



U.S. Department of Health and Human Services

**National Health Service Corps Report to Congress
for the Year 2013**

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**

EXECUTIVE SUMMARY

The Report to Congress for the Year 2013 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:

- Provides updates on HPSA information;
- Defines the need for primary care services through requests for recruitment and retention assistance from underserved communities;
- Shows the current NHSC Field Strength¹ and the projection for next year;
- Provides explanations on the recruitment efforts for the NHSC Scholarship and Loan Repayment Programs;
- Provides estimates on 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 Jobs Center.

A summary of significant findings in the report include:

- The NHSC and many federal and state programs use HPSA designations for resource allocation. As of September 30, 2013, the following types and number of HPSAs were identified:

HPSA Type	Number of HPSAs
Primary Medical	5,758
Dental	4,571
Mental Health	3,730

- Approximately 58 percent of all HPSAs are designated as non-metropolitan.
- 44 percent of NHSC placements in FY 2013 were in facilities that served rural areas or populations.
- The NHSC Field Strength in fiscal year (FY) 2013 was 8,899. The NHSC clinicians served in urban, rural, and frontier communities in all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, and the Pacific Basin.

¹ Field Strength is defined as the number of practicing NHSC clinicians that are currently providing obligated services in approved NHSC sites.

- The NHSC Ready Responders were phased out in FY 2013. With the creation of the Commissioned Corps Office of Force Readiness and Deployment (OFRD), and the expansion of OFRD’s training of U.S. Public Health Service (PHS) Commissioned Corps in response to a declared emergency, the maintenance of a separate cadre within the NHSC was no longer deemed necessary.
- 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 47 percent of NHSC clinicians serve in health centers; the remaining offer patient care services in non-grant-supported rural health clinics, group or private practices, hospital-based outpatient clinics, and similar locations. In FY 2013, NHSC clinicians provided care to approximately 9.3 million underserved people.
- The NHSC Scholarship and Loan Repayment Programs continue to serve as vital recruitment tools for underserved communities in need of primary care, oral health, and mental and behavioral health services. In FY 2013, the NHSC made the following new and continuation awards:

NHSC Program	Number of Awards
Scholarship	196
Loan Repayment	4,505
Students-to-Service Loan Repayment	78

- 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 2013, all awards listed above were funded through the Affordable Care Act. The NHSC also made 32 continuation grants to states through the State Loan Repayment Program with Affordable Care Act funds.

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INTRODUCTION

This Report to Congress describes the program activities of the National Health Service Corps (NHSC) for 2013. This program is located in the Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS). The NHSC was established on December 31, 1970, by the Emergency Health Personnel Act of 1970 (Public Law 91-623), and the law has been amended and reauthorized several times in the ensuing 43 years. The most recent legislative action, the Affordable Care Act, authorizes a maximum annual loan repayment award of \$50,000,² offers the option of half-time service for both scholars and loan repayors, allows service credit for teaching, and appropriates funds for the NHSC through fiscal year (FY) 2015.

The NHSC posted a decrease in Field Strength from 9,908 clinicians in FY 2012 to 8,899 in FY 2013, but this total still represents more than double the FY 2008 NHSC Field Strength of 3,601 clinicians. Field Strength includes clinicians recruited through the NHSC Scholarship Program (SP), Loan Repayment Program (LRP), and the State Loan Repayment Program (SLRP).

Nearly 7,500 applications were received for the NHSC SP and LRP in FY 2013, demonstrating that interest in these programs is strong among both students and clinicians. BHW successfully used social networking for the NHSC, specifically Facebook, to target current applicants, potential applicants, and sites; NHSC Ambassadors (volunteers who educate and inform prospective Corps members and support new and existing members); and organizations with similar missions as the NHSC. In FY 2013, the NHSC participated in and exhibited at five national conferences representing eligible NHSC disciplines with a total of 5,200 conference attendees. The NHSC also conducted 32 recruitment visits and school presentations to health professions schools reaching over 11,200 attendees around the country to raise awareness and recruit applicants for NHSC SP and LRP.

