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

REPORT TO CONGRESS

NATIONAL HEALTH SERVICE CORPS FOR THE YEAR 2021

Executive Summary

The report to Congress for 2021 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 by 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.

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, 2021, there were HPSA designations of the following types:
    - Primary care: 6,272
    - Dental health: 5,678
    - Mental health: 5,391

- As the result of a National Shortage Designation Update that was part of the Shortage Designation Modernization Project, the number of HPSAs decreased 11.1 percent from fiscal year (FY) 2020 to FY 2021. HPSAs that no longer meet designation criteria are in a 'Proposed for Withdrawal' status. The Health Resources and Services Administration (HRSA) anticipates that the number of HPSAs in FY 2022 will remain stable.

- The NHSC field strength in FY 2021 was 19,984, the program's largest to date. NHSC clinicians served in urban, rural, and frontier communities in all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.[2]

- In FY 2021, NHSC clinicians provided care to approximately 21 million people. Over 56.0 percent of NHSC clinicians served in health centers supported by HRSA grants. The remaining clinicians provided patient care services at sites not supported by HRSA

[1] "NHSC field strength," as this term is used in this report, includes clinicians recruited through the NHSC Loan Repayment Program, the NHSC Scholarship Program, the NHSC Students to Service Loan Repayment Program, the NHSC Substance Use Disorder Workforce Loan Repayment Program, the NHSC Rural Communities Loan Repayment Program, 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.

grants in Rural Health Clinics; Indian Health Service facilities, Tribal Health Programs,[3] and urban Indian organizations;[4] group or private practices; Critical Access Hospitals; hospital-based outpatient clinics; and similar outpatient sites located in HPSAs.

- Approximately 35.0 percent of NHSC placements in FY 2021 were in facilities that served rural areas.[5]

- 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. NHSC continues to expand the number of behavioral health clinicians in the program, implement the Substance Use Disorder (SUD) Workforce and Rural Community Loan Repayment Programs (LRP), and include registered nurses and pharmacists in the State Loan Repayment Program.

- In FY 2021, NHSC made 1,192 new and seven continuation Scholarship Program awards, and 6,553 new and 2,277 continuation LRP awards. Additionally, eligibility for the Students to Service (S2S) LRP was expanded to include Advanced Practice Registered Nurses. Overall, HRSA made 257 new S2S LRP awards, which provides loan repayment to medical students (Doctor of Medicine or Doctor of Osteopathic Medicine), dental students (Doctor of Dental Medicine or Doctor of Dental Surgery), and nursing students (Nurse Practitioner or Certified Nurse Midwife) in their final year of school in return for providing health care in urban, rural, or frontier communities with limited access to care. These awards are vital recruitment tools for underserved communities in need of primary care, oral health, and behavioral and mental health services.

- The American Rescue Plan Act of 2021 authorized and appropriated $800 million for NHSC. These funds, in addition to the $310 million in FY 2021 mandatory funding, enabled NHSC to fund all qualified applications across scholarship, loan repayment continuation, S2S LRP, and new loan repayment. Of the American Rescue Plan Act funds, $100 million is dedicated to the State Loan Repayment Program to fund a new grant cycle in FY 2022.

- Beginning with appropriations for 2018 and annually through 2021, appropriations acts provided funding to NHSC for the express purpose of expanding and improving access to quality opioid use disorder and substance use disorder treatment in rural and underserved areas nationwide. This funding implemented both the NHSC SUD Workforce LRP and the NHSC Rural Community LRP. In FY 2021, the NHSC SUD Workforce LRP made 900 new awards and the NHSC Rural Community LRP made 603

[3] An Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 5301 et. seq.).
[4] Urban Indian organizations that receive grant and contract funding through Title V of the Indian Health Care Improvement Act are Federally Qualified Health Centers that provide health care to American Indians and Alaska Natives living in urban centers.
[5] NHSC uses the Federal Office of Rural Health Policy definition of rural for identifying NHSC-approved sites that are in rural areas. (http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html)

new awards. Additionally, the appropriations acts for 2019, 2020, and 2021 included funding to support loan repayment awards to clinicians serving in Indian Health Service facilities, Tribal Health Programs, and urban Indian organizations.

- The 1-year retention rate among NHSC participants who completed their NHSC service obligation in FY 2020 was 84.0 percent. HRSA continues to use the Clinician Dashboard to calculate retention rates. The Clinician Dashboard is a data visualization tool supported by NHSC that includes data on clinicians with National Provider Identifier numbers.[6]

[6] The Clinician Dashboard also includes data regarding the Nurse Corps LRP and Scholarship Programs authorized under section 846 of the Public Health Service Act (https://data.hrsa.gov/topics/health-workforce/clinician-dashboards).

HRSA
Health Resources & Services Administration

National Health Service Corps Report to Congress for the Year 2021

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Acronym List

CAH	Critical Access Hospital
COVID-19	Coronavirus Disease 2019
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, Tribal, or urban Indian Health Clinic
LRP	Loan Repayment Program
NHSC	National Health Service Corps
OUD	Opioid Use Disorder
PHS Act	Public Health Service Act
PCO	Primary Care Office
SAMHSA	Substance Abuse and Mental Health Services Administration
SLRP	State Loan Repayment Program
SP	Scholarship Program
SUD	Substance Use Disorder
S2S LRP	Students to Service Loan Repayment Program
VJF	Virtual Job Fair

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:[7]

> "*The Secretary shall submit an annual report to Congress, and shall include in such report with respect to the previous calendar year—*
>
> *(1) the number, identity, and priority of all health professional shortage areas designated in such year and the number of health professional shortage areas which the Secretary estimates will be designated in the subsequent year;*
> *(2) 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."*[8]

This report includes updates and fiscal year (FY) data[9] 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.

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[7] Data provided in this report are FY data reported in accordance with how Congress appropriates funds to NHSC.

[8] 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 NHSC assignees reimburse the agency for health services provided by those Corps members. Therefore, reporting element #8 is no longer relevant.

[9] The Bureau of Health Workforce Management Information System Solution collects NHSC Program data. It is an IT system that replaced and/or retired several legacy systems that contained information collected from

II. Introduction

The Bureau of Health Workforce within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services manages the NHSC program. The Emergency Health Personnel Amendments Act of 1972 (P.L. 92-585) established the NHSC program. Congress has amended and reauthorized the Act several times in the 50 ensuing years. Most recently, the American Rescue Plan Act of 2021 authorized and appropriated $800 million to NHSC, of which $100 million is dedicated to the State Loan Repayment Program (SLRP). In FY 2021, Congress also appropriated $412.3 million to NHSC.

The NHSC field strength increased to 19,984 clinicians in FY 2021 from 16,229 clinicians in FY 2020 due to the increased American Rescue Plan Act funding. The field strength, the program's highest ever, includes clinicians recruited through the NHSC Scholarship Program (SP), NHSC Loan Repayment Program (LRP), NHSC Students to Service (S2S) LRP, NHSC Substance Use Disorder (SUD) Workforce LRP, the NHSC Rural Community LRP, and the SLRP who are currently fulfilling their service commitments.

