. He hoped the pandemic would inspire a shift in focus from productivity and compensation to care access and quality, and to increased responsiveness to community needs. Dr. Billings expressed concern for the financial viability of small provider practices. He suggested that providers in practices that closed due to economic pressures during the pandemic could serve in NHSC. Dr. Billings recommended increasing NHSC's budget and encouraged Council members to advocate for this.

Dr. Padilla thanked Dr. Billings and other Council members whose terms are expiring for their contributions. He also thanked HRSA staff for working extraordinarily long hours to ensure funding that supports efforts to address the pandemic is disbursed. Dr. Padilla invited Council members to provide recommendations for encouraging healthcare providers to practice in underserved communities.

NHDC: Flexibilities for Clinicians

Commander Antoine Smith

Director, Division of Participant Support and Compliance

Israil Ali, MPA

Director, Division of National Health Service Corps

Antoine Smith

Commander Smith said that the Division of Participant Support and Compliance (DPSC) is ensuring participants can continue to provide care during the COVID-19 pandemic. To accomplish this, DPSC is committed to flexibility and is working to help NHSC participants meet their service requirements. The Division aims to support those who may need to be away from their service site for more than the normally allotted 7 weeks per year and those who become unemployed as a result of the pandemic. Additionally, the Division communicates with participants to help them to comply with Federal regulations during this time.

Since mid-March, DPSC has received nearly 1,800 inquiries related to COVID-19. Inquiries have been regarding reassignment to administrative duty, furloughs and layoffs, hour reductions, site closings, and how to address personal health concerns. A large number of inquiries are regarding transition to telemedicine. NHSC is pleased to see participants continue to provide service and receive training through telemedicine. NHSC has expedited the site review process to maximize sites available.

Flexibilities offered in response to the COVID-19 crisis include suspension of service obligations for up to 1 year, volunteering and providing services at temporary sites to respond to COVID-19, providing telehealth, and providing service at alternative sites. A suspension pauses a participant's service obligation when service is impossible or involves temporary extreme hardship. Following suspension, participants complete their service obligation. NHSC designed flexibilities to enable sites and clinicians to respond effectively to the emergency. NHSC is expediting site reviews to expand service capacity. Emergency site approval can allow participants whose sites are closed to earn credit for service at another facility that does not meet usual requirements for approval. NHSC has removed limits on the numbers of hours for which participants can receive credit for telehealth services.

Israil Ali

Mr. Ali thanked Commander Smith for his presentation and his leadership during the COVID-19 pandemic. He also thanked his regional team for their work in supporting providers and sites.

Mr. Ali said that in March 2020 NHSC scholarship applications were 59 percent lower than last year. Several students called to report difficulties with requirements such as submitting letters of recommendation with a handwritten signature on academic letterhead, and obtaining financial aid or registrar data. Some applicants were reluctant to provide income verification due to uncertainty of employment at their designated sites. NHSC extended the application cycle by 4 weeks, allowed letters of recommendation to be submitted via e-mail, and adjusted deadlines to accommodate delays in board exam schedules.

Loan repayment applications also declined steeply, with a 40 percent decline in applications to serve at FQHCs. NHSC also extended this deadline by 4 weeks. Data indicated which applicants were serving in COVID-19 hot spots and provided insights about how to reach them during the application period. NHSC collaborated with the Federal Office of Rural Health Policy (FORHP), officers of state community health centers, and other stakeholders to encourage application to NHSC programs. NHSC extended the employment start date requirement. These measures resulted in a 20 percent increase in scholarship applications compared to FY2019 and only a 4 percent decrease in loan repayment program applications.

Mr. Ali thanked Council members for their advocacy and recommendations for NHSC during the crisis and invited discussion.

Discussion

Dr. Billings thanked Commander Smith and Mr. Ali for their efforts. Ms. Stergar and Dr. Schmitz thanked the presenters for the information they shared and for their efforts during the COVID-19 crisis. Dr. Schmitz expressed appreciation for NHSC's patient-centered and community-center approach.

