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

REPORT TO CONGRESS

NATIONAL HEALTH SERVICE CORPS
FOR THE YEAR 2020

Executive Summary

The Report to Congress for 2020 details the program accomplishments of the National Health Service Corps (NHSC), which is charged with helping communities within Health Professional Shortage Areas (HPSA) 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, 2020, there were HPSA designations of the following types:
    - Primary care: 7,203
    - Dental health: 6,487
    - Mental health: 5,733

- The NHSC field strength in fiscal year (FY) 2020 was 16,229. NHSC clinicians served in urban, rural, and frontier communities in all 50 states, the District of Columbia, Commonwealth of Puerto Rico, U.S. Virgin Islands, and Pacific Basin.[2]

- In FY 2020, NHSC clinicians provided care to more than 17 million people. Over 60 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) facilities, Tribal Health Program,[3] and Urban Indian Health Programs[4] (collectively

[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, NHSC Substance Use Disorder (SUD) Workforce LRP, NHSC Rural Communities LRP, and 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.

[3] An Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (25 USC 5301 et. seq.).

[4] Urban Indian Health Centers are designated Federally Qualified Health Centers that provide comprehensive primary

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 35 percent of NHSC placements in FY 2020 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.

- In FY 2020, NHSC made 251 new and 12 continuation Scholarship Program (SP) awards and 5,963 new and 2,355 continuation Loan Repayment Program (LRP) awards. Additionally, eligibility for the Students to Service (S2S) LRP was expanded to include Advanced Practice Nurses; overall, a total of 148 new S2S LRP awards were made. 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 2020, NHSC received $310 million that funded all of the scholarship, loan repayment continuation, S2S LRP, and the majority of new loan repayment awards listed above. The State Loan Repayment Program grants supported 42 states and one territory in the third year of a 5-year funding cycle.

- The Consolidated Appropriations Act, 2018, the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 and the Further Consolidated Appropriations Act, 2020 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 implemented both the NHSC SUD Workforce LRP and the NHSC Rural Community (RC) LRP. In FY 2020, the NHSC SUD LRP made 1,206 new awards, and the NHSC RC LRP made 477 new awards. Additionally, the FY 2019 and FY 2020 appropriations included funding to support loan repayment awards to clinicians serving in ITU facilities.

- In FY 2020, HRSA continued to use the "Clinician Dashboard" to calculate retention rates. The Clinician Dashboard is a data visualization tool supported by the NHSC that includes data on clinicians with National Provider Identifier numbers.[6]

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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.

[5] 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.

[6] 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 2020

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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 Health Programs, and Urban Indian Programs
LRP	Loan Repayment Program
NHSC	National Health Service Corps
PHS	Public Health Service
RC	Rural Community
SAMHSA	Substance Abuse and Mental Health Services Administration
S2S LRP	Students to Service Loan Repayment Program
SLRP	State Loan Repayment Program
SP	Scholarship Program
SUD	Substance Use Disorder
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 the National Health Service Corps.

[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 National Health Service Corps 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. The Bureau of Health Workforce 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 Bureau of Health Workforce Program Officers.

II. Introduction

The Bureau of Health Workforce within the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services manages the NHSC program. The Emergency Health Personnel Act of 1970 (P. L. 91-623) established the NHSC on December 31, 1970. Congress has amended and reauthorized the Act several times in the ensuing 50-plus 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 16,229 clinicians in FY 2020 from 13,053 clinicians in FY 2019. 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 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 2020, NHSC SP, NHSC LRP, NHSC S2S LRP, NHSC SUD Workforce LRP, and NHSC RC LRP received 13,660 applications for new and continuation awards, an increase of more than 2,500 applications compared to FY 2019. The increase in both the number of applications and the field strength is the result of additional appropriations to the NHSC in FY 2018, FY 2019, and FY 2020 (see **Overview**, below, for details). 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 7 national partner conferences and hosted 3 virtual job fairs (VJFs), including 1 rural-focused VJF, all of which resulted in more than 300 participating sites representing all 50 states, the District of Columbia, the U.S. Virgin Islands, and the Northern Mariana Islands with over 12,000 job posts on the HRSA Health Workforce Connector.[10]

An important measure of the success of the 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 (Corp members who complete their service obligation and remain in a 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 their NHSC service obligation has been completed). The Dashboard shows in FY 2020 approximately 81 percent of those who fulfilled their NHSC commitments had remained in service to the underserved 1 year after their commitments ended. Further, 85 percent of those who fulfilled their service commitments between 2012 and 2019 are either still in a Health

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

Professional Shortage Area (HPSA), or have remained in the community where they served, even if it no longer qualifies as a HPSA.[11]

III. Overview

In FY 2020, the NHSC awarded 251 new scholarships and 12 continuations as well as 5,963 new loan repayments and 2,355 loan repayment continuations. The NHSC also continued implementation of the S2S LRP, making 148 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. HRSA makes S2S LRP awards to students in their last year of medical, nursing, or dental school, who agree to make a 3-year service commitment to provide primary health care services in a high priority HPSA.[12] This commitment begins for physicians once the required primary care residency is complete; dental students and advanced practice nurses are encouraged, but not required, to complete approved post-graduate training.

