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

REPORT TO CONGRESS

NATIONAL HEALTH SERVICE CORPS
FOR THE YEAR 2019

Executive Summary

The Report to Congress for 2019 details the program accomplishments of the National Health Service Corps (NHSC), which is charged with helping communities within Health Professional Shortage Areas (HPSAs) of greatest need and providing 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 short-term and long-term retention rates of NHSC clinicians who have fulfilled the service obligation and continue to serve the underserved; and
- Describes the evaluation process to determine compliance with section 333(a)(1)(D) of the Public Health Service Act for inclusion on the Health Workforce Connector (formerly NHSC Jobs Center).

Significant findings in the report include the following:

- NHSC and many federal and state workforce programs use HPSA designations for resource allocation. As of September 30, 2019, there were HPSA designations of the following types:
    - Primary Care: 7,578
    - Dental Health: 6,782
    - Mental Health: 6,069

- The NHSC field strength in fiscal year (FY) 2019 was 13,053. 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 2019, NHSC clinicians provided care to nearly 13.7 million people. Over 61 percent of NHSC clinicians served in health centers supported by Health Resources and Services Administration (HRSA) grants. The remaining clinicians provided patient care services in Critical Access Hospitals, Rural Health Clinics, Indian Health Service (IHS)

[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, the NHSC Substance Use Disorder (SUD) Workforce LRP, the NHSC Rural Communities LRP, and the State Loan Repayment Program who are currently fulfilling the service commitment.

[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.

facilities, Tribally-operated 638 Clinics[3], and Urban Indian Health Programs (collectively known as ITUs), group or private practices, hospital-based outpatient clinics, and similar outpatient sites located in HPSAs but not supported by HRSA grants.

- Approximately 36 percent of NHSC placements in FY 2019 were in facilities that served rural areas.[4]

- The discipline mix of the NHSC field strength reflects the program's efforts to respond to the demand for services in underserved communities as well as the program's commitment to an interdisciplinary approach to patient care.

- In FY 2019, NHSC made new and continuation awards including 211 scholarships, 6,397 new and continuation loan repayments, and 127 Students to Service loan repayments. These awards serve as vital recruitment tools for underserved communities in need of primary care, oral health, and behavioral and mental health services.

- In FY 2019, NHSC received $310 million through the Bipartisan Budget Act of 2018 that funded all of the individual awards listed above. The State Loan Repayment Program grants support 40 states and 1 territory in the second year of a 5-year funding cycle.

- The Consolidated Appropriations Act of 2018 and the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 appropriated funding to the NHSC for the express purpose of expanding and improving access to quality opioid and substance use disorder (SUD) treatment in rural and underserved areas nationwide. This funding was used to implement both the NHSC SUD Workforce Loan Repayment Program (LRP) and the NHSC Rural Community LRP in FY 2019. Additionally, the FY 2019 appropriation included funding to support loan repayment awards to clinicians serving in Indian Health Service, tribal, and Urban Indian facilities.

- In FY 2019, HRSA began using the "Clinician Dashboard" to calculate retention rates. The Clinician Dashboard is a data visualization tool that includes data on clinicians with National Provider Identifier numbers supported by the National Health Service Corps.[5]

[3] Tribal Contract or Compact Health Centers (also called a 638 contract or compact) are operated by Tribes or Tribal organizations, and Urban Indian Health Centers are outpatient health care programs and facilities that specialize in caring for American Indians and Alaska natives. They are operated under the Indian Self-Determination Act. Urban Indian Health Centers are designated Federally Qualified Health Centers that provide comprehensive primary care and related services to American Indians and Alaska Natives. The facilities are owned or leased by Urban Indian organizations and receive grant and contract funding through Title V of the Indian Health Care Improvement Act.
[4] NHSC uses the Federal Office of Rural Health Policy definition of rural for identifying NHSC-approved sites that are in rural areas. See http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.
[5] The Clinician Dashboard also includes data regarding the Nurse Corps Loan Repayment and Scholarship Programs authorized under section 846 of the PHS Act. For more information, visit https://data.hrsa.gov/topics/health-workforce/clinician-dashboards.

HRSA
Health Resources & Services Administration

National Health Service Corps
Report to Congress for the Year 2019

Table of Contents

List of Figures

List of Tables

Acronym List

BHW	Bureau of Health Workforce
CAH	Critical Access Hospital
DATA	Drug Addiction Treatment Act
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
ITU	Indian Health Service, Tribally-operated 638 clinics, and Urban Indian Programs
LRP	Loan Repayment Program
NHSC	National Health Service Corps
PHS	Public Health Service

RC	Rural Community
S2S LRP	Students to Service Loan Repayment Program
SLRP	State Loan Repayment Program
SP	Scholarship Program
SUD	Substance Use Disorder

I. Legislative Language

Section 336A of the Public Health Service (PHS) Act [42 U.S.C. § 254i] sets out the requirements for this Report to Congress:

> "*The Secretary shall submit an annual report to Congress, and shall include in such report with respect to the previous calendar year—*[6]
>
> *(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 applications filed under section 333 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) 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, and the amount which was paid to the Secretary in such year under such agreements."*[7]

This report includes updates and fiscal year (FY) data[8] on each of these requirements and related National Health Service Corps (NHSC) program activities and initiatives and discusses how these activities and initiatives align with the mission of the program.

[6] Data provided in this report are fiscal year data reported in accordance with how Congress appropriates funds to the National Health Service Corps.
[7] The Health Care Safety Net Amendments of 2002 amended Section 334 of the PHS Act [42 U.S.C. § 254g] to eliminate the requirement that entities receiving National Health Service Corps assignees reimburse the agency for health services provided by those Corps members. Therefore, reporting element #8 is no longer relevant.
[8] The BHW Management Information System Solution collects NHSC Program data. The BHW Management Information System Solution is an IT system modernization program that replaced and/or retired a multitude of legacy systems that contained information collected from individual scholarship and loan repayment applications, 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.

II. Introduction

The Bureau of Health Workforce (BHW) in the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services manages this program. The Emergency Health Personnel Act of 1970 (Pub. L. 91-623) established the NHSC on December 31, 1970. Congress has amended and reauthorized the Act several times in the ensuing 49 years. Congress authorized HRSA to implement changes to the program effective in FY 2011, which included authorizing a maximum annual loan repayment award of $50,000 per year for the NHSC Loan Repayment Program (LRP), offering the option of half-time service for both scholars and participants in the loan repayment program, and allowing service credit for teaching.

The NHSC field strength increased to 13,053 clinicians in FY 2019 from 10,939 clinicians in FY 2018. The field strength includes clinicians recruited through the NHSC LRP, the NHSC Students to Service Loan Repayment Program (S2S LRP), the NHSC Substance Use Disorder (SUD) Workforce LRP, the NHSC Rural Community (RC) LRP, the NHSC Scholarship Program (SP), and the State Loan Repayment Program (SLRP) who are currently fulfilling the service commitment.

There continues to be tremendous interest in these programs, and HRSA has maintained its robust online and in-person recruitment activities. In FY 2019, NHSC SP, NHSC LRP, NHSC S2S LRP, NHSC SUD Workforce LRP, and NHSC RC LRP received nearly 11,000 applications for new and continuation awards, an increase of approximately 1,500 applications compared to FY 2018. The increase in both the number of applications and the field strength is the result of additional appropriations to the NHSC in both FY 2018 and FY 2019 (see **Overview**, below for details). HRSA used social networking, increased collaboration with stakeholders, and online visibility to recruit eligible NHSC applicants. HRSA collaborated with 35 national health professional organizations with missions similar to NHSC to expand awareness of the program. These organizations represent clinicians, students, residents, school administrators, and sites serving underrepresented racial and ethnic minorities, as well as rural communities. HRSA exhibited at 16 national partner conferences and hosted 8 Virtual Job Fairs, including 4 behavioral health virtual job fairs, all of which resulted in nearly 500 participating sites representing all 50 states, the District of Columbia, the Virgin Islands, and the Northern Mariana Islands with nearly 14,000 job posts on the Workforce Connector.