There continues to be tremendous applicant interest in these programs, and HRSA has maintained its robust online and in-person recruitment activities. In FY 2021, the NHSC SP, NHSC LRP, NHSC S2S LRP, NHSC SUD Workforce LRP, and NHSC Rural Community LRP received 12,347 applications for new and continuation awards. The funding provided by the American Rescue Plan Act enabled NHSC to make awards for the first time in many years to all qualified NHSC SP, NHSC LRP, and NHSC S2S LRP applications. These awards did not exhaust the available American Rescue Plan Act funds for these programs; HRSA projects that the remaining American Rescue Plan Act funds will be obligated in FY 2022. Among other strategies, HRSA used social networking, collaboration with stakeholders, and online visibility to recruit eligible NHSC applicants. Despite the challenges of the Coronavirus Disease 2019 (COVID-19) pandemic, HRSA continued to use both online and in-person recruitment resources to support health professionals and health centers. HRSA exhibited at 15 virtual conferences and held 22 events at health profession schools. HRSA hosted two virtual job fairs (VJF), which included more than 380 participating sites representing 45 states and territories; this resulted in over 13,000 new health clinician and site administrator profiles posted on the HRSA Health Workforce Connector.[10]

An important measure of the success of NHSC is the retention of NHSC clinicians who continue to provide services to the underserved after the fulfillment of their NHSC commitments. In FY 2019, HRSA began using a newly developed Clinician Dashboard to calculate the 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. HRSA tracks short-term retention (Corps members who complete their service obligation and remain in a Health

individual scholarship and loan repayment applications, recruitment and retention assistance applications, and monitoring data from individual sites. HRSA also collects SLRP data at the grantee level and reports it to Bureau of Health Workforce Program Officers.

[10] The HRSA Health Workforce Connector is a searchable database of open job opportunities and information on NHSC-approved sites (https://connector.hrsa.gov/connector/).

Professional Shortage Area (HPSA) for up to 2 years afterward) as well as long-term retention (Corps members who continue to provide care in underserved areas longer than 2 years after completing their NHSC service obligation). In FY 2021, the Dashboard shows approximately 84.0 percent of those who fulfilled their NHSC commitments had remained in service to the underserved 2 years after their commitments ended. Further, 86.0 percent of those who fulfilled their service commitments between 2012 and 2020 are either still in a HPSA, or have remained in the community where they served, even if it no longer qualifies as a HPSA.[11]

III. Overview

In FY 2021, NHSC awarded 1,192 new scholarships and seven continuations as well as 6,553 new loan repayments and 2,277 loan repayment continuations. NHSC also continued implementation of the S2S LRP, making 257 awards for loan repayments to medical and dental students in their last year of school, and beginning in FY 2020, eligibility was extended to advanced practice nurses.

Beginning with appropriations for 2018 and annually through 2021, appropriations acts provided funding to NHSC for the express purpose of expanding and improving access to quality opioid use disorder (OUD) and SUD treatment in rural and underserved areas nationwide. HRSA continues to use 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 providing outpatient services at certain sites, including OUD treatment programs, office-based OUD 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 receive 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, and physician assistants with Drug Addiction Treatment Act (DATA) 2000 Waivers;
- Licensed or certified health professionals providing SUD services; and
- Licensed primary care and behavioral health professionals.

NHSC Rural Community LRP: A portion of the appropriations noted above provided funding for the NHSC Rural Community LRP, which is a program for providers working to combat the opioid epidemic in the nation's rural communities. The NHSC Rural Community LRP made FY 2019 loan repayment awards in coordination with HRSA's Rural Communities Opioid Response Program initiative to provide evidence-based substance use treatment, assist in recovery, and prevent overdose deaths across the nation.

[11] For more detailed information regarding NHSC Field Strength data in the public domain, see https://data.hrsa.gov/topics/health-workforce/field-strength and also https://data.hrsa.gov/data/download.

NHSC and IHS: Appropriations Acts for 2019, 2020, and 2021 Appropriations Acts of 2019 through 2021 included an annual set-aside of $15 million to support awards under the NHSC LRP programs to fully-trained medical, nursing, dental, behavioral/mental health clinicians, and SUD providers to deliver health care services in IHS, Tribal,[11] and urban Indian organizations (collectively known as ITUs). Federal IHS Clinics, Tribal Health Clinics, urban Indian organizations, and dually-funded Tribal Health Clinics/Community Health Centers are automatically designated as HPSAs.

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.

As part of HRSA's cooperative agreement with state Primary Care Offices (PCOs), the state PCOs assess needs in their states, determine what areas are eligible for designations, and submit designation applications to HRSA. Communities or facilities that would like HRSA to designate them as a geographic, population, or facility HPSA may submit data to their state PCO. HRSA reviews the HPSA applications submitted by the state PCOs, and if they meet the designation eligibility criteria for the type of HPSA requested in the application, HRSA designates a HPSA. The designation process takes two forms: (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 HRSA created the HPSA designation for the placement of NHSC clinicians, more than 30 federal and state agencies and programs currently use the HPSA designation for resource allocation. HRSA is required to publish updated lists of designated HPSAs annually in the *Federal Register* by July 1 of each calendar year.[13]

As of September 30, 2021, there were 7,447 primary care HPSAs, 6,678 dental health HPSAs, and 5,930 mental health HPSAs. Overall, the number of HPSAs has increased by 3.3 percent from FY 2020. HRSA anticipates that the number of HPSAs in FY 2022 will remain stable.

In September 2021, HRSA completed a National Shortage Designation Update as part of the Shortage Designation Modernization Project, which evaluated certain existing HPSAs using the applicable regulatory designation criteria. This National Shortage Designation Update led to identifying HPSAs that no longer met designation criteria, which HRSA then put in a

[12] The Health Care Safety Net Amendments of 2002 established the automatic facility HPSA designation for these facilities for a period of 6 years; the Health Care Safety Net Act of 2008the automatic facility designation permanent.

[13] HRSA maintains an online database (updated daily) of designated HPSAs and their HPSA scores (http://hpsafind.hrsa.gov).

"proposed for withdrawal" status. All HPSAs proposed for withdrawal remain designated until HRSA publishes the annual Federal Register Notice of designated HPSAs on or before July 1 of each year. State PCOs may submit new, updated, or reinstatement designation applications to replace HPSA designations currently proposed for withdrawal based on up-to-date data at any time.

Since September 2021, HRSA received over 2,500 designation applications from state PCOs, many of which were to update or create new HPSAs in areas where an old HPSA no longer met the designation criteria. HRSA approved many of these applications and continues to work to review and approve the remaining designation applications that qualify.

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). 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).