NHSC Ambassadors were given several new tools – including a tool kit, tutorial, and communications templates – to use in recruiting eligible NHSC applicants. Many of these tools are available online. Building on this effort, in FY 2013, webinars and quarterly Ambassador conference calls were held to share best practices and information on how to use these newly created tools.

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 NHSC commitment. A recent study completed in FY 2013 showed 85 percent of those who had fulfilled their NHSC commitment remained in service to the underserved in the short term, defined as up to 2 years after their NHSC commitment.³ An evaluation conducted in FY 2012 showed that 55 percent of NHSC clinicians continue to practice in underserved areas 10 years after completing their NHSC service

² Beginning with FY 2012, the total amount is determined by the Secretary on an annual basis to reflect inflation.

³ FY 2013 National Health Service Corps Customer Satisfaction Survey.

commitment.⁴ This reaffirmed findings from an earlier study in FY 2000 which showed the majority of NHSC clinicians remained committed to service to the underserved in both the short and long term.⁵

PROGRAM ACHIEVEMENTS IN FY 2013

In FY 2013, the NHSC made 180 new scholarship awards, 16 scholarship continuation awards, 2,106 new loan repayment awards, and 2,399 loan repayment continuation awards out of funds received through the Affordable Care Act.

In FY 2013, the NHSC continued implementation of the Students to Service (S2S) Loan Repayment Pilot 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 Health Professional Shortage Area (HPSA) with a score of 14 or above,⁶ which begins once their primary care residency is completed. In FY 2013, the NHSC made 78 S2S Loan Repayment awards.

In FY 2013, the NHSC also continued implementation of the enhanced award structure in the NHSC LRP to incentivize clinicians to work in the most underserved areas of the 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 2013, the NHSC also continued implementation of the Critical Access Hospital (CAH) pilot program to extend the reach of the NHSC in rural areas, 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 program, clinicians may now spend up to 24 hours per week in the CAH inpatient setting, with no fewer than 16 hours per week being spent in an affiliated outpatient clinic.⁷ As of September 30, 2013, 176 active CAH sites had been approved to be NHSC sites.

⁴ “Evaluating Retention in BCRS Programs” Final Report. March 30, 2012. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. The Bureau of Clinician Recruitment and Service (BCRS) is now known as BHW.

⁵ “Evaluation of the Effectiveness of the National Health Service Corps” Final Report. May 31, 2000. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill and Mathematica Policy Research, Inc.

⁶ HPSA scoring methodology is described in more detail later in the report.

⁷ For the purposes of the CAH Pilot Program, placement at CAHs is limited to physicians, physician assistants, nurse practitioners, and certified nurse midwives.

NHSC REPORT REQUIREMENTS

The NHSC 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:⁸

- (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) 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.”⁹*

⁸ Data provided in this report are FY data, reported in accordance with how funds are appropriated to the NHSC program.

⁹ The Health Care Safety Net Amendments of 2002 replaced Section 334 [42 USC 254g], entitled “Cost Sharing”, with a new Section 334, entitled “Charges for services by entities using Corps members.” As a result of this statutory change, which provides that NHSC sites cannot discriminate in the delivery of services when an individual is unable to pay, the eighth requirement can no longer be met.

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.