An important measure of the success of NHSC is the retention of NHSC clinicians in service to the underserved after the fulfillment of their NHSC commitment. In FY 2019, HRSA began using a newly developed Clinician Dashboard to calculate retention rate for NHSC providers, using National Provider Identifier numbers from the Centers for Medicare & Medicaid Services in conjunction with other data sources to assist in determining the current practice locations of NHSC alumni. The Dashboard shows approximately 81 percent of those who had fulfilled their NHSC commitments remained in service to the underserved 1 year after their NHSC commitments ended. Further, 85 percent of those who fulfilled their service commitments between 2012 and 2018 are either still in a Health Professional Shortage Area (HPSA), or have remained at the NHSC site where they served even if it no longer qualifies as a HPSA.

III. Overview

In FY 2019, NHSC awarded 200 new scholarships and 11 continuations as well as 4,012 new loan repayments and 2,385 loan repayment continuations. NHSC also continued implementation of the S2S LRP making 127 awards for loan repayments to medical and dental students in their last year of school. The program encourages medical and dental students to select a primary care specialty and requires a 3-year service commitment in a high priority HPSA[9] that begins for physicians once the required primary care residency is complete; dental students are encouraged, but not required, to complete approved post-graduate training.

In FY 2019, the 104 clinicians awarded NHSC loan repayment contracts under the Zika Response and Preparedness Act (Pub. L. 114-223) entered the last year of their 3-year commitment in Puerto Rico and other territories affected by the Zika virus or other vector-borne diseases.

In FY 2019, 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. The program offers 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. HRSA introduced these tiers in FY 2012. Prior to FY 2012, there was no differentiation in loan repayment amount based on HPSA score.

In FY 2019, NHSC continued placing clinicians in Critical Access Hospitals (CAH) and Indian Health Service (IHS) and Tribal hospitals to extend the reach of NHSC in rural areas. Prior to the FY 2012-2015 CAH pilot program, only a CAH outpatient clinic was an eligible site and NHSC clinicians were generally limited to no more than 8 hours per week in the inpatient setting. The pilot program allowed clinicians to spend up to 24 hours per week in the CAH inpatient setting and no less than 16 hours per week in an affiliated outpatient clinic.[10] These are now permanent program requirements and CAHs are eligible sites. As of September 30, 2019, there are 223 active CAHs approved as NHSC sites, with 66 NHSC clinicians practicing in them.

The Consolidated Appropriations Act of 2018 and the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 appropriated funding to the NHSC for the express purpose of expanding and improving access to quality opioid and SUD treatment in rural and underserved areas nationwide. HRSA began the utilization of these funds through the implementation of the following programs and activities:

NHSC SUD Workforce LRP: The primary purpose of this funding is to expand the availability of SUD treatment providers by making available dedicated NHSC funding for the SUD workforce providing outpatient services at sites including opioid treatment programs, office-

[9] A "high priority HPSA" is currently defined as having a HPSA score of 14 or above. HPSA scoring methodology is described in more detail later in the report.

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

based opioid treatment facilities, and non-opioid outpatient SUD facilities. The funding supports the recruitment and retention of health professionals needed in underserved areas to provide evidence-based SUD treatment and prevent overdose deaths. Providers are given loan repayment to reduce their educational financial debt in exchange for a service commitment to work at SUD treatment facilities.

SUD providers include:

- Physicians (allopathic and osteopathic physicians), nurse practitioners, physician assistants with Drug Addiction Treatment Act (DATA) 2000 Waivers;
- Licensed or certified health professionals providing SUD services; and
- Licensed primary care and mental and behavioral health professionals.

NHSC Rural Community (RC) LRP: A portion of the FY 2018 and FY 2019 appropriations provided funding for the NHSC RC LRP, a new program for providers working to combat the opioid epidemic in the nation's rural communities. The NHSC RC LRP made FY 2019 loan repayment awards in coordination with the Rural Communities Opioid Response Program initiative within the Federal Office of Rural Health Policy to provide evidence-based substance use treatment, to assist in recovery, and to prevent overdose deaths across the nation.

NHSC and the IHS: The FY 2019 appropriation included funding to support loan repayment awards to fully trained medical, nursing, dental and behavioral/mental health clinicians, and SUD providers, to deliver health care services in IHS facilities, Tribally-operated 638 Clinics[11], and Urban Indian Health Programs (ITU). Federal IHS Clinics, Tribal Health Clinics, Urban Indian Health Clinics, and dually funded Tribal Health Clinics/Community Health Centers are automatically designated as HPSAs. These sites had received NHSC placements before FY 2019.

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 a HPSA 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

[11] Tribal Contract or Compact Health Centers (also called a 638 contract or compact) are operated by Tribes or Tribal organizations, and Urban Indian Health Centers are outpatient health care programs and facilities that specialize in caring for American Indians and Alaska natives. They are operated under the Indian Self-Determination Act. Urban Indian Health Centers are designated Federally Qualified Health Centers that provide comprehensive primary care and related services to American Indians and Alaska Natives. The facilities are owned or leased by Urban Indian organizations and receive grant and contract funding through Title V of the Indian Health Care Improvement Act.

process involves two actions: (1) the analysis of the data submitted with each new request, and (2) the review of previously designated HPSAs. Additionally, there is a permanent automatic designation of certain facility HPSAs (e.g., Federally Qualified Health Centers [FQHC]), FQHC Look-Alikes, and those Rural Health Clinics that provide services regardless of ability to pay).[12] 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 created for the placement of NHSC clinicians, currently more than 30 federal and state programs and agencies use the HPSA designation for resource allocation. HRSA publishes a list of designated HPSAs 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, 2019, there were 7,578 primary care HPSAs, 6,782 dental health HPSAs, and 6,069 mental health HPSAs. Overall, the number of HPSAs has increased more than 18.5 percent from FY 2018. HRSA anticipates that the number of HPSAs in FY 2020 will remain relatively stable.

Requirement #2: The number of site applications filed under section 333 of the PHS Act 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 NHSC evaluates formal requests from facilities seeking eligibility for NHSC recruitment and retention assistance (see **Requirement #7** for a description of the evaluation process). The NHSC determines eligibility based on the following:

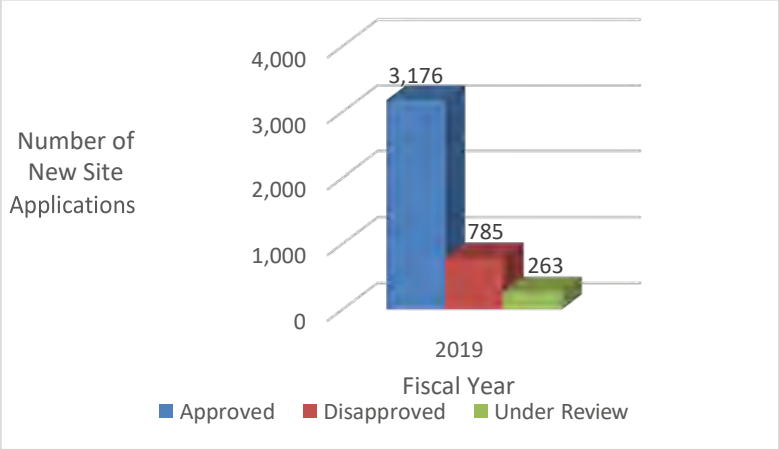
- Continued need for health professionals in the area;
- Appropriate and efficient use of NHSC members previously assigned to the entity;
- Support by the community for the assignment of an NHSC member to that entity;
- Unsuccessful efforts by the facility to recruit health professionals from other sources;
- Reasonable prospect of sound financial management by the entity; and
- Willingness of the entity to support or facilitate mentorship, professional development, and training opportunities for Corps members.

