



U. S. Department of Health and Human Services

**National Health Service Corps Report to Congress
for the Year 2012**

Submitted to

**The Committee on Health, Education, Labor, and
Pensions
U.S. Senate**

and

**The Committee on Energy and Commerce
U.S. House of Representatives**

November 2013

EXECUTIVE SUMMARY

The report to Congress for the year 2012 details the program accomplishments of the National Health Service Corps (NHSC), which is charged with helping communities in Health Professional Shortage Areas (HPSAs) of greatest need to provide primary health care services through the recruitment and retention of primary care health professionals. The report:

- updates HPSA information;
- defines the need for primary care services through requests for recruitment and retention assistance by underserved communities;
- shows the current NHSC Field Strength and the projection for next year;
- explains the recruitment efforts for the NHSC Scholarship and Loan Repayment Programs;
- estimates the number of patients seen by NHSC clinicians;
- details the most recent short term and long term retention of NHSC clinicians in service to the underserved; and
- describes the evaluation process to determine an entity's compliance with section 333(a)(1)(D) for inclusion on the NHSC Job Center.

The significant findings in the report include:

- The NHSC and many federal and state programs use HPSA designations for resource allocation. As of September 30, 2012, the following types of HPSAs were identified:

Primary Medical:	5,759
Dental:	4,458
Mental Health:	3,707

- Approximately 60 percent of all identified HPSAs are rural, and 45 percent of NHSC placements in FY 2012 were in rural areas.
- The NHSC Field Strength in fiscal year (FY) 2012 was 9,908. The NHSC clinicians serve in urban, rural, and frontier communities in all 50 states, the District of Columbia, Commonwealth of Puerto Rico, the United States Virgin Islands, and the Pacific Basin.
- The NHSC supported 17 Ready Responders in FY 2012. These U.S. Public Health Service Commissioned Corps officers are primary care clinicians who are highly trained to respond in the event of a declared emergency.
- The NHSC remains committed to the interdisciplinary approach to patient care. The discipline mix of the NHSC Field Strength reflects both this commitment and the program's efforts to respond to underserved communities' demand for services.
- About 46 percent of NHSC clinicians serve in health centers; the remaining offer patient care services in small, non-grant-supported rural health clinics, group or private practices,

hospital-based outpatient clinics, and the like. In FY 2012, NHSC clinicians provided care to approximately 10.4 million underserved people.

- The NHSC Scholarship and Loan Repayment Programs continue to serve as a vital recruitment tool for underserved communities in need of primary care, oral health, and mental and behavioral health services. In FY 2012, the NHSC made the following new and continuation awards:

Scholarships	222
Loan Repayment	4,267
Students-to-Service Loan Repayment	69

- In FY 2010, the NHSC received \$1.5 billion through the Affordable Care Act to be allocated to the program in annual allotments through FY 2015. In FY 2012, all awards listed above were funded through the Affordable Care Act. The NHSC also made 7 new grant awards and 25 continuation grants to states through the State Loan Repayment Program with Affordable Care Act funds.

INTRODUCTION

This Report to Congress describes the program activities of the Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Clinician Recruitment and Service (BCRS), National Health Service Corps (NHSC) for the year 2012. The NHSC was established on December 31, 1970, by the Emergency Health Personnel Act of 1970 (Public Law 91-623), and it has been amended and reauthorized several times in the ensuing 40 years. The most recent legislative action, the Affordable Care Act of 2010, authorizes a maximum annual loan repayment award of \$50,000, offers the option of half-time service for both scholars and loan repayors, allows service credit for teaching, and appropriates specific funds for the NHSC through fiscal year (FY) 2015.

Although the NHSC posted a slight decrease in Field Strength from 10,279 clinicians in FY 2011 to 9,908 in FY 2012, this still represents nearly a tripling of the 3,601 NHSC clinicians posted in 2008. Field Strength includes clinicians recruited through the NHSC Scholarship Program (SP), Loan Repayment Program (LRP), and the State Loan Repayment Program (SLRP). In FY 2012, the NHSC also supported 17 Ready Responders, the U.S. Public Health Service (PHS) Commissioned Corps officers who are primary care clinicians working in high-need NHSC sites who are also highly trained to respond in the event of a declared emergency.