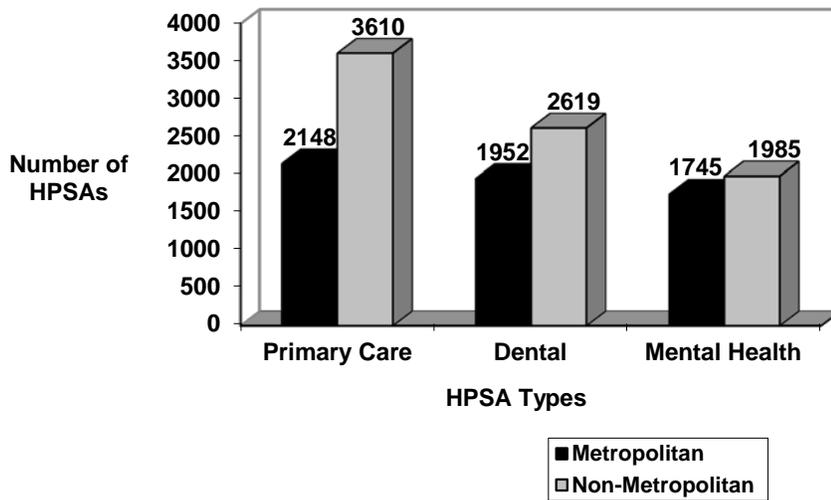
The designation of HPSAs is an applicant-driven process. Any individual or agency may apply to have a geographic area, population group, or facility designated as a HPSA. The designation process involves two types of actions: (1) the analysis of the data submitted with each new request, and (2) the review of previously-designated HPSAs (which is done every 3 years). HRSA determines the priority of a HPSA by assigning a numerical score based on a calculation weighing a number of 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, 2013, there were 5,758 primary care HPSAs, 4,571 dental HPSAs, and 3,730 mental health HPSAs (more information on HPSAs can be found at <http://www.hrsa.gov/shortage/>).¹⁰ Graph 1 shows the metropolitan/non-metropolitan distribution of these FY 2013 HPSAs. Overall, the total number of HPSAs has increased roughly one percent from FY 2012; HRSA anticipates that the total number of HPSAs in FY 2014 will increase by the same percentage.

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-Alikes, and those Rural Health Clinics that provide services regardless of ability to pay. 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.

¹⁰ State Primary Care Offices self-report metropolitan/non-metropolitan status when applying for new HPSAs or updating existing HPSAs.

Graph 1: HPSAs by Type by Metropolitan/Non-Metropolitan Distribution

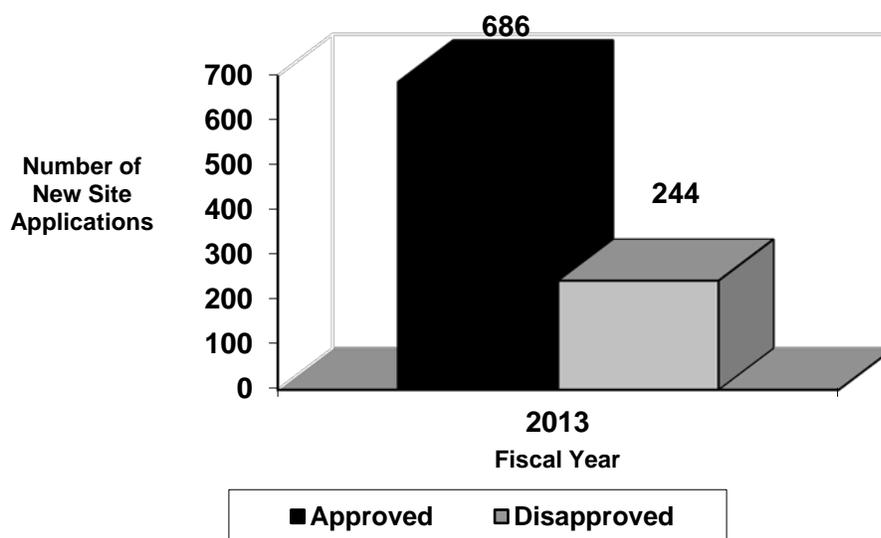


Requirement 2: The number of site applications filed under section 333 of this title in such year for assignment of Corps members and the action taken on each such application.

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 (<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. In FY 2013, the NHSC instituted an application cycle which limited the period of time in which new site applications could be submitted. The first cycle opened October 1, 2012, and closed December 17, 2012. The most recent cycle opened September 3, 2013, and closed November 1, 2013. The number of site applications approved in FY 2013 (through September 30, 2013) was 686, with 244 disapproved. Graph 2 shows the disposition of site applications received in FY 2013.