Specific requirements for participation as an NHSC-approved site include 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. More information on site eligibility is available on the NHSC website (http://www.nhsc.hrsa.gov/sites/index.html).

[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.

The NHSC accepted new site applications in FY 2019 between April 16 and June 13, 2019, and re-certification applications between January 1 and February 26, 2019, and August 20 and October 1, 2019. The NHSC also accepted streamlined applications from sites classified as NHSC auto-approved (e.g., FQHCs and IHS sites) throughout the year from October 1, 2018 through September 30, 2019. The cumulative number of NHSC site applications, including NHSC auto-approved sites, submitted for FY 2019 was 4,224 with 3,176 approved, 785 disapproved or cancelled, and 263 under review, including 46 pending a site visit (See Figure 1). There are currently more than 17,740 NHSC approved sites.

Figure 1: Disposition of NHSC Site Applications, FY 2019



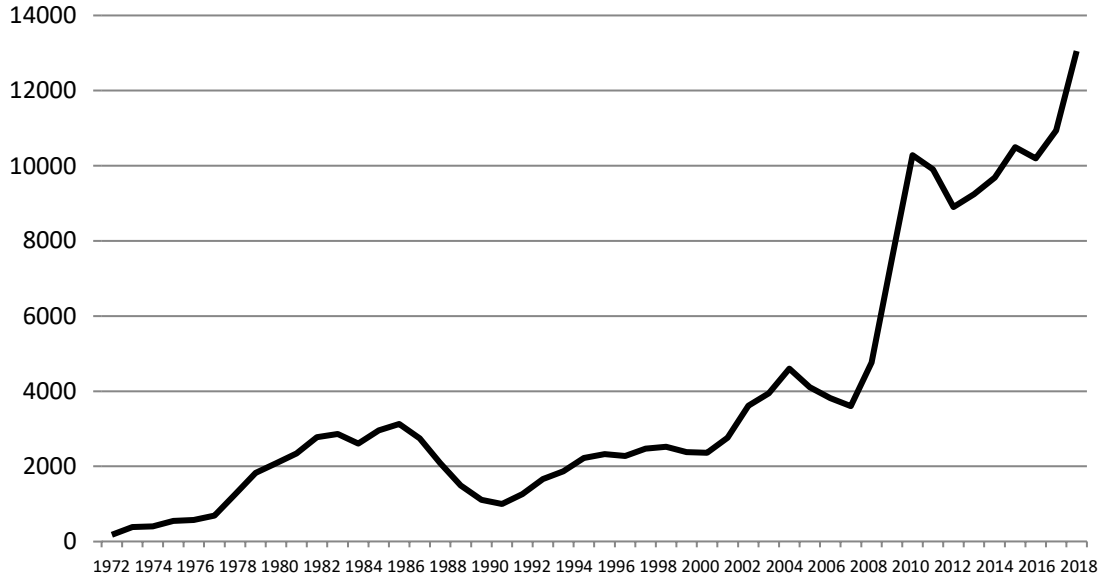
Requirement #3: The number and types of Corps members assigned in such year to HPSAs, the number and types of additional Corps members, which the Secretary estimates will be assigned to such areas in the subsequent year, and the need for additional members for the Corps.

The 13,053 clinicians enumerated in the FY 2019 NHSC field strength are the largest cohort of NHSC providers in the program's history. See **Appendix A** for distribution of NHSC clinicians by discipline and program for FY 2019. NHSC recruits clinicians by several mechanisms including the NHSC SP and LRP, the S2S LRP, the SUD Workforce LRP, the RC LRP, and the SLRP. Though NHSC clinicians who have chosen the Private Practice Option provided under section 338D of the PHS Act (42 U.S.C. §254n) and the participants in SLRP are not considered to be "members of the Corps,"[13] the yearly NHSC field strength calculation includes them as Private Practice Option clinicians, and SLRP participants are supported by NHSC funds. The field strength in FY 2019 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 NHSC.

[13] "Members of the Corps" is a term of art and has certain guarantees under the law (e.g., members may work half time to fulfill their service requirement while non-members [i.e., Private Practice Option] cannot.) Awardees through the State Loan Repayment Program have contracts with states, not the Secretary, and they are not members of the Corps. Both members and non-members are included in the field strength, as noted above, because they are federally funded.

NHSC clinicians who fulfill their service commitment and remain in service to the underserved (see **Requirement 6**) are not included. Figure 2 illustrates the history of the NHSC field strength from FY 1972 through FY 2019.

Figure 2: NHSC Field Strength, FYs 1972 – 2019



NHSC estimates the FY 2020 field strength will be approximately 14,133 clinicians. This increase from the FY 2019 level is due in part to the FY 2018 and 2019 Consolidated Appropriations Acts' expansion of the NHSC LRP.

Ensuring greater racial and ethnic diversity of the health care workforce is essential for increasing access to culturally competent care for all patients, improving opportunities and representation of all groups within the health professions, and meeting the overall needs of our diverse population, particularly in the most underserved areas.[14] Many racial and ethnic and minority groups are underrepresented nationally within the major health professions,[15] and the NHSC is working to increase the number of minority clinicians. As a result, in FY 2019, the share of racial and ethnic minority NHSC providers exceeds their share in the national workforce, as shown in the following instances:

Primary Care

- Black or African American physicians represented 13.6 percent of the NHSC LRP and SP participants, exceeding their 5 percent share in the national physician workforce.[16]

[14] Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. Health Aff (Millwood). 2002 Sep-Oct; 21(5): 90-102 (http://content.healthaffairs.org/content/21/5/90.full).
[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2010-2012), Rockville, Maryland; 2014 (https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/diversityushealthoccupations.pdf).
[16] Association of American Medical Colleges, Diversity in Medicine: Facts and Figures, 2019.

- Hispanic or Latino physicians represented 18.2 percent of the NHSC LRP and SP participants, exceeding their 5.8 percent share in the national physician workforce.[17]
- American Indian and Alaska Native physicians represented 1.6 percent of the NHSC LRP and SP participants, exceeding their 0.3 percent share in the national physician workforce.[18]
- Black or African American nurse practitioners represented 19.4 percent of the NHSC LRP and SP participants, exceeding their 11.2 percent share in the national health care workforce averages of nurse practitioners.[19]
- Hispanic or Latino nurse practitioners represented 8.5 percent of the NHSC LRP and SP participants, exceeding their 2.6 percent share in national health care workforce averages of nurse practitioners.[20]

Mental and Behavioral Health

- Asian health services psychologists represented 6 percent of the NHSC LRP participants, exceeding their 3 percent share in the national health care workforce averages of health services psychologists.[21]
- Black or African American health services psychologists represented 9 percent of the NHSC LRP participants, exceeding their 6.5 percent share in the national health care workforce averages of health services psychologists.[22]
- Hispanic or Latino licensed clinical social workers represented 14.1 percent of the NHSC LRP participants, exceeding their 13.4 percent share in the national health care workforce averages of licensed clinical social workers.[23]

Oral Health

- Black or African American dentists represented 13.6 percent of the NHSC LRP participants, exceeding their 1.6 percent share in the national health care workforce averages of dentists.[24]
- Hispanic or Latino dental hygienists represented 17.4 percent of the NHSC LRP participants, exceeding their 8.6 percent share in the national health care workforce averages of dental hygienists.[25]