Dr. Piernot asked whether NHSC anticipates similar challenges during the next application cycle, especially since some universities are still unsure how they will approach teaching. Mr. Ali said NHSC is working to avoid this through measures such as presenting recruitment webinars at universities that prioritize serving underserved communities. Dr. Billings suggested promoting stories about NHSC healthcare heroes meeting community needs during the crisis to support

recruitment. Mr. Ali said this is a part of the current outreach strategy. Commander Smith said the External Affairs team is considering how to do this without burdening NHSC participants.

Commander Smith invited Council input on addressing unemployment among NHSC dentists.

Dr. Billings asked if primary care associations and organizations have shared information about challenges they are addressing in supporting applicants. Commander Smith said this varies between states. A common challenge is sites not opening because patients will not present for care, which results in revenue reduction. This problem is beginning to be less common.

Ms. Stergar suggested that the Council consider making a statement regarding commitment to equity in NHSC programs. Dr. Billings said he would support making such a statement.

Dr. Bockwoldt said COVID-19 has resulted in decreased applications to the College of Nursing where she works, as well as a decline in faculty and staff due to budget cuts. She asked if others had similar experiences. Dr. Bockwoldt said this could decrease the NHSC applicant pool over the long term. Dr. Billings said he also has observed this. He expressed concern about the effects of removing students and trainees from clinical environments. He said it will be important to obtain student and trainee input about this experience and to prepare how to address this kind of emergency in the future.

Dr. Schmitz said students, residents, and physicians in training typically receive the safety protections afforded to non-essential workers, such as not being required to provide in-person care. However, they will no longer have these after board certification, graduation, or program completion. Clinicians generally do have to consider how to treat patients with contagious diseases or with other needs that put healthcare providers at risk. Educators must consider how to balance protecting the workforce with supporting practice. Students are eager to return to clinical learning environments. Dr. Schmitz said the field must consider how best to deliver services that cannot be delivered remotely, and how to address the backlog of healthcare service needs that has accumulated during the pandemic with the current and chronic workforce shortage.

Approval of March 10-11, 2020 Meeting Minutes

Following a break, Ms. Fabiyi-King conducted roll call and confirmed all Council members remained present. Dr. Billings asked Council members to review minutes from the last meeting and consider approval. Dr. Callins made a motion to approve the minutes and thanked staff for producing detailed, readable minutes. Dr. Billings concurred and expressed his appreciation. Ms. Witzel seconded the motion. Dr. Billings invited comments and discussion on the minutes. There was none. Dr. Billings called for a vote on approving the minutes without change. The Council approved unanimously.

As the Council waited for resolution of a technical difficulty, Dr. Billings asked whether Council members had any recommendations for self-care or learning new technology. Dr. Billings said he has been running with one of his sons in the evenings. Dr. Bockwoldt said she monitors the National Zoo Panda Cam on work breaks.

COVID-19 in Rural Communities: Updates and Strategies

Michael McNeely

Deputy Director, Federal Office of Rural Health Policy

Dr. Billings introduced and welcomed Mr. McNeely. Mr. McNeely provided an overview of the Federal Office of Rural Health Policy, which comprises five divisions and responds to rural health needs. A current priority is to increase care value by improving outcomes and containing costs. FORHP's Community-Based Division supports innovative responses to rural community needs. The Hospital-State Division supports critical access hospitals, which are rural hospitals with 25 or fewer beds and average lengths of stay shorter than 96 hours, and rural hospitals with fewer than 50 staffed beds. The Division's focus is on quality and performance improvement. The Office for the Advancement of Telehealth administers telehealth network grants and telehealth resource centers, which are not exclusive to rural communities. These centers have been very active during the COVID-19 pandemic. FORHP's focus is assessing how Federal government regulations impact rural populations and providing a rural perspective on policy.