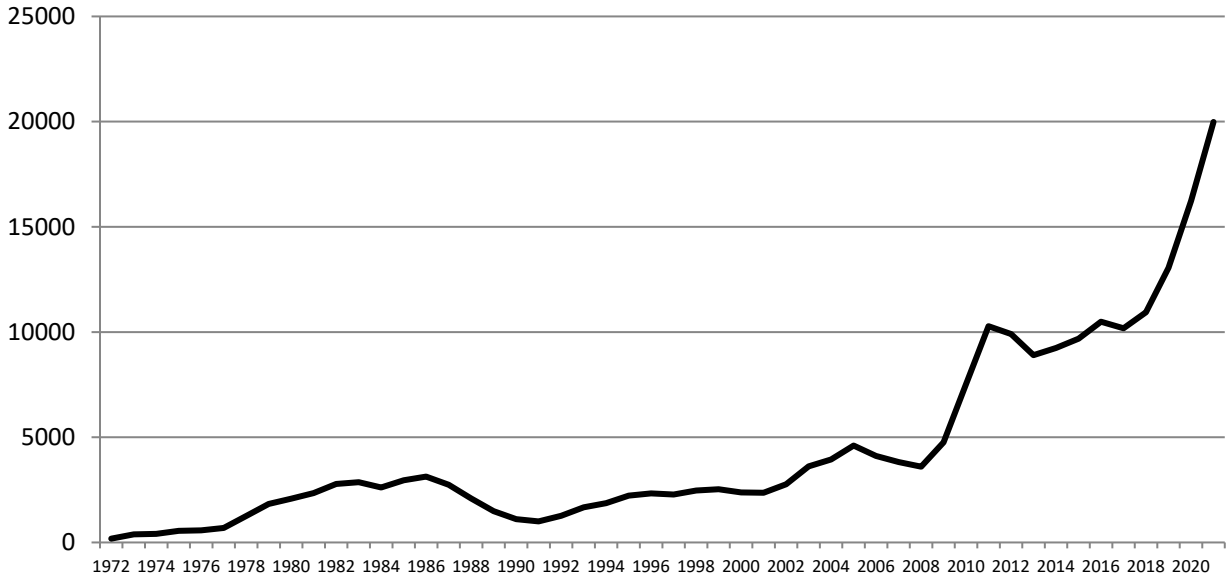
NHSC accepted new site applications in FY 2021 between April 8 and July 1, 2021, and re-certification applications between August 10 and October 19, 2021. NHSC also accepted streamlined applications from sites classified as NHSC auto-approved (e.g., FQHCs and IHS sites) throughout FY 2021. The cumulative number of NHSC site applications, including NHSC auto-approved sites, submitted for FY 2021 was 2,668, with 2,389 approved, 276 disapproved or cancelled, and three under review (which includes two pending a site visit). There were 19,565 NHSC-approved sites as of September 30, 2021.

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 19,984 clinicians in the FY 2021 NHSC field strength is 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 2021). NHSC recruits clinicians through the NHSC SP and LRP, the S2S LRP, the SUD Workforce LRP, and the Rural Community LRP. 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 "Corps members,"[14] the yearly NHSC field strength calculation includes them as Private Practice Option clinicians and SLRP participants who have been supported by NHSC funds. The field strength in FY 2021 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.

NHSC clinicians who have fulfilled their service commitment and remain in service to the underserved (see **Requirement 6**) are not included in the field strength calculation. Figure 1 illustrates the history of the NHSC field strength from FY 1972 through FY 2021.

Figure 1: NHSC Field Strength, FY 1972 – 2021



[14] "Corps members" is defined in 42 U.S.C. § 254d(3)(B) 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 SLRP 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 estimates that the FY 2022 field strength will be approximately 19,739 clinicians, which is essentially maintaining the FY 2021 level, reflecting the obligation of the remaining additional funding for the NHSC recruitment programs provided through the American Rescue Plan Act of 2021.

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.[15] Many racial and ethnic minority groups are underrepresented nationally within the major health professions,[16] and NHSC is working to bolster clinician diversity. As a result, in FY 2021, the percentage of racial and ethnic minority traditional NHSC LRP and Scholarship Program providers exceeded the percentage of racial and ethnic minority providers in the national workforce, as shown in the following instances:

Primary Care Providers

- Black or African American physicians represented 14.9 percent of the NHSC LRP and SP participants, as compared to the 5.0 percent of Black or African American physicians in the national physician workforce.[17]
- Hispanic or Latino physicians represented 12.9 percent of the NHSC LRP and SP participants, as compared to the 5.8 percent of Hispanic or Latino physicians in the national physician workforce.[18]
- American Indian and Alaska Native physicians represented 1.6 percent of the NHSC LRP and SP participants, as compared to the 0.3 percent of American Indian and Alaska Native physicians in the national physician workforce.[19]
- Black or African American nurse practitioners represented 15.7 percent of the NHSC LRP and SP participants, as compared to the 9.1 percent Black or African American nurse practitioners in the national health care workforce of nurse practitioners.[20]
- Hispanic or Latino nurse practitioners represented 9.1 percent of the NHSC LRP and SP participants, as compared to the 6.3 percent Hispanic or Latino nurse practitioners in the national health care workforce of nurse practitioners.[21]

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[15] 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).

[16] 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 (2011-2015). Rockville, Maryland; 2017 (https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/diversity-us-health-occupations-technical.pdf).

[17] Association of American Medical Colleges, Diversity in Medicine: Facts and Figures, 2019. (https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018)

[18] *Ibid.*

[19] *Ibid.*

[20] U.S. Department of Labor, Bureau of Labor Statistics Labor Force Characteristics by Race and Ethnicity, 2020, November 2021, Report 1095. (https://www.bls.gov/opub/reports/race-and-ethnicity/2020/pdf/home.pdf)

[21] *Ibid.*

Behavioral Health Providers

- Asian health services psychologists represented 5.8 percent of the NHSC LRP participants, as compared to the 4.1 percent of Asian health services psychologists in the national health care workforce of health services psychologists.[22]
- Hispanic or Latino health services psychologists represented 20.0 percent of the NHSC LRP participants, as compared to the 3.5 percent of Hispanic or Latino health service psychologists in the national health care workforce of health services psychologists.[23]
- Hispanic or Latino licensed clinical social workers represented 15.4 percent of the NHSC LRP participants, as compared to the 15.2 percent of Hispanic or Latino licensed clinical social workers in the national health care workforce of licensed clinical social workers.[24]

Oral Health Providers

- Black or African American dentists represented 13.0 percent of the NHSC LRP and SP participants, as compared to the 1.4 percent of Black or African American dentists in the national health care workforce of dentists.[25]
- Hispanic or Latino dental hygienists represented 20.0 percent of the NHSC LRP participants, as compared to the 10.5 percent of Hispanic or Latino dental hygienists in the national health care workforce of dental hygienists.[26]

Based on self-reports of the 2,523 NHSC scholars (i.e., those in school, pursuing post-graduate training, or awaiting placement in an NHSC-approved service site), 22.0 percent are Black or African American, 16.8 percent are Asian or Pacific Islander, and 2.3 percent are American Indian or Alaska Native. Moreover, 14.1 percent of NHSC scholars self-reported as Hispanic or Latino. Black or African American and American Indian and Alaska Native NHSC scholars exceeded national student enrollment averages in dentistry,[27] medicine,[28] physician assistant,[29] and nursing disciplines,[30] while Hispanic or Latino NHSC scholars exceeded student enrollment averages in dentistry, representing 15.7 percent of the Corps' dental participants, while comprising 9.0 percent of the national student enrollment.[31]

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[22] *Ibid.*
[23] *Ibid.*
[24] *Ibid.*
[25] *Ibid.*
[26] *Ibid.*
[27] American Dental Association, 2018-2019 Survey on Dental Education: Academic Programs, Enrollments, and Graduates. (https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/sde1_2018-19.xlsx?rev=19ddfc2cdcff4c80a90d4534448c559a&hash=0806B5546AE4B923E5268FBB24D7CC3C)
[28] Association of American Medical Colleges Total U.S. Medical School Enrollment, 2020-2021. (https://www.aamc.org/media/9621/download?attachment)
[29] 35th Physician Assistant Education Association Annual Report, 2019. (https://paeaonline.org/wp-content/uploads/2020/11/program-report35-20201014.pdf)
[30] American Association of Colleges of Nursing, 2021. (https://www.aacnnursing.org/Portals/42/Publications/Annual-Reports/2021-AACN-Annual-Report.pdf)
[31] See footnote 27.