Based on self-reports of the 1,479 NHSC scholars (i.e., those in school, pursuing post-graduate training, or awaiting placement in an NHSC-approved service site), 20.5 percent are Black or African American, 20.5 percent are Asian or Pacific Islander, and 2 percent are American Indian or Alaska Native. Moreover, 14.3 percent of NHSC scholars self-reported as Hispanic or Latino. Black or African American NHSC scholars exceeded national student enrollment averages in

[17] *Ibid.*
[18] *Ibid.*
[19] U.S. Department of Labor, Bureau of Labor Statistics Labor Force Characteristics by Race and Ethnicity, 2018, October 2019, Report 1082.
[20] *Ibid.*
[21] *Ibid.*
[22] *Ibid.*
[23] *Ibid.*
[24] *Ibid.*
[25] *Ibid.*

dentistry, medicine, physician assistant, and nursing disciplines.[26] Hispanic or Latino NHSC scholars exceeded student enrollment averages in dentistry as they represent 12.3 percent of the Corps' dental participants, compared to their 9 percent share of the national student enrollment.[27] American Indian and Alaska Native NHSC scholars exceed national student enrollment averages in dentistry, medicine, physician assistant, and nursing disciplines.[28]

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 annual NHSC Satisfaction Surveys to measure site and participant satisfaction and to identify areas where NHSC may improve recruitment and retention of Corps members in HPSAs. NHSC also uses results from this voluntary and anonymous satisfaction survey to improve program delivery and prioritize future projects and initiatives. In FY 2019, a survey of NHSC participants resulted in an average rating of 8.16 out of 10 for overall program satisfaction among the NHSC LRP, NHSC S2S LRP, and NHSC SP.

NHSC Recruitment Materials

There are a few ways that NHSC LRP, NHSC SUD Workforce LRP, NHSC RC LRP, NHSC S2S LRP, and NHSC SP applicants become aware of the Corps. Feedback from NHSC applicants indicates 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 2019, NHSC continued to develop and implement communication materials used for a variety of distribution channels to recruit eligible applicants and raise awareness of NHSC.

One popular item is the email signup options, via GovDelivery, for all loan repayment and scholarship programs. This option allows those interested to receive notification when application cycles open and close and to receive relevant program and application submission information and compliance tips. The current opt-in email lists for NHSC programs include more than 781,000 recipients.

Through focused, targeted messaging using social media channels, web content and videos, the NHSC continues to highlight the impact of members' work serving in communities with limited access to care and to promote the rewarding opportunities loan repayment and scholarships provided through its programs. Coinciding with national health observances like National Health Center Week and National Public Health Week, NHSC social media following has grown to almost 58,000 individuals. Videos continue to be popular on NHSC social media channels and support the long-term communications and recruitment strategies for the program. Two

[26]American Dental Association, 2018-2019 Survey on Dental Education: Academic Programs, Enrollments, and Graduates. Association of American Medical Colleges, 2019-2020. American Association of Colleges of Nursing, 2019. 34th Physician Assistant Education Association Annual Report, 2018.
[27]*Ibid.*
[28]*Ibid.*

videos were produced in 2019 supporting the SUD Workforce LRP and the NHSC Providers Clinical Support System Medication Assisted Treatment training opportunity and targeting specific clinicians for the NHSC's expanded LRP programs combatting the opioid epidemic. Additionally, the NHSC website had more than 1.3 million visitors and 3.5 million page views, with the SUD Workforce LRP and the RC LRP pages, the two newest LRP expansion programs, among the top-accessed pages during their respective open application cycles.

To support the need for qualified, eligible Tier 1 applicants for the SUD Workforce LRP, the NHSC developed and promoted a new interagency partnership with the Substance Abuse and Mental Health Services Administration's Providers Clinical Support System, which will also increase the number of DATA 2000 Waiver-certified clinicians in high-need communities.[29] A long-term promotional campaign across social media, web, and direct emails reached more than 350,000 individuals. To date, 113 NHSC members (and other eligible clinicians) who learned of the training via these methods have completed the training – a 25 percent increase after 4 months of promotion.

In addition, NHSC conducted direct outreach to potential program participants to announce the opening of the FY 2019 NHSC application cycles. E-blasts (mass emails) via GovDelivery were sent to distribution lists totaling more than 781,000 prospective NHSC LRP, NHSC SUD Workforce LRP, NHSC RC LRP, NHSC S2S LRP, and NHSC SP applicants, school administrators, and NHSC partners including NHSC alumni, the National Advisory Council, professional associations, NHSC sites, program participants, and State Primary Care Offices. As summarized in the Table below, these efforts resulted in more than 1,800 applications to the NHSC SP and over 9,000 new applications to the NHSC LRP Programs (including NHSC SUD Workforce LRP and NHSC RC LRP).

Table 1: Applications and Awards, FY 2019

Program	*Applications*	*New Awards*
NHSC SP	1,877	200
NHSC LRPs	8,874	4,012
S2S LRP	183	127

NHSC Communications Strategy

Broadening its outreach, NHSC collaborated with several Department of Health and Human Services agencies and other HRSA bureaus and offices to amplify its recruitment, program awareness and informational messages. Several channels, including earned, paid, print, online, and social media, allowed for targeted messaging to reach specific audiences more effectively. These efforts increased the NHSC's ability to reach high-quality applicants and health care sites, and aid in the retention of current members:

[29] Tier 1 applicants are those who are SUD professionals with SUD licensure/certification or DATA 2000 Waiver employed in either a Substance Abuse and Mental Health Services Administration-certified opioid treatment program or an office-based opioid treatment facility.

- Social media efforts continue to increase the number of followers who track and want to learn more about NHSC programs. Between October 1, 2018 and September 30, 2019, the number of NHSC followers for all social media increased by 8 percent.
- In 2019, NHSC hosted its largest Facebook chat to date, the NHSC LRP and SUD Workforce LRP Frequently Asked Questions event. More than 1,200 potential applicants, site administrators, and program staff members attended. The reach for this event was more than 16,300 individuals.
- A multi-pronged paid campaign to promote HRSA's first Behavioral Health Virtual Job Fair garnered 15 stakeholder features through four platforms including online and print newsletters and website banners, nearly 500,000 Facebook impressions, and 35,000 video views. The Behavioral Health Virtual Job Fair exceeded job seeker registration goals (more than 3,000) and produced 1,300 user profiles on the Health Workforce Connector.
- The HRSA Virtual Job Fair paid media campaign, from October 1 to October 16, 2019, helped drive traffic to the Health Workforce Connector, which saw 978 user profiles created in that time. During the same time, the Health Workforce Connector homepage received over 10,575 visitors, of which 75 percent were new.

NHSC Stakeholder Engagement and Conferences/Exhibits

In FY 2019, NHSC expanded stakeholder engagement and promotion of its scholarship and loan repayment programs through webinars, conference calls, and social media to include Facebook chats, e-blasts, presentations, and exhibits at 16 conferences. By fostering relationships with 35 national health organizations, state primary care offices, and primary care associations, the NHSC expanded its reach to larger and more diverse audiences including pipeline and health professions students, clinicians, faculty, school administrators, and sites serving underrepresented racial and ethnic minorities and rural communities.

These groups included the Association of American Medical Colleges, the Association of Clinicians for the Underserved, National Medical Association, Hispanic Medical Association, Black Nurses Association, National Rural Recruitment and Retention Network, National Rural Health Association, National Association of Alcohol and Drug Abuse Counselors, the Association for Addiction Professionals, National Association of Rural Health Clinics, and the National Council for Behavioral Health. Student groups included the American Medical Student Association, Student National Medical Association, and Latino Medical Student Association.

In addition to professional associations, HRSA promoted NHSC program opportunities to eligible health professions schools through e-blasts and in-person visits when possible. HRSA shared information with medical, dental, nursing, and behavioral and mental health students at 63 health professions school events throughout the United States and its territories in FY 2019.

