*U.S. Department of Health and Human Services*

# NATIONAL HEALTH SERVICE CORPS REPORT TO CONGRESS FOR THE YEAR 2015

**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 year 2015 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 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 Strength[1] and the projection for next year;
- Explains 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 statistics on 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) of the Public Health Service Act for inclusion on the NHSC Jobs Center.

Significant findings in the report include the following:

- The NHSC and many federal and state workforce programs use HPSA designations for resource allocation. As of September 30, 2015, the following types and number of HPSAs were identified:

| HPSA Type | Number of HPSAs |
|---|---|
| Primary Medical | 6,222 |
| Dental | 5,108 |
| Mental Health | 4,128 |

- The NHSC Field Strength in fiscal year (FY) 2015 was 9,683. 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.[2]

- In FY 2015, NHSC clinicians provided care to approximately 10.2 million underserved people. About 52.5 percent of NHSC clinicians serve in health centers supported by Health Resources and Services Administration (HRSA) grants; the remaining offer patient care services in Rural Health Clinics, group or private practices, hospital-based

[1] "NHSC Field Strength," as this term is used in this report, includes clinicians recruited through the NHSC Loan Repayment Program, NHSC Scholarship Program, NHSC Students to Service Loan Repayment Program, and the State Loan Repayment Program.
[2] Pacific Basin includes American Samoa, the Federated States of Micronesia, Guam, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, and the Republic of Palau.

outpatient clinics, and similar sites located in HPSAs that are not supported by HRSA grants.

- Approximately 47 percent of NHSC placements in FY 2015 were in facilities that served rural areas.[3]

- The NHSC remains committed to an interdisciplinary approach to patient care. The discipline mix of the NHSC Field Strength reflects this commitment and the program's efforts to respond to underserved communities' demand for services.

- 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 behavioral and mental health services. In FY 2015, the NHSC made the following new and continuation awards:

| NHSC Program | Number of Awards |
|---|---|
| Scholarship | 207 |
| Loan Repayment | 4,775 |
| Students-to-Service Loan Repayment | 96 |

- 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 2015, all individual awards listed above were funded through the Affordable Care Act. The NHSC also awarded 37 continuation grants to states through the State Loan Repayment Program with Affordable Care Act funds.

[3] The NHSC uses the Federal Office of Rural Health Policy definition for identifying when an NHSC approved site is rural. See http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

# National Health Service Corps
# Report to Congress
# For the Year 2015

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# Acronym List

| | |
|---|---|
| ACSI | American Customer Satisfaction Index |
| BCRS | Bureau of Clinician Recruitment and Service |
| BHW | Bureau of Health Workforce |
| BMISS | Bureau of Health Workforce Management Information System Solution |
| CAH | Critical Access Hospital |
| CHIP | Children's Health Insurance Program |
| CSI | Customer Satisfaction Index |
| FQHC | Federally Qualified Health Center |
| FY | Fiscal Year |
| HPSA | Health Professional Shortage Area |
| HRSA | Health Resources and Services Administration |
| IHS | Indian Health Service |
| LRP | Loan Repayment Program |
| NHSC | National Health Service Corps |
| PHS | Public Health Service |
| PPO | Private Practice Option |
| S2S LRP | Students to Service Loan Repayment Program |
| SLRP | State Loan Repayment Program |
| SP | Scholarship Program |

# I. Legislative Language

The current report requirements are found at section 336A of the Public Health Service (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:*[4]
>
> *(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."*[5]

These requirements are discussed below, and related program information and activities are highlighted. Data provided in this report are fiscal year (FY) data, reported in accordance with how funds are appropriated to the National Health Service Corps (NHSC) Program.[6] This report

[4] Data provided in this report are FY data, reported in accordance with how funds are appropriated to the NHSC Program.

[5] The Health Care Safety Net Amendments of 2002 amended Section 334 [42 USC § 254g] to eliminate the requirement that entities receiving NHSC assignees reimburse the agency for health services provided by those Corps members. Therefore, reporting element #8 is no longer relevant.