More than 7,000 applications for the NHSC SP and LRP were received in FY 2012, demonstrating that interest in these programs remains strong among both students and clinicians. BCRS successfully used social networking for the NHSC, specifically Facebook, to target current applicants, potential applicants, sites; NHSC Ambassadors (volunteers who educate and inform prospective Corps members and support new and existing members); and like-minded organizations. In FY 2012, the NHSC participated in 106 national conferences and exhibits representing eligible NHSC disciplines with a total of 35,500 conference attendees. The NHSC also conducted 70 recruitment visits and school presentations to health professions schools reaching over 2,400 attendees around the country to raise awareness and recruit applicants for NHSC SP and LRP.

The NHSC Ambassador Program was re-launched in FY 2011, and Ambassadors were given several new tools – including a tool kit, tutorial, and communications templates – to use in recruiting eligible NHSC applicants. Building on this effort, in FY 2012, webinars and quarterly Ambassador conference calls were held to share best practices and how to use these newly created tools. NHSC Ambassadors conducted more than 1,200 recruitment activities on behalf of the Corps, which was a significant increase from FY 2011.

An important measure of the success of the NHSC is the retention of NHSC clinicians in service to the underserved after the fulfillment of their service commitment. Studies completed in FY 2012 showed 82 percent of those who had fulfilled the service commitment remained in service to the underserved in the short-term, defined as up to 1 year after their service completion, and 55 percent of NHSC clinicians continue to practice in underserved areas 10 years after completing their service commitment.¹ This reaffirmed findings from an earlier study in FY

¹“FY 2012 National Health Service Corps Customer Satisfaction Survey” and “Evaluating Retention in the BCRS Programs,” Final Report, March 30, 2012, Cecil G. Sheps Center for Health Services Research, the University of North Carolina at Chapel Hill.

2000 which showed the majority of NHSC clinicians remained committed to service to the underserved in both the short and long term.²

MILESTONES

In FY 2012, the NHSC made 212 new scholarship awards, 10 scholarship continuation awards, 2,342 new loan repayment awards, and 1,925 loan repayment continuation awards out of funds received through the Affordable Care Act.

In FY 2012, the NHSC implemented the Students to Service (S2S) Loan Repayment Program, offering loan repayment awards to medical students in their last year of school; this program is designed to encourage medical students to select a primary care specialty and requires a 3-year service commitment in a HPSA of 14 and above³, which will begin once their residency is completed.

In FY 2012, the NHSC implemented an enhanced award structure in the NHSC LRP to incentivize clinicians to work in the most underserved areas of our country, offering up to \$60,000 for an initial 2-year contract for those clinicians serving in HPSAs with a score of 14 or higher. For those serving in HPSAs below that score, the maximum award for an initial 2-year contract is \$40,000.

In FY 2012, to extend the reach of the NHSC in rural areas, the NHSC implemented the Critical Access Hospital (CAH) pilot program, which allows the inpatient setting of a CAH to qualify as an NHSC site. Prior to FY 2012, only the outpatient clinic of a CAH was eligible, and NHSC clinicians were generally limited to no more than 8 hours per week in the inpatient setting. With the pilot, clinicians may now spend up to 24 hours per week in the CAH, with no fewer than 16 hours per week being spent in an affiliated outpatient clinic.⁴

NHSC REPORT REQUIREMENTS

The Health Care Safety Net Amendments of 2002, in conformity with the Federal Reports Elimination and Sunset Act of 1995 (Public Law 104-66), eliminated several of the annual reports required of the NHSC in the previous legislation. The remaining report requirements are found at Section 336A of the PHS Act [42 USC 254i]:

“The Secretary shall submit an annual report to Congress, and shall include in such report with respect to the previous calendar year:

(1) the number, identity, and priority of all health professional shortage areas designated in such year and the number of health professional shortage areas which the Secretary estimates will be designated in the subsequent year;

² “Evaluation of the Effectiveness of the National Health Service Corps,” Final Report, May 31, 2000, Cecil G. Sheps Center for Health Services Research, the University of North Carolina at Chapel Hill, and Mathematica Policy Research, Inc.

³HPSA scores range from 1 to 25 for primary care and mental health and 1 to 26 for dental; a higher score indicates greater need for primary care services. HPSA scoring methodology is described in more detail later in the report.