HRSA and IHS work together to use NHSC programs as recruitment tools to fill health professional vacancies at sites serving Tribal communities. IHS ITUs that exclusively serve Tribal members can qualify as NHSC sites and extend their ability to recruit and retain primary care providers by utilizing NHSC scholarship and loan repayment incentives. The Division of Regional Operations in HRSA's ten Regional Offices worked with ITUs, offering hands-on assistance for completing site profiles and posting vacancies on the Health Workforce

Connector. HRSA's Shortage Designation Branch works with ITUs to verify that their HPSA scores are current, enabling the sites to be competitive in recruiting NHSC scholars and loan repayment participants. At the end of FY 2019, 864 ITUs were NHSC approved and 722 clinicians from those sites were in an NHSC commitment. This is an increase of nearly 150 clinicians over the previous year, and is due in part to a $15 million set-aside for applicants serving in ITUs in the FY 2019 appropriation (as described in the **Overview**, above).

NHSC Recruitment Resources

HRSA's Virtual Job Fairs and the Health Workforce Connector offer platforms to link large numbers of career-seeking clinicians with job opportunities at NHSC approved sites. While HRSA Virtual Job Fairs and the Health Workforce Connector are recruitment tools intended for NHSC and other HRSA supported health care provider recruitment and retention programs, prospective program participants and career-seeking health professionals alike can access these free, public-facing resources.

HRSA leveraged both recruitment resources to combat the opioid epidemic with its first Regional Behavioral Health Virtual Job Fairs in February and March 2019. HRSA hosted four separate virtual job fairs focused on behavioral health vacancies and targeted specific regions in the United States for each event. There were 117 participating sites promoting over 200 job vacancies to over 1,400 participating job seekers. Promotion for the Regional Behavioral Health Virtual Job Fairs resulted in over 3,000 sites with job postings and over 2,000 new health clinician profiles on the Connector. The four other FY 2019 HRSA Virtual Job Fairs included nearly 380 participating sites representing all 50 states, the District of Columbia, the Virgin Islands, and the Northern Mariana Islands with nearly 14,000 job posts on the Connector and 4,500 participating job seekers.

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 2019 saw approximately 13.7 million patients and generated 54.8 million patient visits. NHSC estimates that primary care NHSC clinicians saw 6.4 million patients and generated 25.6 million patient visits. Dental health NHSC clinicians saw 1.9 million patients and generated 7.6 million patient visits, and behavioral and mental health NHSC clinicians saw 5.4 million patients and generated 21.6 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.

NHSC continues to monitor the retention rates of NHSC scholars and loan repayment participants 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.

Short-Term Retention

NHSC is committed to continuous performance improvement. In FY 2019, HRSA began using a newly developed Clinician Dashboard to calculate retention rate for NHSC providers. The Clinician Dashboard uses National Provider Identifier numbers from the Centers for Medicare & Medicaid Services in conjunction with other data sources to assist in determining the current practice locations of providers who previously served in the NHSC. It allows HRSA to calculate a more accurate retention rate that is not dependent on survey response rates. The short-term retention rate among respondents who completed their NHSC service commitment in the past year is 81 percent (2,002 of 2,478 clinicians).

The experiences that NHSC providers have at their sites while completing their service obligations 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.[30]

Long-Term Retention

The Clinician Dashboard also collects data that enables the NHSC to measure the long-term retention of NHSC clinicians. The data show that fully 85 percent of those who fulfilled their service commitments between 2012 and 2018 (14,226 of 16,797 clinicians) are either still in a HPSA, or have remained at the NHSC site where they served even if it no longer qualifies as a HPSA.

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 NHSC evaluates formal requests from facilities seeking eligibility for NHSC recruitment and retention assistance (see **Requirement 2** above for eligibility requirements and the number of applications received and

[30] The 2019 National Health Service Corps Participant Satisfaction Survey (see **Requirement 4** above).

their disposition). To become an NHSC site, an entity's compliance with section 333(a)(1)(D) of the PHS Act must be determined through a three-step process.

First, is the geographic area, the population group served by the site, or the site itself designated as a HPSA? As noted in **Requirement 1** above, designation of a HPSA involves the evaluation of a number of factors and data, including the continued need for health professionals in a geographic area. 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 C.F.R. Part 5).

Second, is the area, population group, or facility a HPSA of greatest need? Indicators analyzed and scored to determine which HPSAs are in greatest need include measures of need for primary care, dental, and mental health services such as:

- 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 SUD.

HPSA scores range from zero to 25 for primary care and mental health, and zero to 26 for dental health; higher scores are intended to indicate greater need. Certain types of facilities, including FQHCs and Rural Health Clinics providing access to care regardless of ability to pay, receive automatic facility HPSA designation. These facilities may have a HPSA score of zero, indicating either relatively low need or that insufficient data was provided to compute a HPSA score.

Third, 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 Children's Health Insurance Program beneficiaries;
- Maintain a sliding discount fee schedule; and
- Have general community support for the assignment of an NHSC member to that entity.

NHSC offers NHSC recruitment and retention assistance to all facilities that apply and meet the above requirements. Upon approval of their application, facilities post vacancies on the Health Workforce Connector as they occur. NHSC lists vacancies on the Health Workforce Connector, which includes primary care, dental health, and behavioral and mental health provider vacancies in designated HPSAs, as well as information related to the services provided and populations

served by NHSC-approved sites. From October 1, 2018, through September 30, 2019, the number of new vacancies created was 13,921, and 1,525 vacancies were filled. As of September 30, 2019, there were 5,531 vacancies listed. The Health Workforce Connector is located at https://connector.hrsa.gov/.

V. Conclusion

The achievements of NHSC in 2019 reflect the increased promotion and outreach of the program and the greater collaboration with partners made possible by the enhanced resources provided to NHSC. These resources allowed NHSC to achieve to record levels and serve the health care needs of approximately 13.7 million patients across the United States.

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

One of the critical activities of the NHSC in FY 2019 was the implementation of the NHSC RC LRP and the NHSC SUD Workforce LRP. Funding provided through the FYs 2018 and 2019 Consolidated Appropriations Acts enables the NHSC to continue to focus on expanding access to and improving the quality of opioid and SUD treatment in rural and underserved areas nationwide.

Appendix A: National Health Service Corps FY 2019 Field Strength

National Health Service Corps – Overall Field Strength (as of 9/30/2019)