[6] NHSC Program data is collected in the Bureau of Health Workforce (BHW) Management Information System Solution (BMISS). The BMISS is an IT system modernization program that replaces and/or retires a multitude of legacy systems that contain information collected from individual scholarship and loan repayment applications,

enables the NHSC to discuss activities and initiatives that are aligned with the mission of the program.

# II. Introduction

This report to Congress describes the program activities of the NHSC for 2015. The program is located in the Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA), Department of Health and Human Services. 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 45 years. The Affordable Care Act appropriated $1.5 billion in funds for the NHSC from FY 2010 through FY 2015. NHSC authorizes a maximum annual loan repayment award of $50,000 per year for the NHSC Loan Repayment Program (LRP), offers the option of half time service for both scholars and loan repayors, and allows service credit for teaching.

The NHSC posted a slight increase in Field Strength from 9,242 clinicians in FY 2014 to 9,683 in FY 2015, more than doubling the 3,601 NHSC clinicians who served in 2008. Field Strength includes clinicians recruited through the NHSC LRP, the NHSC Students to Service Loan Repayment Program (S2S LRP), NHSC Scholarship Program (SP), and the State Loan Repayment Program (SLRP).

There has been tremendous interest in the program, which can be linked to an increase in recruitment activities conducted by BHW. More than 8,900 applications were received for the NHSC SP and LRP in FY 2015, a 7.6 percent increase from FY 2014, demonstrating that interest in these programs is strong among both students and clinicians. Social networking, increased collaboration, and online visibility were used to recruit eligible NHSC applicants. BHW successfully used social networking for the NHSC, particularly Facebook, to target current applicants, potential applicants, and sites. BHW also collaborated with 16 national health professional organizations with missions similar to that of the NHSC to expand the visibility of the NHSC. These groups represent clinicians, students, residents, school administrators, and/or sites serving underrepresented racial and ethnic minorities, Rural Health Clinics, and communities. BHW exhibited at 15 national partner conferences, developed and launched a new NHSC Partnership webpage (http://www.nhsc.hrsa.gov/partners/index.html) to provide individuals and organizations with resources about the NHSC scholarship and loan repayment opportunities, and hosted 5 Virtual Job Fairs in which 200 representatives of more than 1,200 facilities from 37 states and Washington, DC, participated.

In addition, BHW worked with NHSC Ambassadors (past program participants who educate and inform prospective Corps members and support new and existing members) to further expand the reach of recruitment activities. NHSC Ambassadors have been 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 2015,

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recruitment and retention assistance applications, and monitoring data from individual sites. SLRP data is collected at the grantee level and reported to BHW Program Officers.

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 study completed in FY 2015 showed an estimated 87 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 ended.[7] 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 commitment.[8] 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 the short and long term.[9]

# III. Overview

In FY 2015, the NHSC made 196 new scholarship awards, 11 scholarship continuation awards, 2,934 new loan repayment awards, and 1,841 loan repayment continuation awards.

In FY 2015, the NHSC continued implementation of the S2S LRP, 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 high priority Health Professional Shortage Area (HPSA),[10] which begins once their primary care residency is complete. In FY 2015, the NHSC made 96 S2S LRP awards.

In FY 2015, 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 $50,000 for an initial 2-year contract for those clinicians serving full-time in HPSAs with a score of 14 or higher. For those serving full-time in HPSAs below that score, the maximum award for an initial 2-year contract is $30,000. This HPSA tiering policy was initiated in FY 2012. Previous to FY 2012, all loan repayors were eligible for the same amount of funding regardless of HPSA score.

In FY 2015, to extend the reach of the NHSC in rural areas, the NHSC also continued placing clinicians in Critical Access Hospitals (CAH). Prior to the FY 2012 CAH pilot program, 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

[7] FY 2014 National Health Service Corps Customer Satisfaction Survey.
[8] "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.
[9] "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.
[10] Currently defined as having a HPSA score of 14 or above. HPSA scoring methodology is described in more detail later in the report.

week being spent in an affiliated outpatient clinic.[11] The pilot program ended in FY 2015; CAHs are now permanent NHSC-eligible sites. As of September 30, 2015, 248 active CAH sites had been approved to be NHSC sites, and 61 NHSC clinicians were practicing in a CAH.