⁴ For the purposes of the CAH Pilot Program, placement at CAHs is limited to physicians, physician assistants, nurse practitioners, and certified nurse midwives.

- (2) *the number of site applications filed under section 333 of this title in such year for assignment of Corps members and the action taken on each such application;*
- (3) *the number and types of Corps members assigned in such year to health professional shortage areas, the number and types of additional Corps members which the Secretary estimates will be assigned to such areas in the subsequent year, and the need for additional members for the Corps;*
- (4) *the recruitment efforts engaged in for the Corps in such year and the number of qualified individuals who applied for service in the Corps in such year;*
- (5) *the number of patients seen and the number of patient visits recorded during such year with respect to each health professional shortage area to which a Corps member was assigned during such year;*
- (6) *the number of Corps members who elected, and the number of Corps members who did not elect, to continue to provide health services in health professional shortage areas after termination of their service in the Corps and the reasons (as reported to the Secretary) of members who did not elect for not making such election;*
- (7) *the results of evaluations and determinations made under section 333(a)(1)(D) of this title during such year; and*
- (8) *the amount charged during such year for health services provided by Corps members, the amount which was collected in such year by entities in accordance with section 334 of this title, and the amount which was paid to the Secretary in such year under such agreements.”*⁵

These requirements are discussed below highlighting program information and activities as they relate to the requirements. This report enables the NHSC to discuss activities and initiatives that are aligned with the mission of the program.

Requirement 1: The number, identity, and priority of all HPSAs designated in such year and the number of HPSAs which the Secretary estimates will be designated in the subsequent year.

The designation of HPSAs is an applicant driven process – any individual or agency may apply to have a geographic area, population group, or facility designated as a HPSA. The designation process involves two types of actions: (1) the analysis of the data submitted with each new request and (2) the review of previously designated HPSAs (which is done every 3 years). The analysis and review are carried out by the Shortage Designation Branch (SDB) in the Division of Policy and Shortage Designation at the BCRS. The SDB determines the priority of a HPSA by

⁵ The Health Care Safety Net Amendments of 2002 replaced Section 334 [42 USC 254g], titled “Cost Sharing”, with a new Section 334 entitled “Charges for Services by Entities Using Corps Members.” Therefore, this requirement can no longer be met.

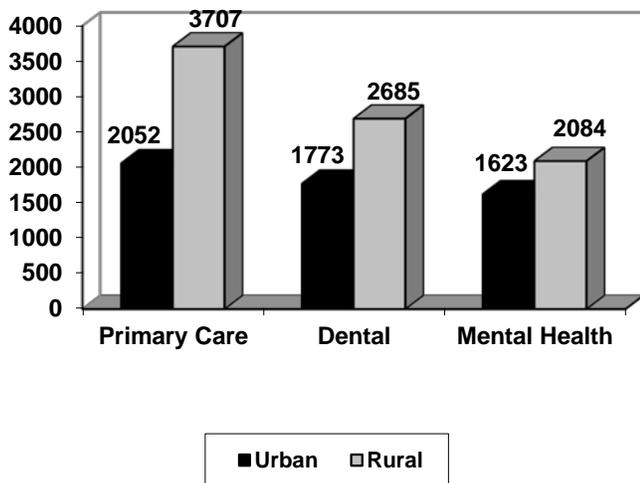
assigning a numerical score based on a calculation weighing several factors of need, including physician-to-population ratio, infant mortality, access to health services, health status, and the ability to pay for health services. While the HPSA designation was originally designed for the placement of NHSC clinicians, currently more than 30 federal and state programs and agencies use the HPSA designation for resource allocation.

A list of designated HPSAs is published annually in the *Federal Register*. Additionally, HRSA maintains an online database (updated daily) of designated HPSAs and their HPSA scores (<http://hpsafind.hrsa.gov>).

As of September 30, 2012, there were 5,759 primary care HPSAs, 4,458 dental HPSAs, and 3,707 mental health HPSAs (more information on HPSAs can be found at <http://www.hrsa.gov/shortage/>). Graph 1 shows the urban/rural distribution of these FY 2012 HPSAs. These numbers are an actual decrease in the number of designated HPSAs over those reported in the previous year. The decline is a result of a number of HPSAs that were withdrawn from the list published on June 29, 2012. SDB anticipates a comparable number of HPSAs in FY 2013.