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.

With increased funding from the American Rescue Plan Act, HRSA's efforts to market and promote all NHSC programs expanded to add several new tactics for outreach to wider, more diverse audiences. Using campaign metrics from social media, web traffic, digital channels, and email/e-blast data, NHSC communications methods continue to adapt and improve while using best practices and focusing on data-driven results to inform effective outreach and recruitment activities.

NHSC Communications Strategy

NHSC continues to expand its outreach strategy by partnering and collaborating with NHSC alumni, other federal agencies, medical, dental, nursing, and other health professional associations and organizations, academic institutions, internal HRSA bureaus and offices, and external state and regional partners.

NHSC uses earned media, paid media, print media, digital media, and social media to amplify messages regarding the recruitment and retention of qualified providers. Through targeted messaging and engaging imagery, NHSC has effectively used its available resources to reach a broader audience of potential applicants, promote the program to health professions students, and gain additional stakeholder and partner support to extend our message. The result is sustained interest among potential applicants in NHSC programs and an increase in NHSC-approved health care sites.

NHSC Stakeholder Engagement and Conferences/Exhibits

In FY 2021, NHSC engaged stakeholders and promoted its scholarship and loan repayment programs through webinars, conference calls, and social media to include Facebook chats, e-blasts, presentations, and exhibits at 15 virtual conferences. By fostering relationships with national health organizations, state PCOs, and primary care associations, NHSC expanded its reach to larger and more diverse audiences including health professions students, clinicians, faculty, school administrators, and sites serving underrepresented racial and ethnic minorities and rural communities.

These groups included: Association of American Medical Colleges, 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 Certified Nurse Midwives, National Association of Nurse Practitioners in Women's Health, National Association of Hispanic Nurses, American Psychiatric Nurses Association, National Association of Alcohol and Drug Abuse Counselors, Association for Addiction Professionals, National Association of Rural Health Clinics, and National Council for Behavioral Health, National Dental Association, American Dental Association, Hispanic Dental Association, American Dental Hygienist Association,

Indian Dental Association, Chinese American Dental Association, Association of State and Territorial Dental Directors, Physician Assistant Education Association, American Association for Marriage and Family Therapy, American Association of Colleges of Osteopathic Medicine, National Association of Community Health Centers, and 3RNet. Student groups included the American Medical Student Association, National Student Nursing Association, Student National Medical Association, Latino Medical Student Association, American Student Dental Association, Student National Dental Association, and American Dental Education Association.

In addition to professional associations, HRSA promoted NHSC program opportunities to students and faculty through regional outreach and visits, when possible. HRSA engaged with medical, dental, nursing, and behavioral and mental health students at 22 events at schools throughout the United States in FY 2021. Due to the COVID-19 pandemic, direct outreach was reduced from previous years, but large scale communications/e-blasts were sent to over 19,000 professional and academic institutions promoting NHSC's various opportunities throughout the year.

HRSA and IHS worked together to use NHSC programs as recruitment tools to fill health professional vacancies at sites serving tribal communities. ITUs that exclusively serve tribal members can qualify as NHSC sites and extend their ability to recruit and retain primary care providers by using NHSC scholarship and loan repayment incentives. HRSA's 10 Regional Offices worked with ITUs and offered assistance for completing site profiles and posting vacancies on the Health Workforce Connector. HRSA's Shortage Designation Branch worked with ITUs to verify that their HPSA scores are current, enabling the sites to be competitive in recruiting NHSC scholars and loan repayment participants. As of 2021, 988 ITUs were NHSC-approved and 1,023 clinicians from those sites were in a NHSC commitment. This is an increase of approximately 9.8 percent of clinicians over the previous year (932 clinicians in FY 2020) and is due in part to a $15 million congressional set-aside for applicants serving in ITUs in the FY 2021 appropriation.

The FY 2021 total for NHSC participants at ITU sites, including SLRP participants, is 1,162. However, HRSA did not have enough information to report SLRP participants by site type in FY 2020 and therefore cannot calculate a comparison that includes those participants.

NHSC Recruitment Resources

HRSA's VJFs and the Health Workforce Connector offer platforms to link large numbers of career-seeking clinicians with job opportunities at NHSC-approved sites. While HRSA intends these recruitment tools 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.

Despite the challenges of COVID-19, HRSA continued to use both recruitment resources to support health professionals and health centers. HRSA hosted two separate VJFs. VJFs in FY 2021 resulted in promoting over 14,500 job opportunities posted to more than 5,000 registered job-seeking health care professionals. There was a 3.0 percent increase in the number of NHSC sites that committed to formally present their site and job opportunities

during the two VJFs. VJF events and promotions contributed to over 13,000 new health clinician and site administrator profiles on the Health Workforce Connector. The two FY 2021 HRSA VJFs included over 380 participating sites representing 45 states and territories. HRSA hosted fewer VJFs than previous years due to the retirement of the software used as the VJF platform. HRSA has finalized a new platform for VJFs and expects to begin hosting VJFs by Quarter 4 of FY 2022.

NHSC Recruitment Activities

To inform recruitment strategy and ensure successful outcomes, NHSC obtains data via application submissions and receives program feedback through digital content engagement metrics and anecdotal information collected for analysis. HRSA then uses this data to develop comprehensive communications plans and to direct promotional resources to where they are most effective. This ongoing, data-driven process has resulted in an increase of qualified applicants across most NHSC programs, increased eligible application award pools, and introduced NHSC programs to new providers and health professional students, which in turn, expanded the applicant pool. With increased funding and targeted messaging, FY 2021 application recruitment efforts saw a 23.0 percent increase in the number of awards. In fact, every eligible applicant who applied received an award.

As part of a larger outreach strategy, HRSA regularly updates NHSC web content to ensure relevance and accuracy for the NHSC website's visitors. In FY 2021, in HRSA's continuous effort to improve user experience and meet website best practices, HRSA redesigned the NHSC website. The new site provides information in a way that visitors can easily access and use as evidenced by a bounce rate that continues to be rated excellent by industry standards. The website also saw a traffic increase of 14.9 percent with more than 1.5 million visitors (up from 1.3 million in FY 2020) and more than 3.8 million page views. The most-visited pages continue to be the main loan repayment page, the NHSC.hrsa.gov home page, and the NHSC LRP page.

NHSC program expansion has increased patient access to qualified SUD providers. NHSC continues to align its recruitment activities with guidance from the Department of Health and Human Services' Five-Point Strategy to Combat the Opioid Crisis[32] and the Administration's strategy on mental health.[33] Adding to its focused communications campaigns during program application cycles, NHSC recruitment efforts now include pre-launch messaging

[32] In 2017, the U.S. Department of Health and Human Services launched a comprehensive 5-Point Strategy to empower local communities on the frontlines (https://www.hhs.gov/opioids/sites/default/files/2018-09/opioid-fivepoint-strategy-20180917-508compliant.pdf). The opioid epidemic is one of the Department's top priorities; through the 5-Point Strategy and the Agency Priority Goal of Reducing Opioid Morbidity and Mortality, the Department continues to focus on most effective efforts for addressing OUD (https://www.performance.gov/health_and_human_services/APG_hhs_2.html).