# IV. Report Requirements

## 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. 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. Although HRSA reviews and updates HPSAs on a general three-year cycle, the exception to this process is the permanent automatic designation of certain facility HPSAs (e.g., Federally Qualified Health Centers [FQHCs], FQHC Look-Alikes, and those Rural Health Clinics that provide services regardless of ability to pay).[12] 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, 2015, there were 6,222 primary care HPSAs, 5,108 dental HPSAs, and 4,218 mental health HPSAs (more information on HPSAs can be found at http://www.hrsa.gov/shortage/). Overall, the total number of HPSAs has increased slightly less than 1 percent from FY 2014, and HRSA anticipates that the total number of HPSAs in FY 2016 will increase by the same or slightly higher percentage.

## 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 (see

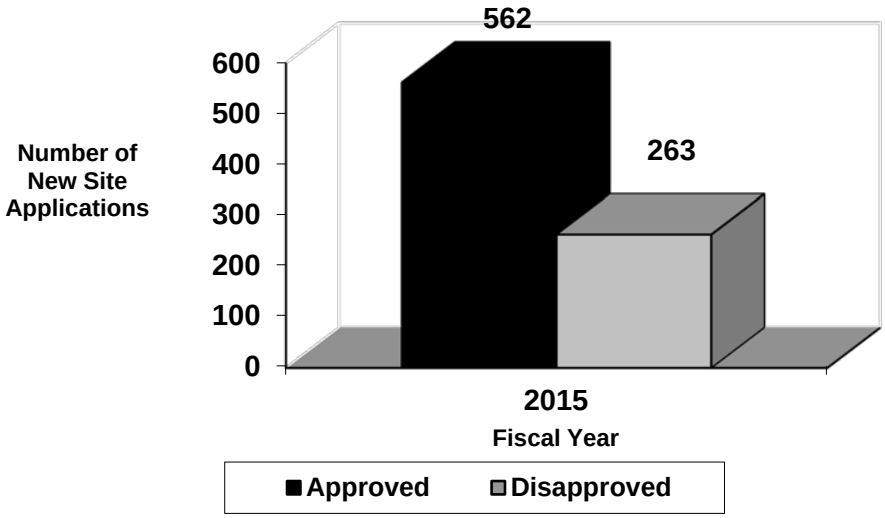
[11] Placement at CAHs is limited to physicians, physician assistants, nurse practitioners, and certified nurse midwives.

[12] The Health Care Safety Net Amendments of 2002 established the automatic facility HPSA designation for these facilities for a period of 6 years; subsequent amendments to the Act were made through the Health Care Safety Net Act of 2008, which made the automatic facility designation permanent.

**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, providing health services in or to 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).

Facility vacancies for primary care medical, dental, and mental health providers in high-need areas are listed in the NHSC Jobs Center and are used by HRSA to process applications for assignment of Corps members. In FY 2013, the NHSC instituted an application cycle which limited the period of time in which new site applications could be submitted. The FY 2015 new site application cycle opened March 31, 2015, and closed June 2, 2015. The number of new site applications approved in FY 2015 was 562, with 263 disapproved. There are currently more than 15,000 NHSC-approved sites. Figure 1 shows the disposition of new site applications received in FY 2015.