The Health Care Safety Net Amendments of 2002 revised the authority for designation of HPSAs to provide for automatic facility HPSA designation, for a period of 6 years, of Federally Qualified Health Centers (FQHCs), FQHC Look-a-Likes, and those Rural Health Clinics (RHC) that provide services regardless of ability to pay.⁶ The Amendments also required that the Secretary submit a report to Congress on any proposed changes to the HPSA criteria and regulations or to the standards for determining priorities among HPSAs. Automatic designation of these facilities was made permanent in the Health Care Safety Net Act of 2008.

Graph 1: HPSAs by Type by Urban/Rural Distribution



Requirement 2: The number of site applications filed under section 333 of this title in such year for assignment of Corps members and the action taken on each such application.

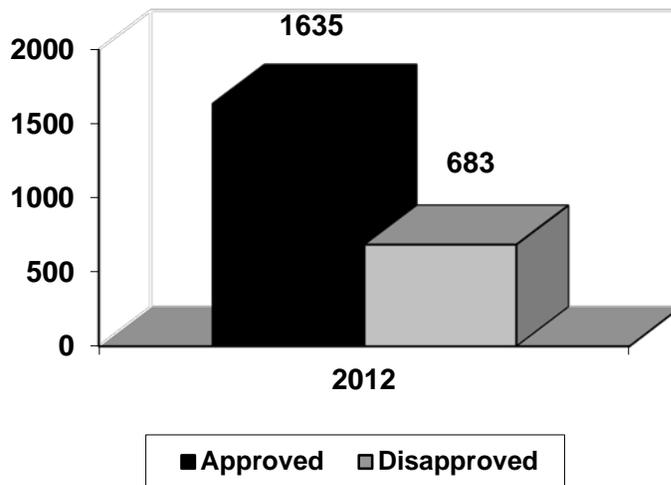
⁶RHCs must request an automatic facility designation if they meet the criteria. Further information for RHCs can be found at: <http://bhpr.hrsa.gov/shortage/hpsas/ruralhealthhpsa.html>.

Section 333 of the PHS Act establishes the framework by which the NHSC evaluates formal requests from facilities seeking eligibility for NHSC recruitment and retention assistance on an ongoing basis throughout the year (see Requirement 7 for a description of the evaluation process). Eligibility is based on the continued need for health professionals in the area; the appropriate and efficient use of NHSC members previously assigned to the entity; community support for the assignment of an NHSC member to that entity; the facility's unsuccessful efforts to recruit health professionals from other sources; the reasonable prospect of sound financial management by the entity; and the entity's willingness to support or facilitate mentorship, professional development, and training opportunities for Corps members. Specific requirements to qualify to participate as an NHSC-approved site include, but are not limited to, being located in a designated HPSA; providing comprehensive primary care services; providing services on a free or reduced fee schedule basis to individuals at or below 200 percent of the federal poverty level; and accepting patients covered by Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). More information on site eligibility is available on the NHSC website at <http://www.nhsc.hrsa.gov/sites/index.html>.

HRSA processes applications for assignment of Corps members as requests for inclusion of vacancies at the facility on the NHSC Jobs Center, which lists primary care medical, dental, and mental health provider job vacancies in high-need areas.

The number of Site Applications approved in FY 2012 was 1,635, with 683 being disapproved. Graph 2 shows the disposition of Site Applications received in FY 2012.

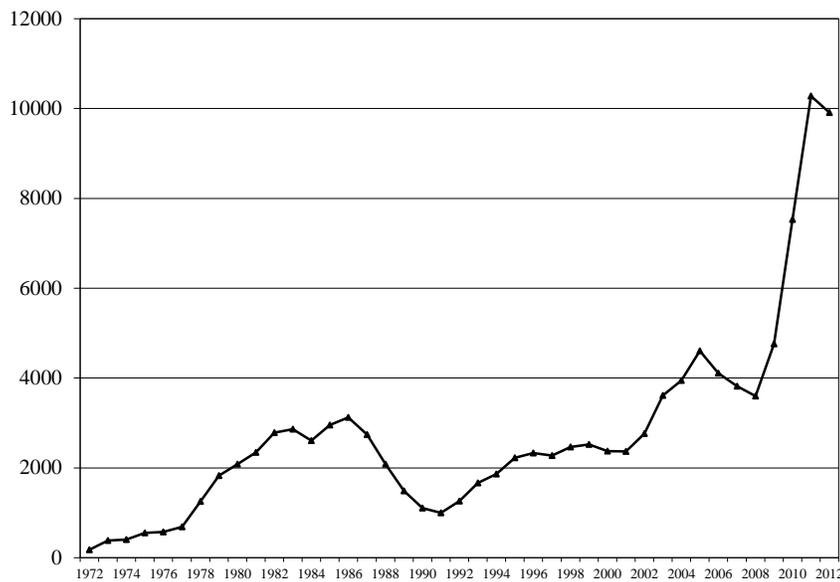
Graph 2: Disposition of New Site Applications – FY 2012