In FY 2020, the NHSC continued 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.

The establishment of the FY 2012-2015 Critical Access Hospital (CAH) 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.[13] These are now permanent program requirements and CAHs are eligible sites. Historically, only a CAH outpatient clinic was an eligible site and NHSC clinicians were generally limited to serving no more than 8 hours per week in the inpatient setting. In FY 2020, the NHSC continued placing clinicians in CAHs and Indian Health Service (IHS) and tribal hospitals to extend the reach of the NHSC in rural areas. As of September 30, 2020, there are 232 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, Continuing Appropriations Act, 2019, and the Further Consolidated Appropriations Act, 2020 also 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 continues 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 providing outpatient services at certain sites including opioid treatment programs, office-based opioid treatment facilities, and non-opioid outpatient SUD facilities. The funding supports the recruitment and retention of health professionals needed in

[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.
[12] A "high priority HPSA" is currently defined as having a HPSA score of 14 or above. Higher HPSAs indicate higher need. HPSA scoring methodology is described in more detail later in the report.
[13] Placement at CAHs is limited to physicians, physician assistants, nurse practitioners, and certified nurse midwives.

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, 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 RC LRP: A portion of the FY 2018, FY 2019, and FY 2020 appropriations provided funding for the NHSC RC LRP, which is a 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 HRSA's Federal Office of Rural Health Policy's Rural Communities Opioid Response Program initiative to provide evidence-based substance use treatment, assist in recovery, and prevent overdose deaths across the nation.

NHSC and IHS: The FY 2019 and FY 2020 appropriations included a set-aside of $15 million in funding 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 971 IHS facilities, Tribal Health Programs,[11] and Urban Indian Health Programs (collectively known as ITUs). Federal IHS Clinics, Tribal Health Clinics, Urban Indian Health Clinics, 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.

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 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).[14] 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

[14] 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 2008 made subsequent amendments to the Act, which made the automatic facility designation permanent.

federal and state agencies and programs 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, 2020, there were 7,203 primary care HPSAs, 6,487 dental health HPSAs, and 5,733 mental health HPSAs. Overall, the number of HPSAs has decreased by 1.97 percent from FY 2019. This decrease is a direct result of data clean-up conducted as part of the Shortage Designation Modernization Project.[15] HRSA anticipates that the number of HPSAs in FY 2021 will remain 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.

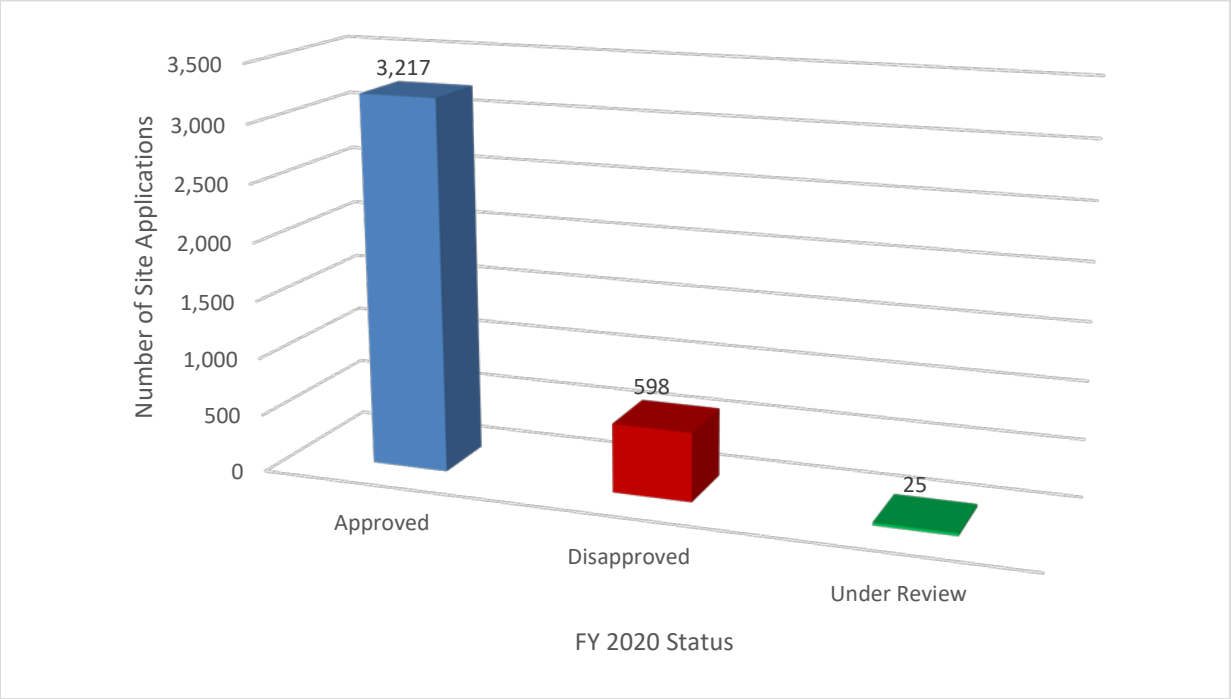
Specific requirements for participation as an NHSC-approved site include providing health services in or to a designated HPSA; providing comprehensive primary care services; providing services on a free or reduced fee schedule basis to individuals at or below 200 percent of the federal poverty level; 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).