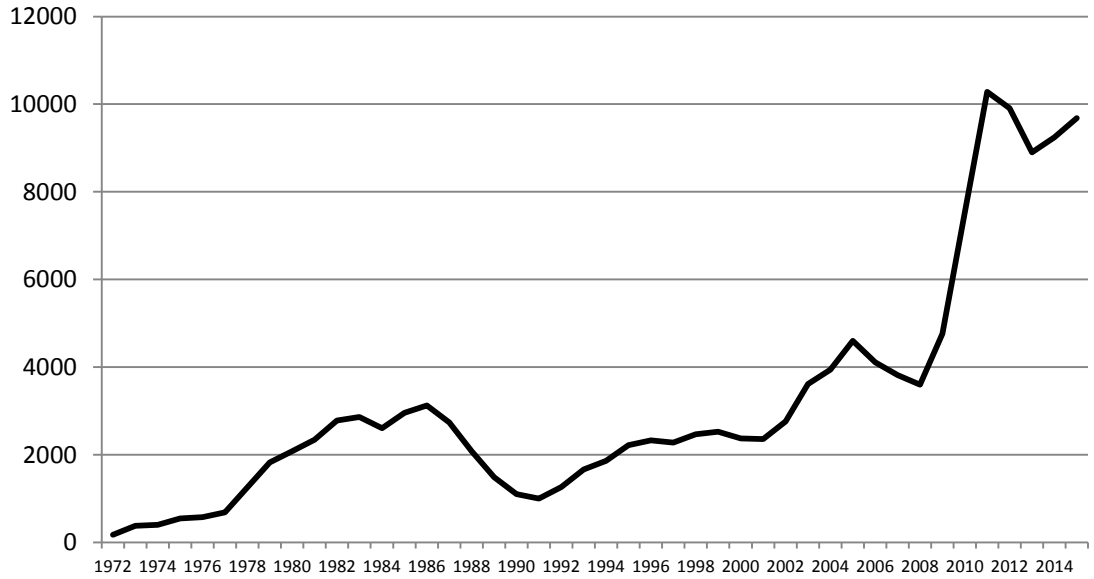
**Figure 1: Disposition of New Site Applications, FY 2015**



## 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 9,683 clinicians enumerated in the FY 2015 NHSC Field Strength make this the 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 2015). NHSC clinicians are recruited by several mechanisms: the NHSC SP and LRP, the S2S LRP, and the SLRP.[13] 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 considered to be "members of the Corps," the yearly NHSC Field Strength calculation accounts for them, as PPO clinicians and SLRP participants are supported by NHSC funds. The Field Strength in FY 2015 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**). Figure 2 shows the history of the NHSC Field Strength from FY 1972 through FY 2015.

**Figure 2: NHSC Field Strength, FYs 1972 – 2015**




[13] 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 FY 2014, the SLRP awarded 38 new grants to the states. Note: in Appendix A, SLRP clinicians are not included in the Urban/Rural and Grant/Non-Grant columns.

The NHSC is working to increase the number of minority clinicians.[14] In FY 2015, Black or African American physicians represented 17.2 percent of the Corps physicians, exceeding their 6.3 percent share in the national physician workforce.[15] Hispanic or Latino physicians represented 17.6 percent of the Corps physicians, exceeding their 5.5 percent share in the national physician workforce.[16] Hispanic or Latino, Black or African American, and Asian NHSC LRP and SP participants surpassed national health care workforce averages of dentists, and Black or African American NHSC LRP and SP participants surpassed national health care workforce averages of nurse practitioners.[17] Among NHSC participants, the proportion of Hispanic or Latino psychologists is above the national health workforce average.[18]

Based on self-reports of the 1,253 NHSC scholars in the pipeline (i.e., those in school, pursuing post-graduate training, or awaiting placement in an NHSC-approved service site), 17.1 percent are Black or African American, 14.8 percent are Asian or Pacific Islander, and 2.1 percent are American Indian or Alaska Native. Moreover, 15.4 percent of NHSC scholars self-identified as Hispanic or Latino. Blacks or African Americans exceed national student enrollment averages for students participating in the NHSC pipeline across all eligible disciplines/specialty categories except nurse practitioners and nurse midwives.[19] Hispanic or Latino NHSC scholars exceeded student enrollment averages in dentistry as they represent 12.4 percent of the Corps dental participants compared to their 7.0 percent share of the national student enrollment.[20] American Indian and Alaska Natives exceed national student enrollment averages in dentistry, medicine, physician assistants, and nursing disciplines for the NHSC pipeline.[21]

The NHSC estimates the FY 2016 Field Strength to be over 9,100 clinicians. This will represent a reduction from the FY 2015 level due, in part, to a projected decrease in the number of NHSC LRP and SLRP participants in service as more of them fulfill the service obligation and are no longer counted in the Field Strength.