Requirement 3: The number and types of Corps members assigned in such year to HPSAs, the number and types of additional Corps members which the Secretary estimates will be assigned to such areas in the subsequent year, and the need for additional members for the Corps.

The 9,908 clinicians enumerated in the FY 2012 NHSC Field Strength make this the second largest in the program’s 40-year history (for distribution of NHSC clinicians by discipline and program for FY 2012, see Appendix A). NHSC clinicians are recruited by several mechanisms: The NHSC Scholarship and Loan Repayment Programs, the State LRP⁷, and the NHSC Ready Responders.⁸ Though NHSC clinicians who have chosen the Private Practice Option provided under Section 338D of the PHS Act [42 USC 254n] and the participants in the State LRP are not technically considered to be ‘members of the Corps,’ the program includes them in the Field Strength because they are supported jointly by NHSC and state matching funds. The number in FY 2012 includes those who began service in that year, as well as those whose service began in previous years and who are still fulfilling a service commitment to the NHSC; it does not include those NHSC clinicians who have fulfilled their service commitment but have been retained in service to the underserved (see Requirement 6). Graph 3 shows the history of the NHSC Field Strength from FY 1972 through FY 2012.

Graph 3: NHSC Field Strength – FYs 1972 – 2012



The NHSC is working to increase the number of minority clinicians and those dedicated to serving in underserved communities. In FY 2012, African American physicians represented 17.3 percent⁹ of the Corps physicians and exceeding their 6.3 percent share in the national physician workforce.¹⁰ Hispanic physicians represented 16.2 percent of the Corps physicians exceeding their 5.5 percent¹¹ share in the national physician workforce. The percentage of physician

⁷ The State LRP is a grant program to states for the purpose of offering loan repayment awards to clinicians in return for a minimum 2-year commitment to provide primary care services in a HPSA in the state. The state must match the Federal grant funds dollar-for-dollar and must provide funding for the administration of the program; no federal funds may be used for this purpose. In 2012, the State LRP awarded 7 new and 25 continuation grants to the states.

⁸ NHSC Ready Responders are USPHS Commissioned Corps officers who are primary care providers who are also highly trained to respond to a declared emergency. They are paid and supported out of the NHSC Field Line and are considered ceiling-exempt employees.

⁹ With regards to race and ethnicity reporting in this Report to Congress, participant data are self-reported and individuals may select multiple racial categories.

¹⁰ Diversity in the Physician Workforce: Facts and Figures 2010, Association of American Medical Colleges.

¹¹ Diversity in the Physician Workforce: Facts and Figures 2010, Association of American Medical Colleges.

assistants among NHSC LRP and SP participants who are Hispanic also surpassed national health care workforce averages of physician assistants.¹² Among NHSC participants, American Indian and Alaska Native participation in the mental health discipline is above national health care workforce averages in the specialty areas of Marriage and Family Therapy as well as Licensed Clinical Social Work.¹³

For pipeline programs - NHSC SP and S2S - African Americans exceeded national student enrollment averages across all eligible disciplines and specialty categories. Hispanics exceeded student enrollment averages in dentistry; Asians exceeded national student enrollment averages in the physician assistant discipline; and American Indian and Alaska Natives exceeded national student enrollment averages in dentistry, medicine, and physician assistants.¹⁴

The NHSC estimates the FY 2013 Field Strength to be over 7,400 clinicians. This will represent a reduction from the FY 2012 level due, in part, to the fact that those funded by the American Recovery and Reinvestment Act will have completed their service obligation and do not have additional educational debt to warrant a continuation contract. However, the FY 2013 projection still represents a more than doubling of the field strength over the 2008 level of 3,601.