State	Total	NHSC LRP Total	NHSC SUD LRP Total	NHSC RC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	Non-Rural	Rural	BPHC Grantee	Non-BPHC Grantee
AK	271	104	9	2	9	3	144	99	172	24	103
AL	99	79	11	1	3	5	0	69	30	52	47
AR	79	72	2	2	0	3	0	21	58	43	36
AS	1	1	0	0	0	0	0	0	1	0	1
AZ	549	398	21	7	20	9	94	384	165	208	247
CA	1,166	757	51	9	75	34	240	951	215	682	244
CO	271	189	20	5	9	11	37	184	87	161	73
CT	303	243	49	1	7	3	0	288	15	197	106
DC	171	112	9	0	12	5	33	171	0	101	37
DE	47	19	5	0	1	0	22	33	14	15	10
FL	501	434	37	1	15	14	0	432	69	327	174
GA	255	205	29	2	9	7	3	151	104	129	123
GU	1	1	0	0	0	0	0	0	1	1	0
HI	78	46	6	1	2	1	22	45	33	50	6
IA	124	84	7	1	2	1	29	53	71	64	31
ID	265	191	19	3	6	9	37	143	122	123	105
IL	625	478	41	6	23	14	63	518	107	386	176
IN	158	102	18	3	3	4	28	102	56	91	39
KS	113	71	9	2	3	3	25	35	78	60	28
KY	182	91	23	16	4	4	44	44	138	71	67
LA	202	127	10	1	5	5	54	154	48	87	61
MA	256	113	52	1	9	14	67	236	20	180	9
MD	200	128	23	1	12	6	30	174	26	110	60
ME	96	59	15	6	4	3	9	25	71	58	29
MI	579	318	42	8	12	15	184	321	258	273	122
MN	215	145	28	7	9	11	15	97	118	58	142
MO	571	492	23	6	9	23	18	315	256	256	297
MP	16	10	0	0	0	0	6	0	16	1	9
MS	124	115	3	0	4	2	0	33	91	64	60
MT	208	160	13	1	5	5	24	43	165	72	112
NC	275	207	24	6	23	9	6	119	156	172	97
ND	81	29	7	0	0	0	45	16	65	19	17
NE	101	63	6	0	2	0	30	50	51	52	19
NH	26	16	6	3	0	1	0	9	17	20	6
NJ	64	31	11	0	3	3	16	57	7	44	4
NM	270	212	7	11	12	6	22	130	140	150	98
NV	114	62	12	2	5	0	33	66	48	29	52
NY	755	552	108	7	24	20	44	602	153	362	349
OH	283	174	38	7	9	9	46	193	90	196	41
OK	340	301	26	6	4	3	0	102	238	80	260
OR	432	313	47	2	25	13	32	234	198	264	136
PA	253	169	14	5	21	10	34	210	43	160	59
PR	164	139	24	0	0	1	0	153	11	157	7
RI	91	15	10	0	3	4	59	91	0	31	1
SC	182	141	15	7	11	8	0	109	73	153	29
SD	56	46	8	0	0	2	0	8	48	25	31
TN	224	132	1	2	4	5	80	138	86	87	57
TX	227	151	20	0	13	12	31	170	57	133	63
UT	143	100	19	3	8	1	12	80	63	53	78
VA	196	113	6	8	12	5	52	91	105	83	61
VI	9	9	0	0	0	0	0	0	9	8	1
VT	44	4	11	1	0	1	27	15	29	17	0
WA	546	384	38	5	33	26	60	380	166	324	162
WI	266	134	15	4	18	16	79	120	146	135	52
WV	139	107	20	0	3	0	9	72	67	100	30
WY	46	25	6	2	1	0	12	8	38	8	26
Total	**13,053**	**8,973**	**1,074**	**174**	**506**	**369**	**1,957**	**8,344**	**4,709**	**6,806**	**4,290**
Percentage of Total Field Strength		**68.74%**	**8.23%**	**1.33%**	**3.88%**	**2.83%**	**14.99%**	**63.92%**	**36.08%**	**61.34%**	**38.66%**

National Health Service Corps – Primary Care Field Strength (as of 9/30/2019)

State	Total	NHSC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	PHY	NP	PA	CNM	RN (SLRP)	PHARM (SLRP)	Non-Rural	Rural	BPHC Grantee	Non-BPHC Grantee
AK	150	57	6	1	86	55	31	23	4	18	19	55	95	17	47
AL	51	45	1	5	0	16	29	6	0	0	0	32	19	43	8
AR	26	24	0	2	0	4	21	1	0	0	0	3	23	23	3
AS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AZ	282	201	12	5	64	98	119	44	11	0	10	182	100	117	101
CA	596	330	61	23	182	194	228	149	13	0	12	504	92	346	68
CO	99	63	6	9	21	40	22	29	8	0	0	73	26	67	11
CT	68	61	5	2	0	15	38	12	3	0	0	66	2	57	11
DC	99	65	8	4	22	51	32	10	5	1	0	99	0	62	15
DE	26	13	0	0	13	10	12	3	0	0	1	19	7	12	1
FL	296	275	12	9	0	92	151	42	11	0	0	253	43	210	86
GA	156	144	5	4	3	46	82	20	8	0	0	95	61	100	53
GU	1	1	0	0	0	1	0	0	0	0	0	0	1	1	0
HI	30	10	2	0	18	13	16	1	0	0	0	23	7	10	2
IA	48	35	1	0	12	9	33	2	2	0	2	25	23	32	4
ID	113	70	4	7	32	44	27	41	0	0	1	46	67	66	15
IL	339	257	21	10	51	113	150	61	15	0	0	274	65	246	42
IN	48	32	2	2	12	19	22	5	2	0	0	32	16	34	2
KS	56	35	2	0	19	11	24	12	0	9	0	15	41	28	9
KY	75	37	3	1	34	22	44	4	0	0	5	19	56	33	8
LA	84	55	4	2	23	23	57	3	1	0	0	64	20	49	12
MA	108	60	6	7	35	33	60	14	0	0	1	94	14	73	0
MD	83	43	9	6	25	39	21	17	6	0	0	68	15	54	4
ME	27	15	1	2	9	11	11	5	0	0	0	3	24	16	2
MI	274	127	4	9	134	94	98	77	5	0	0	131	143	115	25
MN	46	32	1	7	6	20	12	13	1	0	0	21	25	23	17
MO	251	229	5	9	8	89	133	28	1	0	0	117	134	87	156
MP	11	7	0	0	4	1	1	5	0	1	3	0	11	1	6
MS	83	78	4	1	0	14	65	4	0	0	0	23	60	55	28
MT	95	65	5	3	22	26	28	34	0	6	1	16	79	32	41
NC	161	136	17	8	0	45	58	53	5	0	0	65	96	102	59
ND	53	21	0	0	32	5	29	14	0	4	1	4	49	14	7
NE	55	34	1	0	20	17	17	11	3	0	7	29	26	30	5
NH	4	3	0	1	0	1	2	1	0	0	0	2	2	4	0
NJ	29	15	1	1	12	10	15	1	3	0	0	25	4	17	0
NM	136	113	7	3	13	55	59	17	5	0	0	55	81	68	55
NV	55	30	2	0	23	11	21	19	0	1	3	25	30	17	15
NY	393	329	21	18	25	170	121	78	24	0	0	315	78	235	133
OH	108	73	4	4	27	48	59	0	1	0	0	91	17	65	16
OK	130	127	3	0	0	22	79	20	9	0	0	45	85	54	76
OR	189	136	16	7	30	73	60	52	0	0	4	92	97	127	32
PA	112	79	12	6	15	45	43	21	3	0	0	100	12	71	26
PR	89	88	0	1	0	88	1	0	0	0	0	85	4	85	4
RI	37	1	1	4	31	14	7	3	2	11	0	37	0	6	0
SC	113	99	8	6	0	37	55	19	2	0	0	63	50	101	12
SD	22	22	0	0	0	2	12	6	2	0	0	3	19	15	7
TN	128	50	2	3	73	25	83	17	3	0	0	73	55	42	13
TX	77	60	10	7	0	25	39	13	0	0	0	54	23	59	18
UT	60	47	3	0	10	18	13	29	0	0	0	30	30	29	21
VA	86	44	8	2	32	30	37	15	1	2	1	33	53	49	5
VI	9	9	0	0	0	3	1	4	1	0	0	0	9	8	1
VT	22	1	0	0	2. 21	10	8	4	0	0	0	8	14	1	0
WA	203	115	23	19	46	77	54	51	6	10	5	125	78	120	37
WI	98	29	5	9	55	43	36	15	4	0	0	41	57	34	9
WV	69	59	3	0	7	20	36	11	0	0	2	27	42	52	10
WY	23	10	1	0	12	7	7	9	0	0	0	5	18	4	7
Total	**6,082**	**4,196**	**338**	**229**	**1,319**	**2,104**	**2,519**	**1,148**	**170**	**63**	**78**	**3,784**	**2,298**	**3,418**	**1,345**
Percentage of Primary Care Field Strength		**68.99%**	**5.56%**	**3.77%**	**21.69%**	**34.59%**	**41.42%**	**18.88%**	**2.80%**	**1.04%**	**1.28%**	**62.22%**	**37.78%**	**71.76%**	**28.24%**
Percentage of Total Field Strength		**32.15%**	**2.59%**	**1.75%**	**10.10%**	**16.12%**	**19.30%**	**8.79%**	**1.30%**	**<1%**	**<1%**	**28.99%**	**17.61%**	**30.80%**	**12.12%**