[14] 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 Latino self-reported ethnicity data in the BMISS is separate from the race category. Therefore, the total percent of Hispanics or Latinos 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.

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

[16] *Ibid.*

[17] U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Characteristics by Race and Ethnicity (2013) used for comparison.

[18] *Ibid.*

[19] American Dental Association, 2012-2013 Survey on Dental Education: Academic Programs, Enrollments, and Graduates – vol.1. Association of American Medical Colleges, 2013. American Association of Nursing, 2013. 28th Physician Assistant Education Association Annual Report, 2011-2012.

[20] *Ibid.*

[21] *Ibid.*

# 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.

Since FY 2010, NHSC has used data collected from the NHSC Satisfaction Surveys as a baseline to measure site and participant satisfaction and to identify areas where the NHSC may improve recruitment and retention of Corps members in HPSAs. Results from the survey are also used to improve program delivery and prioritize future projects and initiatives. In FY 2015, NHSC sites had an overall Customer Satisfaction Index (CSI)[22] score of 79 (6 point increase since last measured in 2011) and NHSC participants had a CSI score of 79 (same as in FY 2014). Compared to the general public's satisfaction with government programs overall (CSI score of 64), both NHSC sites and participants consistently report higher satisfaction with their experience in the NHSC Program.

## *NHSC Recruitment Materials*

There are a few ways that NHSC LRP applicants become aware of the Corps. Feedback from NHSC LRP applicants indicate that many became aware of the Corps through their work site, school, NHSC web searches and social media, and friend or family word of mouth. In FY 2015, the NHSC developed communication materials that could be used via a variety of distribution channels to recruit eligible applicants and raise awareness of the NHSC.

The NHSC also 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 Health Center Week. There were more than 240,000 views of NHSC videos in FY 2015 compared to a total of 83,400 views for all of the previous years combined. The popularity of the member videos can be directly related to active promotional efforts and the campaigns implemented for them. Videos were selected for these campaigns because they represent gender, discipline, and racial diversity both in the providers and in the population served. They provide a compelling glimpse into the life of an NHSC provider, featuring those who are implementing best practices for care in their communities.

In addition, outreach was conducted directly to potential program participants to announce the opening of the FY 2015 NHSC application cycles. E-Blasts (mass emails) were sent to a large mailing list of more than 810,000 prospective NHSC LRP and 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.

[22] 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 United States and it 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.

As summarized in the Tables below, in FY 2015, these efforts resulted in more than 2,100 applications submitted to the NHSC SP and more than 6,700 applications submitted to the NHSC LRP.

**Table 1: NHSC SP Applications, FY 2015**

| | FY 2015 |
|---|---|
| Applications Received | 2,112 |
| New Awards | 196 |

**Table 2: NHSC LRP Applications, FY 2015**

| | FY 2015 |
|---|---|
| Applications Received | 6,703 |
| New Awards | 2,934 |

**Table 3: S2S LRP Applications, FY 2015**

| | FY 2015 |
|---|---|
| Applications Received | 170 |
| New Awards | 96 |

## *NHSC Communications Strategy*

In FY 2015, the Corps used multiple communications vehicles, including media tours and social media, to increase awareness among prospective program participants. In January, a Spanish-language radio media tour highlighted the application cycle for the NHSC LRP and the open enrollment period. The radio media tour resulted in 9 interviews (2 national and 7 local) with a total listenership of nearly 400,000.