Requirement 4: The recruitment efforts engaged in for the Corps in such year and the number of qualified individuals who applied for service in the Corps in such year.

Background

In FY 2010, the BCRS commissioned a Customer Satisfaction Survey to measure factors related to partner and participant satisfaction with the NHSC and to identify areas in which the NHSC may improve to support recruitment into the NHSC and retention of Corps members in HPSAs following their service commitment to the Corps. Results from this inaugural survey – which established a baseline measurement for customer satisfaction – highlighted the need to provide clear, concise, and timely information about the Corps and the need for improved responsiveness to program participants. BCRS commissioned the NHSC Customer Satisfaction Survey again in FYs 2011 and 2012 to gather feedback on program improvement efforts and identify overall satisfaction with the program.

Specifically, the FY 2012 Customer Satisfaction Survey showed a significant two point improvement in overall satisfaction among NHSC program participants compared to the 2011 survey. The Customer Satisfaction Index (CSI) score was 80, higher than the federal government CSI of 67. The survey also indicated a high likelihood that NHSC members would recommend the Corps to others and a high likelihood that they would continue to provide services in HPSAs after completion of their service commitment. Finally, the priority area for improvement continues to be communication. These findings will be used to guide and shape communication and recruitment initiatives for the Corps in FY 2013.

¹² U.S. Department of Labor, Bureau of Labor Statistics (BLS) Labor Force Characteristics by Race and Ethnicity, 2011 used for comparison.

¹³ *Ibid.*

¹⁴ American Dental Association (ADA): 2008-2009 Survey on Dental Education: Academic Programs, Enrollments, and Graduates – vol.1 Chicago, IL 2008. Association of American Medical Colleges, Diversity in Medical Education: Facts and Figures 2012. American Association of Nursing (AAN), 2012. 25th Physician Assistant Education Association Annual Report, 2008-2009.

NHSC Recruitment Materials

Feedback from NHSC LRP applicants indicated that many become aware of the Corps through their work site, school, NHSC website, and friend or family/word of mouth. In FY 2012, the NHSC developed communication materials that could be used in those settings to recruit eligible applicants and raise awareness of the NHSC.

The NHSC also redesigned and launched the NHSC website to better provide information for potential applicants and existing Corps members and restore a sense of community in the Corps by highlighting personal stories and real-life examples of service in underserved communities. More than 50 member stories were developed, featuring NHSC loan repayors, scholars, alumni, Ambassadors, and sites. To showcase some of these stories, the NHSC launched a series called *40 Clinicians in 40 Weeks*, which highlighted a new provider each week on the NHSC website and Facebook page to celebrate 40 years since the NHSC made its first award.

Outreach was conducted directly to potential program participants to announce the opening of the FY 2012 NHSC application cycles. E-Blasts were created and sent to more than 27,000 prospective NHSC LRP and NHSC SP applicants, community partners, and school administrators. This effort resulted in 5,714 applications being submitted for the NHSC LRP and 1,373 applications being submitted for the NHSC SP. The NHSC also launched the new S2S Loan Repayment “Pilot” Program which provides loan repayment assistance to medical students (M.D. and D.O.) in their last year of school, in return for a commitment to provide primary health care services in HPSAs of greatest need for a period of 3 years after completion of a primary care residency. S2S received 95 applications in FY 2012.

Mass Media

In FY 2012, the Corps used mass media to support efforts to increase visibility among prospective Corps members. The FY 2012 media relations activities resulted in coverage by more than 68 outlets generating more than 51 million impressions. These activities included two radio media tours with HRSA Administrator Mary K. Wakefield, Ph.D., R.N., which garnered 11 media interviews with state and local radio stations, reaching an audience of more than 881,000 and a weekly local media outreach in support of the *40 Clinicians in 40 Weeks* series, which garnered coverage by 15 outlets generating more than 740,000 impressions.

Knowing that prospective Corps members expect uninterrupted access to information makes social media outlets necessary for recruitment efforts. The NHSC Facebook page continued to have a positive impact on the NHSC network in 2012. With over 8,400 fans, growing by 28 percent from FY 2011 to FY 2012, the Facebook page has become a place where the NHSC community can connect. In addition to Facebook, the NHSC utilized Twitter and posted more than 600 public health and NHSC-related tweets and grew the number of Twitter followers to more than 1,700, nearly tripling the number of followers from FY 2011. The NHSC also used YouTube to share over 20 videos showcasing Corps members and their stories.