[33] FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union (March 2022). (https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/)

targeting qualified, eligible Tier 1 applicants to the NHSC SUD Workforce LRP and Tier 2 applicants to the NHSC Rural Community LRP.[34]

As a result, in FY 2021, 822 NHSC members reported having a DATA 2000 or X-waiver (permits physicians to prescribe buprenorphine for OUD treatment after an 8-hour training), and more than 3,000 reported having SUD treatment credentials. NHSC also continues to partner with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Providers Clinical Support System, to connect eligible NHSC clinicians and potential applicants with information regarding free training on medications for OUD assisted treatment training. The NHSC medications for OUD treatment training webpage had more than 42,000 views (an increase of 67.0 percent) during the FY 2021 promotional campaign as compared to FY 2020 numbers. FY 2021 efforts added focused outreach to health professional students – a newly eligible group for the training.

HRSA continued to employ successful traditional recruitment tactics, including strong social media campaigns and paid and earned media such as radio media tours, mat releases, and audio news releases. New marketing tactics in FY 2021 included podcast interviews, display ads, and audio news releases repurposed with quote graphics to multiply reach. Combined, these tactics had more than 5.5 million impressions.

In addition to provider recruitment, the FY 2021 marketing campaign sought to recruit eligible health centers and treatment facilities to become NHSC-approved sites. These efforts resulted in more than 1,400 new sites becoming NHSC-approved (an increase of 32.0 percent over the FY 2020 numbers). In FY 2021, HRSA also introduced a sustained, evergreen site recruitment campaign for FQHCs and other site types eligible for auto-approval. This new tactic of promoting NHSC benefits to auto-approved site types year-round resulted in more than 560 new NHSC auto-approved sites (about 40.0 percent of all new sites recruited). New sites are vital to the NHSC's ability to increase distribution of a qualified, diverse health workforce and increase access to quality health care across the nation.

NHSC conducted direct email outreach to potential program participants to announce the opening of the FY 2021 NHSC application cycles via GovDelivery. The current GovDelivery opt-in email lists for NHSC programs include more than 817,500 recipients. HRSA sent e-blasts (mass distribution emails) to targeted distribution lists that included prospective applicants, schools, and NHSC partners including NHSC alumni, the National Advisory Council on the NHSC, professional associations, NHSC sites, program participants, and state PCOs. As summarized in the table below, these efforts resulted in more than 1,900 applications to the NHSC SP and over 9,900 new applications to the NHSC LRP Programs (including NHSC SUD Workforce LRP and NHSC Rural Community LRP).

[34] Tier 1 applicants to the NHSC SUD Workforce LRP are defined as clinicians who are SUD professionals with SUD licensure/certification or a DATA 2000 Waiver and employed in either a SAMHSA-certified OUD treatment program or an office-based OUD treatment facility. Tier 2 applicants to the NHSC RC LRP are those not serving at a Rural Communities Opioid Response Program Consortium Member facility but who have a DATA 2000 Waiver and are working in a SAMHSA-certified OUD treatment program or at an office-based OUD treatment facility (https://www.hrsa.gov/rural-health/rcorp).

Table 1: Eligible Applications and New Awards, FY 2021

Program	*Applications*	*New Awards*
NHSC SP	1,982	1,192
NHSC LRPs	9,985	8,830
S2S LRP	380	257

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 2021 saw approximately 21 million patients and generated 84 million patient visits. NHSC estimates that primary care NHSC clinicians saw 9 million patients and generated 36 million patient visits. Dental health NHSC clinicians saw an estimated 2 million patients and generated 8 million patient visits, and behavioral and mental health NHSC clinicians saw approximately 10 million patients and generated 40 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 who are providing services 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, even if the community where they served no longer qualifies as a HPSA.

Short-Term Retention

NHSC is committed to continuous performance improvement. In FY 2019, HRSA began using a newly-developed Clinician Dashboard (https://data.hrsa.gov/topics/health-workforce/clinician-dashboards) to calculate the 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 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 2020 is estimated at 84.0 percent.

The data sources that contribute to the retention calculations do not include a narrative describing the experiences that NHSC providers have at their sites while completing their service obligations. Historically, 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.[35]

Long-Term Retention

The Clinician Dashboard also collects data that enables NHSC to measure the long-term retention of NHSC clinicians. The data show that 86.0 percent of those who fulfilled their service commitments between 2012 and 2020 (of 21,113 clinicians tracked) are either still in a HPSA or have remained in the same community 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 their disposition). HRSA determines an entity's compliance with section 333(a)(1)(D) of the PHS Act through a three-step process to become an NHSC site.

First, is whether or not the geographic area, the population group served by the site, or the site itself is 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 if the area, population group, or facility is a HPSA of greatest need. HRSA analyzes and scores indicators to determine which HPSAs are in greatest need with 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;

[35] HRSA last conducted the National Health Service Corps Participant Satisfaction Survey in 2019.

- Ratios of population under 18 and over 65; and
- Prevalence of SUD or alcohol abuse.

HPSA scores range from 0 to 25 for primary care and mental health and 0 to 26 for dental health; higher scores 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.

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. The Health Workforce Connector is located at https://connector.hrsa.gov/.

V. Conclusion

The achievements of NHSC in FY 2021 reflect increased promotion of and outreach by the program and greater collaboration with partners, all of which was made possible by the enhanced resources provided to NHSC. This new funding allowed NHSC to achieve its largest field strength level to date (19,984) and serve the health care needs of approximately 21 million patients across the United States. Moreover, NHSC is working to bolster clinician diversity and as a result, in FY 2021, the percentage of NHSC providers representing various racial and ethnic minorities exceeded comparable percentages of racial and ethnic minorities in the national workforce.

One of the critical activities of NHSC in FY 2021 was the continuation of the NHSC Rural Community LRP and the NHSC SUD Workforce LRP. Funding provided by appropriations from FY 2018 through FY 2021 enables NHSC to continue to focus on expanding access to and improving the quality of OUD and SUD treatment in rural and underserved areas nationwide.

In FY 2022, HRSA will implement a new SLRP grant cycle funded by the $100 million in dedicated appropriations in the American Rescue Plan Act. This program includes two

significant flexibilities derived from the American Rescue Plan Act: (1) the dollar-for-dollar federal-state match is not required, and (2) up to 10.0 percent of the federal grant funds may be utilized to administer the program at the state level.

NHSC will continue to focus on ensuring that NHSC providers are serving in high-need HPSAs 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.