Mr. McNeely provided a summary of factors that distinguish rural populations from urban and suburban populations. Poverty is more prevalent in rural communities. People in rural communities are more likely to experience social isolation. Weather is more of a risk factor in rural settings. The proportion of elderly people is higher in rural communities (19%) than urban communities (15%). Population growth in rural communities is currently 3 percent, compared

with 13 percent in urban and 16 percent in suburban communities. Population is declining in about half of rural counties. About 80 percent of residents in rural communities are non-Hispanic White people. The percentage is 44 percent in urban and 68 percent in suburban communities.

Life expectancy is 3 years shorter in rural communities, where mortality due to heart disease and stroke are higher. Maternal mortality rates are higher among rural women. Tobacco use and physical inactivity are more prevalent in rural communities, as are diabetes and hypertension. Mental health problems are more prevalent, and mental healthcare services are more difficult to access in rural communities. Since 2010 about 120 rural hospitals have closed, and the clinician shortage has increased. Rural people must travel farther than urban and suburban residents to healthcare providers and have less access to transportation. It is not uncommon for it to take four hours to reach the nearest medical facility. In addition, rural populations are less likely to be insured or adequately insured, or to have affordable health care options than other populations.

The CARES Act allocated \$180 million to FORHP for the purpose of implementing telehealth and rural health activities authorized by Sections 330A and 330I of the Public Health Service Act. Funds are for the purpose of preventing, preparing for, and responding to COVID-19 over the next 3 years. Of these funds, \$150 million are allocated to support 1,785 small rural hospitals in 46 states. Each hospital received approximately \$84,000 for testing, laboratory services, personal protective equipment, or otherwise responding to the pandemic.

FORHP awarded \$11.5 million to support 14 telehealth resource centers to increase capacity. The Office also awarded \$15 million in grants to 52 tribes, tribal organizations, and urban Indian Health Organizations to support efforts to prepare and respond to COVID-19 through testing, personal protective equipment, telehealth, and other activities. FORHP awarded \$5 million to support two Licensure Portability grants to assist telehealth clinicians across the U.S. in meeting emerging needs related to COVID-19. The CARES Act allowed FORHP to extend its telehealth programs from 4 to 5 years, and its outreach programs from 3 to 5 years. The Act allows support for public/private partnerships to expand services to rural communities.

The Paycheck Protection Program and Healthcare Enhancement Act allocated \$225 million for FORHP to support 4,549 rural health clinics. An additional \$500,000 will support the National Association of Rural Health Clinics in providing technical assistance.

Current issues related to meeting rural demands for COVID-19 services include inadequate test supply, spillover of COVID-19 patients from urban hospitals, concerns regarding reopening,

shortages of personal protective equipment, underutilization of emergency department services, and underutilization of 911 call services in cases of drug overdose.

Mr. McNeely pointed out that COVID-19 is both undermining rural health infrastructure and causing underutilization of rural health services. It also has led to development of a mental health hotline and increased collaboration with police departments regarding response to medical and mental health crises, including a digital resource for treatment referrals. Some school systems are loaning their Chromebooks to provide Wi-Fi access to people in need of telehealth services for substance use disorder recovery. FORHP monitors COVID-19 prevalence, impact, and effective responses in rural communities.

With the increased use of telehealth, FORHP has observed a decrease in appropriate care coordination. The main barriers to care coordination are telehealth shortfalls and staff turnover. In addition, staff who conduct intake screens are not participating in visits or conducting screens that indicate issues such as substance use disorder, domestic violence, or mental illness. Responses to COVID-19, such as not allowing visitors to hospitals or nursing facilities, result in lack of social supports, including peer navigation services, for patients. During the pandemic, healthcare professionals frequently experience extreme fatigue and neglect to ask patients about their well-being. Mr. McNeely noted that there are not evidence-based practices for addressing provider burnout. At the same time, need for mental healthcare services has increased which is expected to result in increased compassion fatigue. Childcare services have closed, which is a burden on the healthcare workforce. Many grantee sites have enacted hiring freezes and cancelled elective services, which decreases revenue. State budget reductions may reduce healthcare capacity. With current demand for acute care services, it is difficult to offer prevention services or to convene collaborators.