Partner Engagement and Conference/Exhibits

In order to reach prospective clinicians through the organizations and individuals they trust and interact with regularly, and to address the request for information during non-practice or training hours, the NHSC expanded engagement (e.g., webinars, e-Blasts, conference calls, presentations, meetings) with academic institutions and their financial aid officers, Area Health Education Centers, Health Centers, NHSC alumni, Ambassadors, professional associations, residency directors, State Offices of Rural Health, State Primary Care Offices, and State Primary Care Associations, as well as the HRSA Office of Health Equity and the Office of Women's Health. These partners were also sent regular announcements for distribution to prospective members on topics including application openings, program changes, and announcements on new initiatives.

In addition to the increased engagement described above, in FY 2012, the NHSC participated in 106 national conferences and exhibits representing eligible NHSC disciplines with a total of 35,500 conference attendees. The NHSC also conducted 70 recruitment visits and school presentations to health professions schools reaching over 2,400 attendees around the country to raise awareness and recruit applicants for NHSC loan repayment and scholar programs.

New and Pipeline Programs

As noted above, BCRS launched the S2S LRP pilot in FY 2012 aimed at promoting an interest in, and encouraging physicians to pursue careers in, primary care. The S2S LRP pilot provides loan repayment assistance to medical students in their last year of school in return for serving in eligible HPSAs of greatest need.

In an effort to increase the NHSC pipeline and increase the number of minority clinicians and those dedicated to serving in underserved communities, throughout FY 2012, the NHSC targeted academic medical institutions, such as Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions (HSIs), and Indian/Tribal Academic Institutions, and those medical schools with strong rural health tracks to encourage their interest in applying for the S2S program. It has been reported that these providers are more likely to return to underserved communities and practice culturally competent health care. Also, the NHSC fostered relationships with other medical schools and presented to third and fourth year medical students, as well as faculty and school administrators throughout the country on S2S opportunities.

Strategic outreach and effective and efficient recruitment efforts resulted in the NHSC receiving more applications than the NHSC was able to fund. As summarized in the tables below, in FY 2012, the Corps received 7,182 applications and made 2,623 new awards for the Scholarship, Loan Repayment, and S2S LRP "Pilot" Programs.

Table 1 shows the results of these recruiting efforts for the SP in FY 2012.

Table 1: SP Applications, FY 2012

	FY 2012
Applications Received	1,373
New Awards	212

Table 2 shows the results of these recruiting efforts for the LRP in FY 2012.

Table 2: LRP Applications, FY 2012

	FY 2012
Applications Received	5,714
New Awards	2,342

Table 3 shows the results of these recruiting efforts for the S2S in FY 2012.

Table 3: S2S LRP “Pilot” Applications, FY 2012

	FY 2012
Applications Received	95
New Awards	69

Requirement 5: The number of patients seen and the number of patient visits recorded during such year with respect to each HPSA to which a Corps member was assigned during such year.

NHSC clinicians serving in FY 2012 saw 10.4 million patients and generated 41.6 million visits.

Requirement 6: The number of Corps members who elected, and the number of Corps members who did not elect, to continue to provide health services in HPSAs after termination of their service in the Corps and the reasons (as reported to the Secretary) of members who did not elect for not making such election.

The NHSC continues to track the retention rates of NHSC scholars and loan repayors in service to the underserved beyond the fulfillment of their service commitment. Retained clinicians are those who provide care in a designated HPSA.

Short-Term Retention

The NHSC is committed to continuous performance improvement. The FY 2012 Customer Satisfaction Survey (see Requirement 4 above) found that 82 percent of NHSC providers who completed their NHSC service commitment in FYs 2010 and 2011 have continued to work in a HPSA. This remained consistent with the FY 2011 short-term retention rate of 82 percent.

Over half of the respondents reported the NHSC site experience itself as an influence to remain at the site where they completed their obligation. The most common reasons given by

participants for not remaining at their NHSC approved site following their service commitment were family considerations and problems with the employer, including workload and salary.