Graph 2: Disposition of New Site Applications, FY 2013

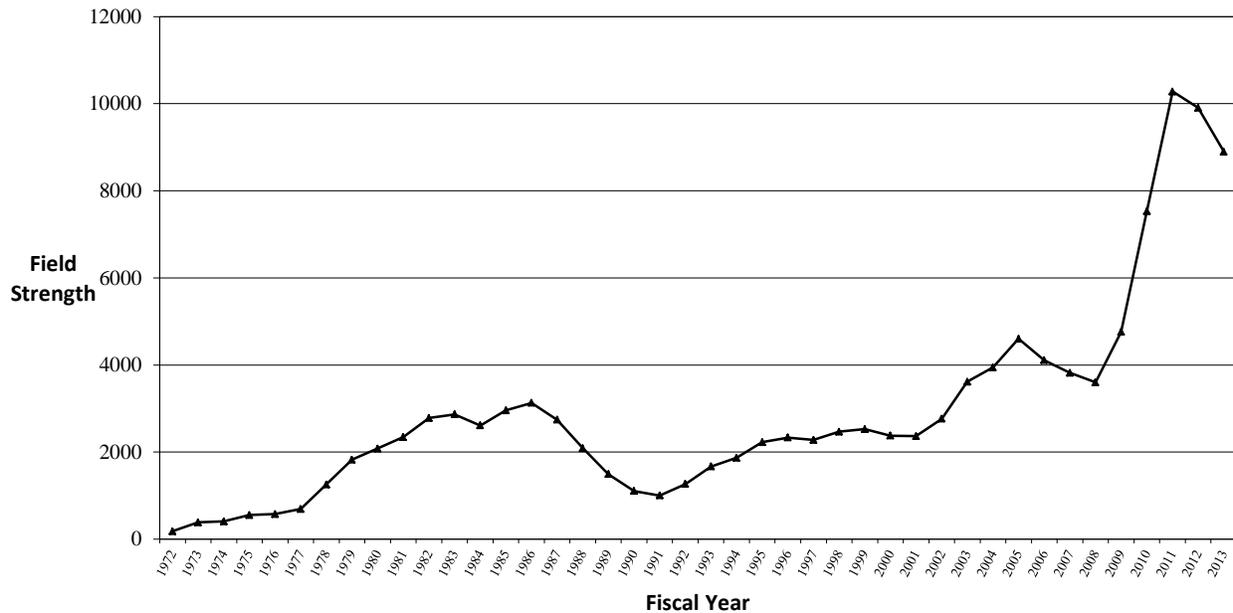


Requirement 3: The number and types of Corps members assigned in such year to HPSAs, the number and types of additional Corps members which the Secretary estimates will be assigned to such areas in the subsequent year, and the need for additional members for the Corps.

The 8,899 clinicians enumerated in the FY 2013 NHSC Field Strength make this the program’s third-largest cohort since the first placements were made in 1972. See **Appendix A** for distribution of NHSC clinicians by discipline and program for FY 2013. NHSC clinicians are recruited by several mechanisms: the NHSC Scholarship and Loan Repayment Programs, the S2S LRP, and the SLRP.¹¹ Though NHSC clinicians who have chosen the Private Practice Option (PPO) provided under Section 338D of the PHS Act [42 USC 254n] and the participants in the SLRP are not technically considered to be “members of the Corps,” the program includes them in the Field Strength because PPO clinicians have been supported by scholarship or loan repayment awards, and SLRP participants are supported jointly by NHSC and state matching funds. The Field Strength in FY 2013 includes those who began service in that year, as well as those whose service began in previous years and who were still fulfilling a service commitment to the NHSC in 2013. 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 1972 through FY 2013.

¹¹ The SLRP 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 2013, the SLRP awarded 32 continuation grants to the states. Note: in **Appendix A**, SLRP clinicians are not included in the Urban /Rural and Grant/Non-Grant columns.