Discussion

Mr. McNeely invited questions and comments.

Dr. Billings said a critical access hospital where he works, which serves a 12,000 square mile area, declared bankruptcy 12 weeks ago. He thanked Mr. McNeely for his work and advocacy on behalf of rural communities.

Dr. Taylor-Desir said she has served as a psychiatrist and Chief Medical Officer to a tribal community in rural North Dakota. She recalled that recruiting qualified information technology (IT) personnel was difficult, and they are critical for mental health resource center and primary care clinic operations. Dr. Taylor-Desir asked whether FORHP funding can be spent on improving IT capacity. Mr. McNeely said this is an important point. Some current funds support development and implementation of IT infrastructure, but not staff salaries, while others can support salaries. He said support requires delineation between work supported by the grant and other work conducted for the grantee organization. Mr. McNeely said that the U.S. Department of Agriculture is collaborating with the Federal Communications Commission to implement the American Broadband Initiative to support expansion of broadband access in rural communities. Dr. Taylor-Desir said telehealth services are critical for rural communities. Mr. McNeely advised her to monitor FORHP Telehealth Network funding announcements for opportunities to support telehealth installation and personnel.

Ms. Stergar thanked Mr. McNeely for his accurate description of rural communities. She said rural Montana is moving to reopen and has removed quarantine restrictions for travelers. An increase in COVID-19 cases has followed and Ms. Stergar expects this to recur in the fall and winter. She said it is difficult to convene and coordinate stakeholders during a crisis. Rural communities need State and Federal resources and plans for allocating and utilizing those resources to respond to complex issues during crises. Effective response requires adequate infrastructure. Telehealth cannot be delivered without broadband access, which requires planning among multiple stakeholders.

Mr. McNeely concurred that coordination is critical for expanding broadband access.

Dr. Schmitz said he is a family physician and medical educator who has served in a rural critical access hospital. He reiterated that some essential healthcare cannot be delivered through telemedicine. COVID-19 could be transformational to care delivery and workforce requirements. He advised considering which changes are necessary for educating rural healthcare providers who will serve a decade in the future, when requirements are likely to be different from what they are currently. Mr. McNeely agreed.

Dr. Billings thanked Mr. McNeely for his presentation, time, and work, and asked him, on behalf of the Council, to thank his staff for their work. Mr. McNeely thanked the Council for having him.

Application Program Guidance (APG) Discussion

NACNHSC APG Workgroup

Dr. Billings invited the APG workgroup to provide updates on their work. Dr. Bockwoldt said the group had identified three areas for improvement: application requirements, alignment between application guidance and the application, and clinical practice requirements. Dr. Schmitz said the group had discussed recommendations to change policy regarding credit for telemedicine and hospital care, including emergency services and obstetrical care. Dr. Billings asked whether the COVID-19 pandemic has implications for recommended changes to clinical practice requirements. Dr. Schmitz said some changes that have been made in response to the acute situation only apply to the acute situation, while others should be enduring, such as allowing credit for more telehealth service hours, which will improve access to healthcare. The workgroup's recommendations are intended to apply to the long term. He said that the workgroup recommends continuing to teach students and trainees in rural and underserved areas, since research shows this is linked to continued service to those communities. Dr. Bockwoldt invited Council members to review workgroup documents and the APG. She said that Dr. Brown had compared guidance to the application to identify discrepancies. Dr. Bockwoldt noted that the guidelines do not identify psychology or mental health as a specialty area that meets requirements for nurse practitioner applicants, although this is an area for which there is much need. Dr. Bockwoldt said the workgroup recommended updating guidelines to align with the changes made in response to COVID-19, for example updating the restriction of telehealth to services delivered from and to approved sites.

Dr. Schmitz said all rural communities, not just Teaching Health Centers, need teaching capacity. Providers can provide patient care with a learner present. The workgroup recommends including NHSC educational opportunities in more settings. The workgroup also recommends allowing learners to earn credit for providing emergency and intensive care services in rural and underserved communities. Physicians with emergency and obstetrical skills may be needed to serve more hours. NHSC should support them in serving where needed.