National Health Service Corps – Oral Health Field Strength (as of 9/30/2019)

State	Total	NHSC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	DD	RDH	Non-Rural	Rural	BPHC Grantee	Non-BPHC Grantee
AK	27	5	2	2	18	24	3	8	19	3	6
AL	6	4	2	0	0	6	0	4	2	5	1
AR	9	8	0	1	0	8	1	5	4	9	0
AS	0	0	0	0	0	0	0	0	0	0	0
AZ	72	52	5	3	12	65	7	51	21	38	22
CA	224	167	13	10	34	211	13	191	33	157	33
CO	38	30	3	2	3	20	18	28	10	30	5
CT	29	28	0	1	0	16	13	27	2	28	1
DC	22	13	2	0	7	18	4	22	0	13	2
DE	5	1	1	0	3	4	1	4	1	2	0
FL	66	58	3	5	0	55	11	57	9	63	3
GA	24	20	2	2	0	21	3	18	6	18	6
GU	0	0	0	0	0	0	0	0	0	0	0
HI	19	18	0	1	0	14	5	9	10	19	0
IA	25	12	0	1	12	22	3	11	14	13	0
ID	25	20	2	2	1	17	8	9	16	24	0
IL	49	33	1	3	12	44	5	42	7	37	0
IN	23	20	1	2	0	19	4	23	0	21	2
KS	26	18	1	3	4	17	9	14	12	20	2
KY	20	10	1	3	6	17	3	8	12	12	2
LA	21	7	1	3	10	20	1	13	8	11	0
MA	27	9	3	6	9	20	7	26	1	18	0
MD	14	11	3	0	0	9	5	11	3	14	0
ME	8	5	2	1	0	7	1	2	6	6	2
MI	96	71	8	6	11	71	25	63	33	74	11
MN	33	18	8	4	3	21	12	23	10	16	14
MO	102	74	4	14	10	80	22	60	42	87	5
MP	3	3	0	0	0	2	1	0	3	0	3
MS	5	4	0	1	0	4	1	2	3	5	0
MT	20	18	0	2	0	14	6	6	14	15	5
NC	34	27	6	1	0	31	3	13	21	30	4
ND	8	7	0	0	1	7	1	4	4	3	4
NE	16	13	1	0	2	13	3	11	5	14	0
NH	2	2	0	0	0	1	1	0	2	2	0
NJ	12	5	2	1	4	11	1	12	0	8	0
NM	51	39	4	3	5	37	14	29	22	31	15
NV	17	12	3	0	2	14	3	13	4	6	9
NY	85	74	3	2	6	70	15	66	19	71	8
OH	57	35	4	5	13	43	14	41	16	42	2
OK	28	24	1	3	0	20	8	8	20	12	16
OR	60	47	7	6	0	37	23	42	18	50	10
PA	56	37	8	4	7	42	14	49	7	45	4
PR	6	6	0	0	0	6	0	6	0	6	0
RI	20	4	1	0	15	14	6	20	0	5	0
SC	18	14	2	2	0	13	5	14	4	18	0
SD	8	6	0	2	0	7	1	1	7	5	3
TN	22	15	2	2	3	15	7	18	4	14	5
TX	41	33	3	5	0	35	6	31	10	39	2
UT	17	12	3	1	1	13	4	12	5	11	5
VA	27	17	4	3	3	25	2	11	16	24	0
VI	0	0	0	0	0	0	0	0	0	0	0
VT	6	1	0	1	4	6	0	0	6	2	0
WA	115	92	8	7	8	94	21	85	30	101	6
WI	79	39	12	7	21	64	15	38	41	46	12
WV	12	10	0	0	2	8	4	3	9	9	1
WY	1	1	0	0	0	1	0	1	0	1	0
Total	**1,836**	**1,309**	**142**	**133**	**252**	**1,473**	**363**	**1,265**	**571**	**1,353**	**231**
Percentage of Oral Health Field Strength		**71.30%**	**7.73%**	**7.24%**	**13.73%**	**80.23%**	**19.77%**	**68.90%**	**31.10%**	**85.42%**	**14.58%**
Percentage of Total Field Strength		**10.03%**	**1.09%**	**1.02%**	**1.93%**	**11.28%**	**2.78%**	**9.69%**	**4.37%**	**12.19%**	**2.08%**

National Health Service Corps – Mental and Behavioral Health Field Strength (as of 9/30/2019)