Appendix A: National Health Service Corps FY 2021 Field Strength

National Health Service Corps – Overall Field Strength (as of 9/30/2021)

State	Total	NHSC LRP Total	NHSC SUD LRP Total	NHSC RC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee
AK	320	93	17	16	5	0	189	119	201	51	269
AL	140	108	18	5	4	5	0	100	40	91	49
AR	175	151	10	13	0	1	0	66	109	83	92
AS	2	0	1	1	0	0	0	0	2	1	1
AZ	809	461	75	72	30	7	164	547	262	395	414
CA	1,700	1,233	118	35	90	62	162	1,419	281	1,266	434
CO	469	272	87	34	9	9	58	336	133	289	180
CT	467	303	139	10	12	3	0	438	29	265	202
DC	194	119	20	0	18	9	28	194	0	145	49
DE	56	24	10	2	3	2	15	37	19	27	29
FL	764	595	107	8	30	24	0	659	105	476	288
GA	415	311	49	26	14	8	7	242	173	225	190
GU	4	3	1	0	0	0	0	0	4	2	2
HI	127	84	12	3	4	1	23	73	54	97	30
IA	249	143	32	30	4	4	36	76	173	110	139
ID	300	194	64	17	5	4	16	165	135	130	170
IL	937	657	122	27	40	15	76	724	213	607	330
IN	339	205	53	17	11	4	49	226	113	205	134
KS	181	95	24	26	4	3	29	50	131	100	81
KY	367	200	51	62	4	3	47	78	289	197	170
LA	290	167	39	14	7	3	60	212	78	172	118
MA	445	186	123	3	12	13	108	415	30	365	80
MD	352	233	72	11	12	7	17	305	47	177	175
ME	143	52	48	27	4	4	8	51	92	101	42
MI	785	378	99	45	20	16	227	394	391	358	427
MN	413	268	78	41	9	11	6	205	208	105	308
MO	778	552	79	40	18	26	63	416	362	329	449
MP	17	10	0	0	0	1	6	1	16	1	16
MS	145	120	6	14	4	1	0	51	94	71	74
MT	234	154	28	28	6	6	12	54	180	104	130
NC	485	306	90	28	34	17	10	222	263	258	227
ND	98	32	24	12	2	0	28	33	65	22	76
NE	145	59	28	19	0	2	37	62	83	61	84
NH	37	15	11	11	0	0	0	14	23	24	13
NJ	116	60	31	1	3	2	19	104	12	104	12
NM	383	221	32	87	13	8	22	154	229	181	202
NV	192	69	44	10	7	1	61	121	71	68	124
NY	1,465	970	289	41	39	26	100	1,204	261	647	818
OH	525	305	102	56	13	10	39	316	209	402	123
OK	525	365	78	76	4	2	0	190	335	144	381
OR	511	286	125	42	22	18	18	289	222	317	194
PA	464	270	59	12	17	14	92	336	128	341	123
PR	158	78	73	7	0	0	0	134	24	150	8
RI	173	54	40	0	1	3	75	173	0	133	40
SC	230	158	31	18	15	8	0	134	96	181	49
SD	112	73	20	16	1	2	0	18	94	27	85
TN	310	158	17	15	18	7	95	201	109	179	131
TX	532	384	63	11	14	24	36	416	116	352	180
UT	248	104	69	17	5	4	49	166	82	58	190
VA	263	170	32	26	10	6	19	145	118	148	115
VI	11	9	1	1	0	0	0	0	11	9	2
VT	84	25	26	12	0	1	20	23	61	84	0
WA	656	432	89	28	51	27	29	462	194	427	229
WI	338	167	49	23	15	16	68	173	165	190	148
WV	227	150	45	12	6	1	13	119	108	155	72
WY	79	30	16	18	2	3	10	9	70	14	65
Total	**19,984**	**12,321**	**3,066**	**1,226**	**671**	**454**	**2,246**	**12,871**	**7,113**	**11,221**	**8,763**
Percentage of Total Field Strength		**61.65%**	**15.34%**	**6.13%**	**3.36%**	**2.27%**	**11.24%**	**64.41%**	**35.59%**	**56.15%**	**43.85%**

National Health Service Corps – Primary Care Field Strength (as of 9/31/2021)

State	Total	NHSC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	PHY	NP	PA	CNM	RN (SLRP)	PHARM (SLRP)	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee
AK	193	48	5	0	140	70	35	27	4	25	32	73	120	37	156
AL	84	77	3	4	0	22	53	7	2	0	0	58	26	59	25
AR	70	69	0	1	0	14	51	5	0	0	0	22	48	59	11
AS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AZ	429	285	22	4	118	120	210	68	13	0	18	299	130	269	160
CA	856	620	67	41	128	252	337	235	21	0	11	736	120	716	140
CO	155	107	5	4	39	44	46	51	9	0	5	118	37	121	34
CT	95	86	7	2	0	16	59	19	1	0	0	93	2	79	16
DC	96	57	14	7	18	56	25	8	7	0	0	96	0	78	18
DE	28	13	3	2	10	11	14	1	1	0	1	23	5	19	9
FL	404	363	22	19	0	135	199	51	19	0	0	338	66	289	115
GA	237	214	10	6	7	74	134	23	6	0	0	138	99	167	70
GU	2	2	0	0	0	1	0	0	1	0	0	0	2	2	0
HI	62	37	4	1	20	24	29	6	3	0	0	38	24	45	17
IA	84	59	1	1	23	17	53	4	2	0	8	31	53	43	41
ID	97	77	3	2	15	32	28	36	0	0	1	38	59	56	41
IL	488	374	35	12	67	161	219	89	19	0	0	372	116	391	97
IN	133	99	10	2	22	31	83	10	7	2	0	97	36	104	29
KS	73	52	1	0	20	13	47	13	0	0	0	22	51	37	36
KY	155	114	3	2	36	35	100	13	1	2	4	28	127	100	55
LA	121	86	5	1	29	27	85	9	0	0	0	84	37	84	37
MA	184	109	8	9	58	46	106	24	3	0	5	165	19	161	23
MD	102	74	7	6	15	39	44	11	8	0	0	87	15	80	22
ME	37	27	1	1	8	14	16	6	1	0	0	11	26	27	10
MI	362	178	11	9	164	107	143	105	7	0	0	151	211	144	218
MN	76	68	0	7	1	19	37	16	4	0	0	37	39	41	35
MO	310	261	11	7	31	122	156	31	1	0	0	129	181	112	198
MP	12	6	0	1	5	2	2	3	0	1	4	1	11	1	11
MS	82	79	3	0	0	17	63	2	0	0	0	37	45	51	31
MT	81	66	4	3	8	19	27	33	0	2	0	19	62	35	46
NC	231	191	26	14	0	78	89	62	2	0	0	109	122	130	101
ND	38	16	1	0	21	4	16	7	0	8	3	3	35	10	28
NE	60	30	0	1	29	14	23	17	1	0	5	23	37	23	37
NH	7	7	0	0	0	1	4	2	0	0	0	4	3	6	1
NJ	46	29	1	1	15	20	20	4	2	0	0	41	5	44	2
NM	145	120	7	6	12	53	66	21	5	0	0	59	86	74	71
NV	84	32	6	1	45	14	31	25	1	5	8	41	43	44	40
NY	661	532	35	22	72	280	231	110	40	0	0	537	124	369	292
OH	176	145	6	7	18	57	110	7	2	0	0	125	51	141	35
OK	165	161	3	1	0	35	85	34	11	0	0	67	98	95	70
OR	149	104	14	15	16	56	44	46	1	1	1	70	79	105	44
PA	207	143	12	8	44	62	97	45	3	0	0	157	50	173	34
PR	25	25	0	0	0	25	0	0	0	0	0	24	1	24	1
RI	67	25	0	2	40	18	24	4	1	19	1	67	0	47	20
SC	128	109	13	6	0	42	66	18	2	0	0	72	56	111	17
SD	32	31	1	0	0	6	19	5	2	0	0	6	26	13	19
TN	180	91	14	3	72	39	117	18	5	0	1	116	64	123	57
TX	241	214	11	16	0	64	136	37	4	0	0	184	57	197	44
UT	49	45	0	1	3	13	9	25	0	1	1	26	23	23	26
VA	92	75	7	3	7	24	45	21	1	0	1	51	41	78	14
VI	9	9	0	0	0	2	2	4	1	0	0	0	9	9	0
VT	22	7	0	0	15	9	10	3	0	0	0	5	17	22	0
WA	244	169	39	16	20	94	72	63	9	1	5	166	78	189	55
WI	122	62	4	7	49	46	48	23	5	0	0	68	54	69	53
WV	104	89	3	0	12	20	54	27	2	0	1	43	61	80	24
WY	29	16	2	3	8	6	14	8	1	0	0	4	25	10	19
Total	**8,421**	**6,184**	**470**	**287**	**1,480**	**2,622**	**3,833**	**1,542**	**241**	**67**	**116**	**5,409**	**3,012**	**5,616**	**2,805**
Percentage of Primary Care Field Strength		**73.44%**	**5.58%**	**3.41%**	**17.58%**	**31.14%**	**45.52%**	**18.31%**	**2.86%**	**<1%**	**1.38%**	**64.23%**	**35.77%**	**66.69%**	**33.31%**
Percentage of Total Field Strength		**30.94%**	**2.35%**	**1.44%**	**7.41%**	**13.12%**	**19.18%**	**7.72%**	**1.21%**	**<1%**	**<1%**	**27.07%**	**15.07%**	**28.10%**	**14.04%**