Long-Term Retention

On March 30, 2012, a report titled “*Evaluating Retention in BCRS Programs*,” was completed. The report examined long term retention of NHSC clinicians in service to the underserved. This report found that 55 percent of NHSC scholars and loan repayors remained in service to the underserved at least 10 years after fulfilling their NHSC service commitment. This compares favorably with the findings of the 2000 Report titled “*Evaluation of the Effectiveness of the NHSC*,” which found that 52 percent of those who had completed their service commitment were considered to be retained. An NHSC retention brief was released in December 2012 and is available on the NHSC website at <http://nhsc.hrsa.gov/currentmembers/membersites/retainproviders/retentionbrief.pdf>.

Requirement 7: The results of evaluations and determinations made under section 333(a)(1)(D) during such year.

Section 333 of the PHS Act establishes the framework by which the NHSC evaluates formal requests from facilities seeking eligibility for NHSC recruitment and retention assistance on an ongoing basis throughout the year (for the number of applications received and their disposition see Requirement 2). The following describes the process by which the NHSC determines the eligibility of these requests for NHSC recruitment and retention assistance. Eligibility is based on, among other things, the continued need for health professionals in an area, the appropriate and efficient use of NHSC members previously assigned to that entity, community support for the assignment of an NHSC member to that entity, the HPSA’s unsuccessful efforts to secure health professionals, and the reasonable prospect of sound fiscal management by the entity.

There is a three-step process for obtaining approval to become an NHSC site which determines an entity’s compliance with section 333(a)(1)(D) prior to acceptance into the program. First, the geographic area, population group served by the site, or facility must be designated as a HPSA. The need and demand for health professionals is documented by the ratio of available health professionals to the number of individuals in the area. Those ratios which fall below specific thresholds (as defined in 42 CFR Chap.1 Part 5) are designated as HPSAs. Second, the area, population group, or facility must be a HPSA of greatest shortage. Indicators are analyzed and scored to determine which HPSAs have the greatest need and reflect different patient utilization patterns for primary care, dental, and mental health services. Indicators include:

- ratio of health providers to individuals in the area;
- rate of low birth weight births;
- rate of infant mortality;
- rate of poverty;
- accessibility of primary health services (travel time or distance);
- presence of fluoridated water;
- ratios of population under 18 and over 65; and
- prevalence of alcohol or substance abuse.

HPSA scores range from 1 to 25 for primary care and mental health and 1 to 26 for dental. All FQHCs and those Rural Health Clinics that provide access to care regardless of ability to pay receive automatic facility HPSA designation. These facilities may have a HPSA score of zero. NHSC recruitment and retention assistance occurs within this HPSA scoring range.

Finally, for an application to be accepted, the submitting entity must meet all of the following requirements:

- is part of a system of care;
- has a documented record of sound fiscal management;
- verifies appropriate and efficient use of current and former NHSC personnel;
- is accessible to individuals regardless of their ability to pay;
- accepts Medicaid, Medicare, and CHIP beneficiaries;
- maintains a sliding discount fee schedule; and
- has general community support for the assignment of an NHSC member to that entity.

Once the application is approved, facilities post vacancies on the NHSC Jobs Center as they occur. The NHSC lists vacancies through its online Jobs Center, which lists primary care medical, dental, and mental health provider job vacancies in designated HPSAs. In 2012, the NHSC Jobs Center was re-designed to provide users with expanded information related to the services provided and populations served by NHSC approved sites. From October 1, 2011, through September 30, 2012, the number of new vacancies created was 7,878, and during that period, 3,648 vacancies were filled. As of September 30, 2012, there were 3,722 vacancies listed. The NHSC Jobs Center is located on the NHSC website at <http://nhscjobs.hrsa.gov/>.

CONCLUSION

The achievements of the NHSC in FY 2012 are indicative of the increased awareness of the program and the greater collaboration with partners, both made possible by the enhanced resources provided to the NHSC through the American Recovery and Reinvestment Act and the Affordable Care Act. These resources have allowed the NHSC to grow to record levels, serving the health care needs of more than 10 million patients across the United States.

The NHSC will continue its focus on ensuring that NHSC providers are serving in the nation's high need areas and leverage the existing statutory authority to encourage individuals to pursue a career in primary care. These efforts and the fostering of collaborative partnerships will allow the NHSC to continue to address the nationwide shortage of health care providers in underserved communities.