Graph 3: NHSC Field Strength, FYs 1972 – 2013



The NHSC is working to increase the number of minority clinicians.¹² In FY 2013, African-American physicians represented 17.8 percent of the Corps physicians, exceeding their 6.3 percent share in the national physician workforce.¹³ Hispanic or Latino NHSC physicians represented 15.7 percent of the Corps physicians, exceeding their 5.5 percent¹⁴ share in the national physician workforce. Hispanic or Latino NHSC LRP and SP participants surpassed national health care workforce averages of physician assistants, and African-American and Hispanic or Latino NHSC LRP and SP participants surpassed national health care workforce averages of nurse practitioners.¹⁵ Among NHSC participants, Hispanic or Latino participation in the mental health discipline of psychology is above the national health workforce average.¹⁶

Based on self-reports, of the nearly 1,100 NHSC scholars in the pipeline, 18 percent are African-American, 13 percent are Asian or Pacific Islander, and 2 percent are American Indian or Alaska Native. Moreover, 18 percent of NHSC scholars self-identified as Hispanic or Latino. African-Americans exceed national student enrollment averages for students participating in the

¹² With regard to race and ethnicity data discussed in this Report to Congress, participant data are self-reported and individuals may select multiple racial categories. These responses are collected internally and compiled based on the total responses including the non-responses received. Hispanic or Latino/Non-Hispanic or Non-Latino self-reported ethnicity data in BMISS is separate from the race category. Therefore, the total percent of Hispanic or Latino is based on total ethnicity. As a result, Hispanic or Latino data may be over reported as this information is the only metric for capturing ethnicity. This data, with respect to the NHSC programs' Field Strength and pipeline is then compared to national workforce and student enrollment data/percentages respectively.

¹³ Diversity in the Physician Workforce: Facts and Figures 2010, Association of American Medical Colleges.

¹⁴ *Ibid.*

¹⁵ U.S. Department of Labor, Bureau of Labor Statistics (BLS), Labor Force Characteristics by Race and Ethnicity (2012) used for comparison.

¹⁶ *Ibid.*

NHSC pipeline across all eligible disciplines/specialty categories except nurse practitioners and nurse midwives.¹⁷ Hispanic or Latino NHSC scholars exceeded student enrollment averages in dentistry as they represent 12.8 percent of the Corps dental participants compared to their 6.3 percent share of the national student enrollment.¹⁸ American Indian and Alaska Natives exceed national student enrollment averages in dentistry, medicine, physician assistants, and nursing for the NHSC pipeline.¹⁹

The NHSC's FY 2014 Field Strength is 9,242 clinicians, representing a more than doubling of the field strength over the FY 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.

In FY 2010, BHW conducted 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 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. The NHSC Customer Satisfaction Survey was conducted again in FYs 2011, 2012, and 2013 to continue to gather feedback on program improvement efforts and identify overall satisfaction with the program.

The FY 2013 Customer Satisfaction Survey showed a similar overall satisfaction among NHSC program participants compared to the 2012 survey. The Customer Satisfaction Index (CSI) score²⁰ of 79 was higher than the federal government average CSI of 67. The survey indicated a high likelihood that program participants would recommend the Corps to others and a high likelihood that current members would continue to provide services in high-need areas after completion of their service commitment. Further, among participants who had already completed their service obligation, 85 percent had remained working in HPSAs.

¹⁷American Dental Association, 2010-2011 Survey on Dental Education: Academic Programs, Enrollments, and Graduates – vol.1. Association of American Medical Colleges, 2012. American Association of Nursing, 2012. 27th Physician Assistant Education Association Annual Report, 2010-2011.

¹⁸*Ibid.*

¹⁹*Ibid*

²⁰ The American Customer Satisfaction Index (ACSI) methodology is used to identify the drivers of customer satisfaction and their impact on performance. The ACSI is the only uniform, cross-industry/government measure of customer satisfaction in the U.S. and includes more than 200 private-sector company scores and over 100 federal or local government program scores. Performance scores (survey scores on rated items) are on a 0-100 scale.