National Health Service Corps – Oral Health Field Strength (as of 9/30/2021)

State	Total	NHSC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	DD	RDH	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee
AK	29	8	0	0	21	26	3	7	22	3	26
AL	8	7	1	0	0	8	0	6	2	8	0
AR	15	15	0	0	0	13	2	8	7	11	4
AS	0	0	0	0	0	0	0	0	0	0	0
AZ	72	43	8	1	20	65	7	48	24	44	28
CA	295	226	21	19	29	269	26	254	41	252	43
CO	65	47	4	5	9	35	30	48	17	63	2
CT	36	33	2	1	0	22	14	35	1	33	3
DC	25	20	3	0	2	16	9	25	0	22	3
DE	1	1	0	0	0	0	1	0	1	1	0
FL	90	77	8	5	0	73	17	81	9	86	4
GA	26	23	2	1	0	19	7	20	6	17	9
GU	0	0	0	0	0	0	0	0	0	0	0
HI	25	25	0	0	0	21	4	15	10	22	3
IA	35	22	3	3	7	28	7	15	20	34	1
ID	23	19	2	2	0	17	6	12	11	23	0
IL	49	34	4	2	9	44	5	40	9	45	4
IN	28	25	1	2	0	20	8	26	2	27	1
KS	31	22	3	3	3	21	10	13	18	26	5
KY	32	24	0	1	7	24	8	12	20	27	5
LA	23	10	1	1	11	20	3	15	8	19	4
MA	39	17	4	2	16	30	9	37	2	37	2
MD	14	12	1	1	0	9	5	11	3	14	0
ME	13	8	2	3	0	11	2	3	10	12	1
MI	87	62	7	7	11	63	24	52	35	60	27
MN	41	28	7	4	2	27	14	28	13	17	24
MO	121	66	7	17	31	94	27	68	53	108	13
MP	4	4	0	0	0	3	1	0	4	0	4
MS	9	7	1	1	0	7	2	5	4	7	2
MT	26	18	1	3	4	15	11	7	19	16	10
NC	41	31	7	3	0	38	3	18	23	31	10
ND	7	5	1	0	1	5	2	2	5	2	5
NE	18	15	0	1	2	14	4	16	2	17	1
NH	3	3	0	0	0	1	2	0	3	2	1
NJ	14	8	1	1	4	14	0	13	1	12	2
NM	53	40	5	2	6	37	16	30	23	36	17
NV	10	6	1	0	3	8	2	6	4	5	5
NY	132	120	3	3	6	112	20	113	19	110	22
OH	75	51	5	3	16	56	19	54	21	70	5
OK	34	32	1	1	0	24	10	20	14	16	18
OR	67	58	6	3	0	38	29	41	26	60	7
PA	65	35	4	5	21	48	17	51	14	58	7
PR	12	12	0	0	0	12	0	11	1	12	0
RI	28	12	1	1	14	24	4	28	0	26	2
SC	15	12	1	2	0	11	4	13	2	15	0
SD	15	13	0	2	0	9	6	2	13	5	10
TN	20	10	4	2	4	18	2	14	6	12	8
TX	66	56	3	7	0	50	16	47	19	62	4
UT	21	14	5	2	0	18	3	13	8	12	9
VA	32	26	3	3	0	27	5	20	12	32	0
VI	0	0	0	0	0	0	0	0	0	0	0
VT	8	4	0	1	3	6	2	1	7	8	0
WA	123	103	10	9	1	102	21	88	35	112	11
WI	72	38	9	9	16	61	11	39	33	59	13
WV	23	20	2	1	0	16	7	13	10	19	4
WY	1	1	0	0	0	1	0	0	1	0	1
Total	**2,217**	**1,628**	**165**	**145**	**279**	**1,750**	**467**	**1,544**	**673**	**1,827**	**390**
Percentage of Oral Health Field Strength		**73.43%**	**7.44%**	**6.54%**	**12.58%**	**78.94%**	**21.06%**	**69.64%**	**30.36%**	**82.41%**	**17.59%**
Percentage of Total Field Strength		**8.15%**	**<1%**	**<1%**	**1.40%**	**8.76%**	**2.34%**	**7.73%**	**3.37%**	**9.14%**	**1.95%**

National Health Service Corps – Mental and Behavioral Health Field Strength (as of 9/30/2021)