Dr. Billings said NHSC should train learners to use telehealth while they are serving at sites. Dr. Schmitz said that, as telemedicine primary care delivery increases, the primary care workforce may divide into those who deliver most of their services via telemedicine and those delivering care that requires in-person contact. Dr. Schmitz said the NHSC could play an important role in

recruiting providers with skills to provide services that cannot be delivered remotely to serve in rural communities.

Ms. Witzel asked whether the workgroup should submit written recommendations for the Council to consider. Dr. Schmitz said the workgroup aimed to identify themes for discussion rather than make specific recommendations. Ms. Witzel said the workgroup should document specific suggestions for change that members agree upon. Ms. Fabiyi-King invited Council members to comment on the workgroup's document and to submit comments to Dr. Billings, who will forward the comments to her. She said she would submit suggested changes to BHW entities responsible for APG review. Dr. Schmitz said it would be valuable to know the rationale for some requirements the workgroup thinks should be updated. A better understanding of why the requirements are in place could change workgroup recommendations. Without this understanding, he hesitates to advocate for changes. Dr. Billings agreed with this point and thanked the workgroup for their efforts.

Questions from NACNHSC to the Division of Regional Operations

Jeff Jordan

Director, HRSA Division of Regional Operations

Dr. Billings welcomed Jeff Jordan, Director of the Division of Regional Operations who had accepted an invitation to address Council questions. Mr. Jordan explained that the Division of Regional Operations oversees NHSC site applications, scholar placement, and site verification.

The Council had asked Mr. Jordan prior to the meeting what would help regional offices do their work successfully, and what barriers and challenges regional offices face. Mr. Jordan said input from staff at NHSC sites is useful. Partnerships with external stakeholders are important, and DRO would appreciate support in connecting with potential partners. DRO would appreciate advice on how to address workforce shortages. Advocacy for NHSC is helpful. DRO welcomes help in recruiting new NHSC sites. Mr. Jordan said insight from Council members regarding relevant local and regional trends and perspectives is useful.

Mr. Jordan said the most important challenge DRO faces is communicating the importance of compliance with the NHSC site agreement. Requirements in the agreement are designed to ensure underserved populations receive healthcare. Mr. Jordan said the Council could help NHSC participants by conveying this message and could remind participants that compliance is part of fulfilling the NHSC mission.

Mr. Jordan said that the Council had submitted additional questions, which DRO would answer in writing. He reminded Council members that the new site application cycle was currently open and would be until July 21, 2020. He invited Council members to refer potential applicants to the HRSA website. Dr. Billings thanked Mr. Jordan for his input.

NACNHSC 2020-2021 Priorities

Dr. Billings invited discussion about Council priorities for 2020-2021.

Ms. Stergar recommended for the Council to encourage NHSC to renew its commitment to working toward health equity and serving communities with disproportionate need for a larger health workforce. Dr. Billings said he would entertain a motion to make a statement in the meeting minutes that promoting health equity and reducing healthcare disparities are core NHSC values. Ms. Stergar made the motion, which Dr. Billings seconded. The motion passed unanimously.

Dr. Bockwolft suggested that the Council prioritize ongoing assessment of the impact of COVID-19 on the healthcare workforce, especially NHSC scholars and loan repayors. Ms. Stergar suggested issuing a statement that NACNHSC is committed to supporting flexibility during national emergencies, such as COVID-19, in order to support and sustain the health workforce. She suggested that the statement should both address the current pandemic and apply to future emergencies. Dr. Bockwolft said the Council should make pragmatic recommendations for overcoming challenges caused by the pandemic, such as facilitating rapid transfers of furloughed FQHC clinicians, allowing clinicians to serve at multiple sites, or allowing clinicians to relieve providers affected by burnout. She noted that, as a result of diverse state policies, scholars in different states experience different COVID-19 impacts. Dr. Billings agreed that this issue should be considered a priority. He said he is interested in learning about logistical challenges caused by COVID-19 and the effects of the pandemic on the NHSC workforce's mental health.