NHSC Recruitment Materials

Feedback from NHSC LRP applicants indicated that many became aware of the Corps through their work site, school, website, and friend or family word of mouth. In FY 2013, the NHSC developed communication materials that could be used in those contexts to recruit eligible applicants and raise awareness of the NHSC.

The NHSC has continued to use member stories and member videos to highlight the impact of the NHSC on communities with limited access to care, often releasing these materials to coincide with national health observances like National Men’s Week and Nurses Week. In FY 2013, there were over 44,000 webpage views of NHSC member stories and over 3,000 views of the videos. One example is the member video featuring physician Sara Michaels, a former scholar still serving at her Indian Health Service site 10 years beyond completion of her obligation, which has been watched over 1,400 times since its release in March 2013.

Outreach was conducted directly to potential program participants to announce the opening of the FY 2013 NHSC application cycles. E-Blasts, mass emails sent to a large mailing list, were created and sent to more than 139,500 prospective NHSC LRP and NHSC SP applicants, school administrators, and NHSC partners including Ambassadors, NHSC alumni, the National Advisory Council, professional associations, NHSC sites, program participants, and State Primary Care Offices. As summarized in the Tables below, in FY 2013, this effort resulted in 5,710 applications being submitted for the NHSC LRP and 1,739 applications being submitted for the NHSC SP. More than 3,400 of the 5,710 LRP applicants had a site HPSA score of 14 or greater.

Table 1: SP Applications, FY 2013

	FY 2013
Applications Received	1,739
New Awards	180

Table 2: LRP Applications, FY 2013

	FY 2013
Applications Received	5,710
New Awards	2,106

Table 3: S2S LRP Applications, FY 2013

	FY 2013
Applications Received	100
New Awards	78

Mass Media

In FY 2013, the Corps used mass media to support efforts to increase visibility among prospective program participants. The FY 2013 media relations activities resulted in coverage by 38 media outlets (television, radio stations, and newspapers) and nearly 5 million impressions (i.e., the total number of times the coverage may have been seen or heard). These activities included two radio media tours with HRSA Administrator Mary K. Wakefield Ph.D., R.N. and Mayra Alvarez, then Director of Health Policy within the Office of Health Reform at HHS, which garnered 18 media interviews with state and local radio stations reaching an audience of more than 2,390,300 listeners. In addition, weekly local media outreach in support of *40 Clinicians in 40 Weeks* to raise awareness of clinicians through the video rollout and site story initiative garnered coverage in 20 outlets generating more than 2,428,850 impressions.

Knowing that prospective program participants 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 FY 2013. With over 10,700 fans, growing by 33 percent from FY 2012 to FY 2013, 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 800 public health and NHSC-related tweets. The number of Twitter followers grew to more than 2,600, nearly doubling the number of followers from FY 2012.

Partner Engagement and Conference/Exhibits

In order to reach prospective clinicians through the organizations and individuals they trust and interact with regularly, and 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, Federally Qualified Health Centers, NHSC alumni, Ambassadors, 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 HRSA Office of Women's Health. In addition, BHW increased partnership collaboration from 10 to 16 health professional organizations (e.g., American Medical Students Association, National Medical Association, National Association of Hispanic Nurses, and the Rural Health Association) that represent the interests of clinicians, students, racial/ethnic minorities, and health care sites. All partners were sent regular announcements for distribution to prospective members on topics including application openings, program changes, and announcements on new initiatives. As of September 30, 2013, the BHW partner email list included 7,000 individual email addresses for professional and academic partners – nearly double that of FY 2012.