Prospective program participants are able to access NHSC information through a variety of platforms, including social media, which enhances BHW's recruitment efforts. Below are examples of social media outreach:

- Between October 1, 2014, and September 30, 2015, the number of NHSC Facebook page "likes" went up from more than 30,000 to more than 34,000, which is a 13 percent increase. The number of NHSC Twitter followers has increased from more than 7,700 to more than 8,600, which is an increase of nearly 12 percent.
- BHW hosted a Facebook chat in October 2014 to celebrate Corps Community Day which allowed the NHSC community to discuss the current state of primary care. In 2015, there were two Facebook chats to promote the application cycles for the NHSC SP and S2S LRP. More than 600 potential applicants, current members, and Ambassadors attended these chats, which garnered nearly 300 new page likes.
- Various paid media campaigns ran from March to September 2015 to promote the NHSC Jobs Center, NHSC SP and S2S LRP application cycles, and two NHSC Virtual Job Fairs. The campaigns reached more than 7 million people via Facebook and 2.6 million people via Twitter.

## *NHSC Stakeholder Engagement and Conferences/Exhibits*

Stakeholders are important to the NHSC's ability to reach large audiences of individuals through their respective organizations. Collaboration with these organizations enables the NHSC to provide information to targeted groups such as health professions students; residents; clinicians; and academic institutions, which include deans, advisors, faculty, and financial aid officers. By leveraging these relationships, the NHSC was able to expand its outreach to new platforms.

In FY 2015, BHW collaborated with 16 national health professional organizations that represent clinicians, students, residents, school administrators, sites serving underrepresented racial and ethnic minorities, and rural communities. Information shared with stakeholders included annual face-to-face meetings on the opening and closing of application cycles, application technical assistance conference calls, pre-recorded webinars, Virtual Job Fairs, Corps Community Month, NHSC National Advisory Council vacancies, and other resources (e.g., fact sheets, BHW Application and Grants Bulletins, member videos, NHSC and NURSE Corps data).

BHW also exhibited at the national conferences sponsored by the following 15 organizations: American Medical Student Association, National Hispanic Medical Association, Student National Medical Association, Christian Community Health Fellowship, American Association of Colleges of Osteopathic Medicine, Central Association of Advisors for the Health Professions/Regional, Latino Medical Student Association, National Association of Advisors for Health Professions/Regional Conference, Association of Clinicians for the Underserved, National Association of Student Financial Aid Administrators, National Dental Association, Family Medicine Residents and Medical Students, National Black Nurses Association, National Medical Association, and National Association of Medical Minority Educators, Inc.

HRSA and the Indian Health Service (IHS) continue to work together to use the NHSC Program as a recruitment tool to fill health professional vacancies at Tribal sites. Tribal, IHS, and Urban Indian facilities (referred to as Tribal sites) that exclusively serve Tribal members can qualify as NHSC sites, extending their ability to recruit and retain primary care providers by utilizing NHSC scholarship and loan repayment incentives. Since FY 2011, the BHW Division of Regional Operations has worked with Tribal sites, offering hands-on assistance for completing a site profile and posting vacancies on the NHSC Job Center. HRSA's Shortage Designation Branch has worked with Tribal sites to verify that their HPSA scores are current, enabling them to be competitive in recruiting NHSC scholars and loan repayors to their sites. As a result of these efforts, 672 Tribal sites were qualified to offer NHSC loan repayment to eligible clinicians, and 432 NHSC clinicians were serving at Tribal sites across the country as of September 30, 2015.

## *Virtual Job Fairs*

BHW hosted 5 NHSC Virtual Job Fairs, which included presentations from over 200 representatives from over 1,200 facilities within 37 states and Washington, DC. These representatives were recruiting for approximately 1,250 job vacancies. Over 1,000 job-seeking providers participated.

### *Pipeline Programs*

In an effort to increase the pipeline of NHSC-eligible health professionals and increase diversity in the program during FY 2015, the NHSC worked closely with minority serving academic medical institutions, such as Historically Black Colleges and Universities, Hispanic Serving Institutions, Indian/Tribal Academic Institutions, and schools with strong rural health tracks to encourage students' interest in applying for NHSC scholarship and loan repayment programs. Further efforts were increased towards the end of the FY, as the NHSC began to expand outreach efforts to undergraduate and community colleges. Reports indicate that students, including those 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.[23]

The NHSC also 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 the NHSC S2S LRP.