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	CNA	SUD Counselor	RNMH	PHARM MH	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee
AK	98	37	17	16	0	0	28	11	11	1	0	12	37	9	3	1	0	7	2	4	39	59	11	87
AL	48	24	18	5	0	1	0	9	5	0	0	14	6	0	1	0	0	11	0	2	36	12	24	24
AR	90	67	10	13	0	0	0	3	15	0	0	30	40	1	0	1	0	0	0	0	36	54	13	77
AS	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	1	1
AZ	308	133	75	72	0	2	26	16	96	7	3	48	59	20	7	2	1	6	7	36	200	108	82	226
CA	549	387	118	35	2	2	5	33	71	20	0	195	4	85	115	2	0	13	6	5	429	120	298	251
CO	249	118	87	34	0	0	10	12	22	13	2	60	86	14	6	0	0	29	5	0	170	79	105	144
CT	336	184	139	10	3	0	0	19	52	2	0	106	70	29	20	0	0	25	13	0	310	26	153	183
DC	73	42	20	0	1	2	8	4	9	3	0	22	29	2	0	0	0	3	1	0	73	0	45	28
DE	27	10	10	2	0	0	5	1	4	1	0	2	8	5	0	0	0	6	0	0	14	13	7	20
FL	270	155	107	8	0	0	0	17	52	4	0	78	50	31	5	0	0	20	7	6	240	30	101	169
GA	152	74	49	26	2	1	0	4	38	2	0	28	44	11	5	0	0	18	2	0	84	68	41	111
GU	2	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2	0	2
HI	40	22	12	3	0	0	3	6	5	1	0	7	0	20	0	0	0	0	0	1	20	20	30	10
IA	130	62	32	30	0	0	6	2	35	4	0	29	31	8	4	1	0	11	3	2	30	100	33	97
ID	180	98	64	17	0	0	1	15	26	8	0	52	46	12	2	1	0	16	1	1	115	65	51	129
IL	400	249	122	27	1	1	0	20	46	11	0	142	116	23	4	1	0	25	9	3	312	88	171	229
IN	178	81	53	17	0	0	27	7	40	1	0	54	38	16	1	1	0	12	4	4	103	75	74	104
KS	77	21	24	26	0	0	6	1	21	3	0	18	6	6	1	0	0	11	2	8	15	62	37	40
KY	180	62	51	62	1	0	4	14	55	1	0	46	45	7	0	0	0	11	0	1	38	142	70	110
LA	146	71	39	14	1	1	20	7	25	0	0	37	58	8	0	0	0	5	2	4	113	33	69	77
MA	222	60	123	3	0	2	34	19	68	10	3	58	23	10	2	0	0	8	21	0	213	9	167	55
MD	236	147	72	11	4	0	2	14	39	2	0	86	43	26	0	0	0	20	5	1	207	29	83	153
ME	93	17	48	27	1	0	0	10	33	8	0	28	6	2	0	0	0	5	1	0	37	56	62	31
MI	336	138	99	45	2	0	52	13	29	14	0	165	45	10	3	1	0	38	8	10	191	145	154	182
MN	296	172	78	41	2	0	3	11	33	14	1	77	54	25	24	0	1	42	7	7	140	156	47	249
MO	347	225	79	40	0	2	1	12	58	2	0	95	114	33	4	3	0	16	9	1	219	128	109	238
MP	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1
MS	54	34	6	14	0	0	0	0	9	1	0	13	24	2	0	0	0	4	1	0	9	45	13	41
MT	127	70	28	28	1	0	0	10	19	5	0	27	34	3	0	0	0	18	3	8	28	99	53	74
NC	213	84	90	28	1	0	10	21	33	12	2	56	36	16	1	1	0	14	12	9	95	118	97	116
ND	53	11	24	12	0	0	6	1	10	1	1	12	5	3	0	0	0	14	3	3	28	25	10	43
NE	67	14	28	19	0	0	6	2	19	4	0	5	18	4	0	1	0	9	1	4	23	44	21	46
NH	27	5	11	11	0	0	0	4	6	4	1	0	6	1	0	0	0	4	1	0	10	17	16	11
NJ	56	23	31	1	1	0	0	2	10	5	0	24	1	5	0	1	0	2	0	6	50	6	48	8
NM	185	61	32	87	1	0	4	12	31	3	1	35	39	5	3	1	1	8	1	45	65	120	71	114
NV	98	31	44	10	0	0	13	2	8	2	0	24	9	3	13	0	0	33	1	3	74	24	19	79
NY	672	318	289	41	1	1	22	57	92	22	1	186	113	53	13	2	0	104	23	6	554	118	168	504
OH	274	109	102	56	2	0	5	6	79	2	0	72	56	7	1	0	0	22	12	17	137	137	191	83
OK	326	172	78	76	0	0	0	9	24	10	1	52	167	1	11	0	0	17	8	26	103	223	33	293
OR	295	124	125	42	2	0	2	19	52	20	4	72	54	8	11	1	0	31	17	6	178	117	152	143
PA	192	92	59	12	1	1	27	15	38	14	0	54	46	12	0	0	0	5	5	3	128	64	110	82
PR	121	41	73	7	0	0	0	5	0	0	0	24	9	32	0	0	0	11	18	22	99	22	114	7
RI	78	17	40	0	0	0	21	6	24	2	0	24	15	0	0	0	0	3	4	0	78	0	60	18
SC	87	37	31	18	1	0	0	4	22	1	0	13	24	5	1	0	0	8	3	6	49	38	55	32
SD	65	29	20	16	0	0	0	0	14	2	1	11	14	4	1	0	0	13	1	4	10	55	9	56
TN	110	57	17	15	0	2	19	6	32	2	0	16	28	8	2	11	0	2	2	1	71	39	44	66
TX	225	114	63	11	0	1	36	12	39	8	0	40	84	18	5	4	0	13	0	2	185	40	93	132
UT	178	45	69	17	0	1	46	8	21	11	0	72	42	3	10	0	0	7	1	3	127	51	23	155
VA	139	69	32	26	0	0	12	3	23	0	0	32	64	5	2	1	0	7	2	0	74	65	38	101
VI	2	0	1	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2	0	2
VT	54	14	26	12	0	0	2	6	9	3	0	12	11	1	0	0	0	8	4	0	17	37	54	0
WA	289	160	89	28	2	2	8	30	52	13	1	32	75	23	23	1	0	32	3	4	208	81	126	163
WI	144	67	49	23	2	0	3	8	16	0	0	28	48	17	6	0	0	7	3	11	66	78	62	82
WV	100	41	45	12	1	0	1	11	34	3	0	11	13	20	0	0	0	3	1	4	63	37	56	44
WY	49	13	16	18	0	0	2	2	8	1	0	13	13	3	2	0	0	1	0	6	5	44	4	45
Total	**9,346**	**4,509**	**3,066**	**1,226**	**36**	**22**	**487**	**541**	**1,612**	**283**	**22**	**2,450**	**2,109**	**675**	**312**	**38**	**3**	**759**	**245**	**297**	**5,918**	**3,428**	**3,778**	**5,568**
Percentage of Mental Health Field Strength		**48.25%**	**32.81%**	**13.12%**	**<1%**	**<1%**	**5.21%**	**5.79%**	**17.25%**	**3.03%**	**<1%**	**26.21%**	**22.57%**	**7.22%**	**3.34%**	**<1%**	**<1%**	**8.12%**	**2.62%**	**3.18%**	**63.32%**	**36.68%**	**40.42%**	**59.58%**
Percentage of Total Field Strength		**22.56%**	**15.34%**	**6.13%**	**<1%**	**<1%**	**2.44%**	**2.71%**	**8.07%**	**1.42%**	**<1%**	**12.26%**	**10.55%**	**3.38%**	**1.56%**	**<1%**	**<1%**	**3.80%**	**1.23%**	**1.49%**	**29.61%**	**17.15%**	**18.91%**	**27.86%**

Acronyms and Abbreviations Used in Appendix A

(In order of appearance)

Program

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

Rural Status

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

Grantee Status

Health Center Grantee	Clinicians serving in a FQHC that receives Section 330 grant funding from the Health Center Program; does not include SLRP
Non-Health Center Grantee	Clinicians serving at any site type other than FQHC; does not include SLRP

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

CNA	Certified registered nurse anesthetist
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