In FY 2013, the NHSC conducted three Virtual Job Fairs to provide NHSC-approved sites the opportunity to promote job openings and “virtually recruit” to a targeted audience of primary care job seekers. The March 2013 Virtual Job Fair featured recruitment presentations from Indian Health Service and Tribal sites in 8 states, representing more than 32 individual sites and more than 80 job vacancies; nearly 70 providers from a variety of primary care disciplines participated in the evening event. The NHSC Virtual Job Fairs held in July and August focused on helping NHSC Scholars find jobs at high-need sites. Forty-one NHSC sites in 20 states and

the District of Columbia, American Samoa, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, participated in the NHSC Virtual Job Fairs, representing more than 300 individual care delivery sites and over 250 job vacancies. Held on Saturday afternoons to meet the needs of Scholars, over 80 job-seeking participants took part in these two events.

Pipeline Programs

In an effort to increase the pipeline of NHSC-eligible health professionals and increase the number of minority clinicians and those dedicated to serving in underserved communities, throughout FY 2013, the NHSC worked closely with academic medical institutions, such as Historically Black Colleges and Universities, Hispanic-Serving Institutions, Indian/Tribal Academic Institutions, and those medical schools with strong rural health tracks to encourage their students' interest in applying for the S2S Program. It has been reported that students, including those who are from minority populations, who train in these settings are more likely to return to underserved communities and practice culturally-competent health care after becoming providers.²¹ Also, the NHSC fostered relationships with other academic medical schools and presented to third- and fourth-year medical students, as well as faculty and school administrators throughout the country on S2S opportunities.

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.

In aggregate, NHSC clinicians serving in FY 2013 saw 9.34 million patients and generated 37.36 million patient 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 monitor 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 after their service obligation ends.

²¹ The Sullivan Commission. (2004) "Missing persons: Minorities in the health professions." Retrieved from: <http://www.aacn.nche.edu/media-relations/SullivanReport.pdf>. Komaromy M, Grumbach K, Drake M, Vranizan K, Luri N, Keane D, Bindman AB; (1996). "The role of Black and Hispanic physicians in providing health care for underserved populations." *New England Journal of Medicine*; 334:1305-1310. Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, Ford DE; (1999). "Race, gender and partnership in the patient-physician relationship." *Journal of the American Medical Association*; 282(6):583-9.

Short-Term Retention

The NHSC is committed to continuous performance improvement. The FY 2013 Customer Satisfaction Survey (see **Requirement 4** above) found that 85 percent of NHSC providers who completed their NHSC service commitment in the past 2 years have continued to work in a HPSA. This is a decline from the FY 2012 short-term retention rate of 90 percent.

Nearly two-thirds 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 Final Report titled “Evaluating Retention in BCRS Programs,” was completed by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, which 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.²² This compares favorably with the findings from 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.²³ An NHSC retention brief was released in December 2012 and is available on the NHSC website (<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 (see **Requirement 2** for the number of applications received and their disposition). 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.

²² “Evaluating Retention in BCRS Programs” Final Report. March 30, 2012. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. The Bureau of Clinician Recruitment and Service (BCRS) is now known as BHW.

²³ “Evaluation of the Effectiveness of the National Health Service Corps” Final Report. May 31, 2000. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill and Mathematica Policy Research, Inc.

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 the facility must be designated as a HPSA. Generally, 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 are in 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 care 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 1 to 26 for mental health and dental care (with 1 representing the least need). 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. Finally, for an application to be accepted, the submitting entity must meet all of the following requirements:

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

NHSC recruitment and retention assistance is offered to all facilities that meet the above requirements.

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 includes primary care medical, dental, and mental health provider job vacancies in designated HPSAs. In FY 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, 2012, through September 30, 2013, the number of new vacancies created was 9,980; and during that period, 5,352 vacancies were filled. As of September 30, 2013, there were 2,479 vacancies listed. The NHSC Jobs Center is located on the NHSC website: <http://nhscjobs.hrsa.gov/>.

Conclusion

The achievements of the NHSC in FY 2013 are indicative of the increased promotion and outreach of the program and the greater collaboration with partners, both made possible by the enhanced resources provided to the NHSC through the Affordable Care Act. These resources have allowed the NHSC to grow to record levels, serving the health care needs of more than 9 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.