## 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 2015 saw 10.2 million patients and generated 40.8 million patient visits. The NHSC estimates that primary care NHSC clinicians saw 5.2 million patients and generated 20.8 million patient visits; dental health NHSC clinicians saw 1.4 million patients and generated 5.6 million patient visits; and mental and behavioral health NHSC clinicians saw 3.6 million patients and generated 14.4 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.

[23] 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. Based on the most recent Participant Satisfaction Survey results,[24] the short term retention rate among survey respondents who completed their NHSC service commitment in the past 2 years is 87 percent. Applying the survey's NHSC alumni retention rate among survey respondents to the 6,584 clinicians who successfully completed service in that time frame, NHSC estimates that more than 5,700 clinicians are retained and continue to provide primary care services to underserved communities and vulnerable populations within 2 years after completing their service commitment.

The experiences that NHSC providers have at their sites while completing their service obligations continues to significantly influence retention among NHSC providers. The most common reasons given by participants for not remaining at their NHSC-approved site following their service commitment were financial considerations and site operations.

## *Long-Term Retention*

On March 30, 2012, a Final Report entitled "Evaluating Retention in Bureau of Clinician Recruitment and Service (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 estimated that 55 percent of NHSC scholars and loan repayors remained in service to the underserved as long as 10 years after fulfilling their NHSC service commitment.[25] This compares favorably with the findings from the 2000 Report entitled "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.[26] 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).

Based on a more recent study commissioned by the Department of Health and Human Services' Assistant Secretary for Planning and Evaluation, the Lewin Group examined retention rates of NHSC participants over the period between 2005 and 2011. Among key findings from this report were that about 49 percent of NHSC primary care participants were located in the same

[24] The FY 2015 Participant Satisfaction Survey (see **Requirement 4** above) found that 87 percent of those NHSC clinicians who had fulfilled their obligation within the past 2 years (778 of 894 survey respondents) and responded to this voluntary survey, met the program's definition of being retained; that is, they were continuing to practice at their assigned site, were practicing at another NHSC site, or were practicing in a designated shortage area. HRSA uses survey information for **Requirement 6** due to the efficiency of this method as well as a lack of authority to require individuals out of service to provide their current place of employment.

[25] "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 estimated retention figure of 55 percent is based on the finding that 1,745 of the 3,174 respondents to the study met the retention criteria and the sample size was sufficient to generalize to the entire population.

[26] "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.

HPSA where they met their service obligation 1 year after that obligation was completed and 82 percent were located in a HPSA location. By the sixth year after obligation completion, 35 percent of the participants were located in the same HPSA where they served during their NHSC service and 72 percent were in a HPSA location.[27]

## 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 (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 health care facilities for NHSC recruitment and retention assistance. Eligibility is based on, among other criteria, 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; the reasonable prospect of sound fiscal management by the entity; and the entity's willingness to support or facilitate mentorship, professional development, and training opportunities for Corps members.

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) of the PHS Act 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 (see 42 CFR Part 5). 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 mental health and 1 to 26 for 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

[27] Negrusa, S, Ghosh, P, Warner, JT. "Provider Retention in High Need Areas: Final Report". December 2014. https://aspe.hhs.gov/pdf-report/provider-retention-high-need-areas.

facilities may have a HPSA score of zero, indicating either a relatively low need or the possibility that no data was provided in order to compute a HPSA score.

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

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

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

Once their 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 redesigned to provide users with expanded information related to the services provided and populations served by NHSC-approved sites. From October 1, 2014, through September 30, 2015, the number of new vacancies created was 7,678, and during that period, 4,400 vacancies were filled. As of September 30, 2015, there were 4,388 vacancies listed. The NHSC Jobs Center is located on the NHSC website: http://nhscjobs.hrsa.gov/.

# V. Conclusion

The achievements of the NHSC in FY 2015 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. 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.