State	Total	NHSC LRP Total	NHSC SUD LRP Total	NHSC RC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	PHY MH	NP MH	PA MH	CNM MH	LCSW	LPC	HSP	MFT	PNS	SUD Counselor	RN MH	PHARM MH	Non-Rural	Rural	BPHC Grantee	Non-BPHC Grantee
AK	94	42	9	2	1	0	40	9	9	0	0	19	43	6	4	0	4	0	0	36	58	4	50
AL	42	30	11	1	0	0	0	5	5	0	0	7	10	5	1	0	9	0	0	33	9	4	38
AR	44	40	2	2	0	0	0	0	5	0	0	15	24	0	0	0	0	0	0	13	31	11	33
AS	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1
AZ	195	145	21	7	3	1	18	10	64	2	0	33	49	20	8	2	3	3	1	151	44	53	124
CA	346	260	51	9	1	1	24	27	37	9	0	118	2	82	59	3	4	4	1	256	90	179	143
CO	134	96	20	5	0	0	13	4	7	5	0	44	50	14	2	1	5	2	0	83	51	64	57
CT	206	154	49	1	2	0	0	13	25	1	0	70	46	16	17	0	9	9	0	195	11	112	94
DC	50	34	9	0	2	1	4	7	0	1	0	24	14	2	0	0	2	0	0	50	0	26	20
DE	16	5	5	0	0	0	6	0	0	0	0	3	2	7	0	0	4	0	0	10	6	1	9
FL	139	101	37	1	0	0	0	12	18	2	0	33	41	12	5	0	12	2	2	122	17	54	85
GA	75	41	29	2	2	1	0	4	12	1	0	6	32	5	1	0	13	1	0	38	37	11	64
GU	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HI	29	18	6	1	0	0	4	3	3	1	0	3	1	18	0	0	0	0	0	13	16	21	4
IA	51	37	7	1	1	0	5	3	9	1	0	14	12	5	3	0	3	1	0	17	34	19	27
ID	127	101	19	3	0	0	4	5	9	9	0	57	31	9	1	1	5	0	0	88	39	33	90
IL	237	188	41	6	1	1	0	13	18	3	0	96	73	20	2	1	9	1	1	202	35	103	134
IN	87	50	18	3	0	0	16	7	13	0	0	25	26	9	2	0	2	1	2	47	40	36	35
KS	31	18	9	2	0	0	2	0	6	1	0	9	4	2	2	0	4	0	3	6	25	12	17
KY	87	44	23	16	0	0	4	7	14	0	0	20	31	6	1	0	8	0	0	17	70	26	57
LA	97	65	10	1	0	0	21	6	10	2	0	29	42	5	0	0	1	2	0	77	20	27	49
MA	121	44	52	1	0	1	23	14	27	4	3	47	7	2	0	2	4	11	0	116	5	89	9
MD	103	74	23	1	0	0	5	9	16	1	0	37	21	9	0	0	7	3	0	95	8	42	56
ME	61	39	15	6	1	0	0	8	19	0	0	24	6	2	0	0	2	0	0	20	41	36	25
MI	209	120	42	8	0	0	39	8	11	3	0	128	17	14	1	0	23	2	2	127	82	84	86
MN	136	95	28	7	0	0	6	4	10	2	1	34	32	18	11	1	18	4	1	53	83	19	111
MO	218	189	23	6	0	0	0	5	18	1	0	66	83	31	1	1	9	3	0	138	80	82	136
MP	2	0	0	0	0	0	2	0	0	0	0	1	1	0	0	0	0	0	0	0	2	0	0
MS	36	33	3	0	0	0	0	0	7	0	0	2	23	2	1	0	0	1	0	8	28	4	32
MT	93	77	13	1	0	0	2	4	6	2	0	34	35	3	0	0	7	0	2	21	72	25	66
NC	80	44	24	6	0	0	6	7	9	6	0	28	11	7	2	0	7	0	3	41	39	40	34
ND	20	1	7	0	0	0	12	1	2	0	0	4	2	0	0	1	6	4	0	8	12	2	6
NE	30	16	6	0	0	0	8	1	6	1	0	1	12	6	0	0	3	0	0	10	20	8	14
NH	20	11	6	3	0	0	0	1	5	2	0	3	3	4	0	0	2	0	0	7	13	14	6
NJ	23	11	11	0	0	1	0	4	4	0	0	10	0	3	0	0	1	0	1	20	3	19	4
NM	83	60	7	11	1	0	4	3	11	1	0	24	34	5	5	0	0	0	0	46	37	51	28
NV	42	20	12	2	0	0	8	0	4	0	0	14	4	2	10	0	8	0	0	28	14	6	28
NY	277	149	108	7	0	0	13	25	34	8	0	86	54	14	6	0	40	9	1	221	56	56	208
OH	118	66	38	7	1	0	6	9	28	0	0	31	21	4	1	0	10	4	10	61	57	89	23
OK	182	150	26	6	0	0	0	5	8	6	1	27	115	2	6	0	5	0	7	49	133	14	168
OR	183	130	47	2	2	0	2	10	24	7	0	57	42	10	10	0	14	8	1	100	83	87	94
PA	85	53	14	5	1	0	12	3	7	7	0	41	15	8	0	0	0	4	0	61	24	44	29
PR	69	45	24	0	0	0	0	1	0	0	0	18	7	28	0	0	4	1	10	62	7	66	3
RI	34	10	10	0	1	0	13	5	2	1	0	15	4	3	1	0	1	2	0	34	0	20	1
SC	51	28	15	7	1	0	0	4	12	0	0	7	19	4	0	0	4	1	0	32	19	34	17
SD	26	18	8	0	0	0	0	0	2	0	0	7	9	1	0	0	7	0	0	4	22	5	21
TN	74	67	1	2	0	0	4	2	26	1	0	12	12	16	4	0	1	0	0	47	27	31	39
TX	109	58	20	0	0	0	31	5	10	1	0	24	47	10	2	3	5	0	2	85	24	35	43
UT	66	41	19	3	2	0	1	3	5	3	0	29	12	6	1	0	4	1	2	38	28	13	52
VA	83	52	6	8	0	0	17	8	9	1	0	18	38	5	1	1	2	0	0	47	36	10	56
VI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VT	16	2	11	1	0	0	2	3	3	1	0	1	1	0	0	0	6	1	0	7	9	14	0
WA	228	177	38	5	2	0	6	14	24	7	0	37	84	30	14	0	15	2	1	170	58	103	119
WI	89	66	15	4	1	0	3	4	6	0	0	14	34	13	9	0	4	2	3	41	48	55	31
WV	58	38	20	0	0	0	0	8	8	2	0	6	11	18	0	0	3	1	1	42	16	39	19
WY	22	14	6	2	0	0	0	1	4	1	0	4	6	3	1	0	2	0	0	2	20	3	19
Total	**5,135**	**3,468**	**1,074**	**174**	**26**	**7**	**386**	**314**	**631**	**107**	**5**	**1,517**	**1,355**	**526**	**195**	**17**	**321**	**90**	**57**	**3,295**	**1,840**	**2,035**	**2,714**
Percentage of Mental Health Field Strength		**67.54%**	**20.92%**	**3.39%**	**<1%**	**<1%**	**7.52%**	**6.11%**	**12.29%**	**2.08%**	**<1%**	**29.54%**	**26.39%**	**10.24%**	**3.80%**	**<1%**	**6.25%**	**1.75%**	**1.11%**	**64.17%**	**35.83%**	**42.85%**	**57.15%**
Percentage of Total Field Strength		**26.57%**	**8.23%**	**1.33%**	**<1%**	**<1%**	**2.96%**	**2.41%**	**4.83%**	**<1%**	**<1%**	**11.62%**	**10.38%**	**4.03%**	**1.49%**	**<1%**	**2.46%**	**<1%**	**<1%**	**25.24%**	**14.10%**	**18.34%**	**24.46%**

Appendix A - Glossary of Acronyms

Programs

NHSC SP	Scholars fulfilling NHSC obligation
NHSC LRP	Traditional loan repayors fulfilling NHSC obligation
NHSC SUD LRP	Substance use disorder workforce loan repayors fulfilling NHSC obligation
NHSC RC LRP	Rural community loan repayors fulfilling NHSC obligation
S2S LRP	Students to service loan repayors fulfilling NHSC obligation
SLRP	State loan repayors fulfilling NHSC obligation

Discipline

PHY	Allopathic/Osteopathic Physicians serving in the traditional NHSC LRP, excluding Psychiatrists
NP	Nurse Practitioners serving in the traditional NHSC LRP, excluding those with psychiatric specialty
PA	Physician assistants serving in the traditional NHSC LRP, excluding those with psychiatric specialty
CNM	Certified Nurse Midwives serving in the traditional NHSC LRP
RN	Registered Nurses (SLRP Only)
PHARM	Pharmacists (SLRP only)
DD	Dentists
RDH	Registered Dental Hygienists
PHY MH	Allopathic/Osteopathic Psychiatrists serving in the traditional NHSC LRP and SLRP, and all Physicians serving in the NHSC SUD LRP and NHSC RC LRP programs
NP MH	Nurse practitioners with psychiatric specialty serving in the traditional NHSC LRP and SLRP, and all nurse practitioners serving in the NHSC SUD LRP and NHSC RC LRP programs
PA MH	Physician assistants with psychiatric specialty serving in the traditional NHSC LRP and SLRP, and all physician assistants serving in the NHSC SUD LRP and NHSC RC LRP
CNM MH	Certified Nurse Midwives serving in the NHSC SUD LRP and NHSC RC LRP programs
LCSW	Licensed Clinical Social Workers
LPC	Licensed Professional Counselors
HSP	Health Service Psychologists
MFT	Marriage and Family Therapists
PNS	Psychiatric Nurse Specialists
SUD Counselor	Substance Use Disorder counselors serving in the NHSC SUD LRP and SLRP programs
RN MH	Registered Nurses with a psychiatric specialty serving in the SLRP program, and all Registered Nurses serving in the NHSC SUD LRP program
PHARM MH	Pharmacists serving in the NHSC SUD LRP program

Rural Status

Rural	Rural = clinicians serving in a rural setting
Non-Rural	Non-Rural = clinicians serving in any non-rural setting

Grantee Status

BPHC Grantee	Clinicians serving in a Federally Qualified Health Center (FQHC) that receives Section 330 grant funding from the Bureau of Primary Health Care, does not include SLRP
Non-BPHC Grantee	Clinicians serving at any site type other than FQHC, does not include SLRP