Dr. Taylor-Desir said the Council should assess the impact of changes in telehealth capacity on NHSC scholars and loan repayors. She suggested that the Council collaborate with the National Advisory Committee on Rural Health and Human Services (NACRHHS) to develop a statement to the Centers for Medicare and Medicaid Services (CMS) regarding maintaining telehealth capacity and availability in rural communities. Dr. Schmitz agreed that it would be useful to collaborate with the NACRHHS and to develop recommendations regarding telehealth and

services that cannot be delivered through telemedicine. Dr. Billings agreed with these suggestions.

Public Comments

Dr. Billings opened the floor for public comments. No one made a public comment.

Closing Comments

Dr. Billings said it had been an honor and pleasure to serve on the Council since 2012. He thanked Ms. Witzel and Ms. Stergar, whose terms will end in October, for their service on the Council. He noted that Ms. Witzel has been named North Dakota Rural Health Provider of the Year. She has served as a preceptor and advocate to nurse practitioners. Dr. Billings wished her the best in her career. Dr. Billings thanked Ms. Stergar for sharing her perspective as a Chief Executive Officer and for sharing her experiences working for the Governor of Montana and leading the Montana Primary Care Association.

Ms. Fabiyi-King thanked Ms. Stergar, Ms. Witzel, and Dr. Billings for their service. She said that Dr. Billings develops and implements new ideas and advocates for opportunities for other people. NHSC awarded Dr. Billings a scholarship in 1999. He completed his service obligations in 2011 at a rural site. He has advocated for NHSC. He was appointed for a 3-year term to serve on NACNHSC in 2012. In 2014, Dr. Billings was invited to serve as a private sector advisor on health disparities for the U.S. delegation to the World Health Organization in Geneva, Switzerland. In 2017 Dr. Billings testified as an expert witness to the U.S. House of Representatives, Energy and Commerce Committee, Sub-committee on Health to support reauthorization of NHSC. He has earned many medical teaching awards and appointments. He will be leaving as Chair of NACNHSC in October. On behalf of HRSA, Ms. Fabiyi-King thanked Dr. Billings for his dedication to public health and for his commitment to improving health outcomes, especially in frontier communities. She thanked him for upholding the principles of NHSC's mission to build healthy communities by supporting qualified medical, dental, mental, and behavioral healthcare providers in serving underserved communities in the U.S. She wished Dr. Billings success in the future.

Ms. Witzel thanked Dr. Billings for his kind words. She thanked NHSC staff and said it had been a privilege to serve on the Council. She wished new members good luck. Ms. Stergar said she had enjoyed learning other perspectives from across the country while she served on the Council.

She thanked Dr. Billings for his leadership.

Ms. Fabiyi-King adjourned the meeting at 1:32 p.m.

List of Motions and Suggested Actions

Motions Made

- A motion to approve the minutes for the March 10-11, 2020 NACNHSC meeting was approved and unanimously carried.
- A motion to make a statement in the meeting minutes that promoting health equity and reducing healthcare disparities are core NHSC values was approved and unanimously carried.

Suggested Actions

- Submit suggested updates to the NHSC Application Program Guidance for HRSA review, and discuss rationale for current guidance and as well as recommended APG changes with HRSA staff.
- Consider the implications of the potential development of specialization in services that can and cannot be delivered via telehealth for workforce training and education, and how NHSC should respond.
- Commit to taking action to reduce health disparities and increase health equity through NHSC workforce education.
- Consider how NHSC can address the financial impact of the COVID-19 pandemic and future public health emergencies on small providers serving rural and underserved communities.
- Provide input to BHW on how to address unemployment among NHSC clinicians, especially dentists.
- Assess the effects of the pandemic on NHSC learners, including on their mental health, and consider how to prepare the workforce for future public health emergencies.
- Collaborate with NACRHHS to develop a statement on the need for telehealth capacity to submit to the CMS.