The NHSC accepted new site applications in FY 2020 between May 26 and August 4, 2020, and re-certification applications between August 18 and October 13, 2020. The NHSC also accepted streamlined applications from sites classified as NHSC auto-approved (e.g., FQHCs and IHS sites) throughout FY 2020. The cumulative number of NHSC site applications, including NHSC auto-approved sites, submitted for FY 2020 was 3,840 with 3,217 approved, 598 disapproved or

[15] Health Resources and Services Administration. "Fourth Quarter of Fiscal Year 2020 Designated HPSA Quarterly Summary." U.S. Department of Health and Human Services, 30 Sept. 2020.

cancelled, and 25 under review (which includes 11 pending a site visit) (See Figure 1). There are currently 18,548 NHSC-approved sites.

Figure 1: Disposition of NHSC Site Applications, FY 2020



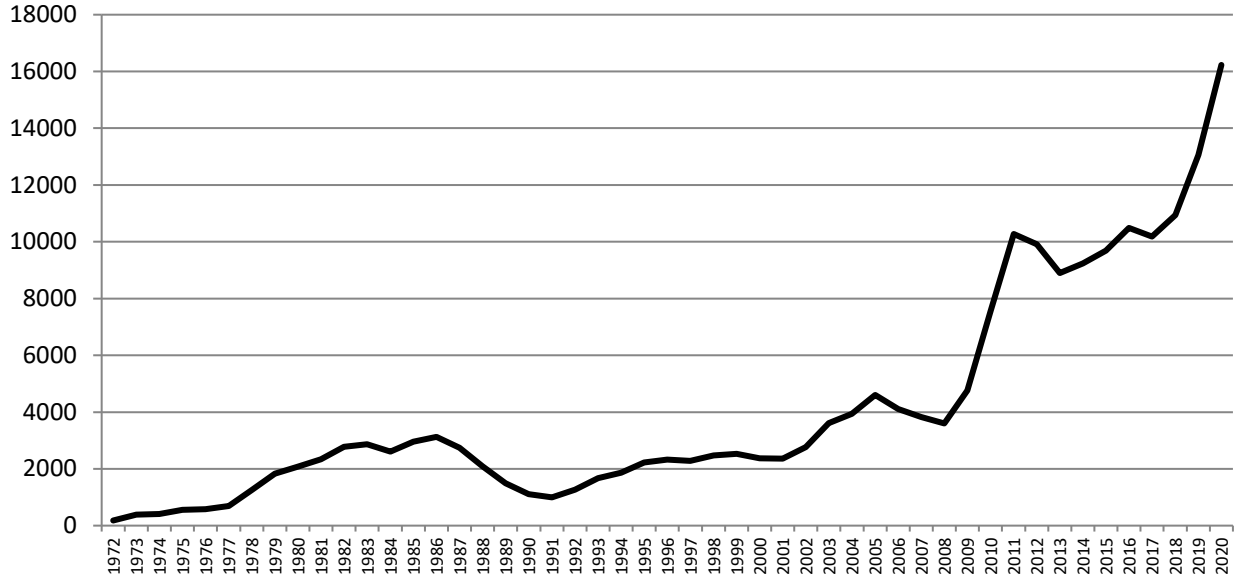
Requirement #3: The number and types of Corps members assigned in such year to HPSAs, the number and types of additional Corps members, which the Secretary estimates will be assigned to such areas in the subsequent year, and the need for additional members for the Corps.

The 16,229 clinicians in the FY 2020 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 2020). The NHSC recruits clinicians through the NHSC SP and LRP, the S2S LRP, the SUD Workforce LRP, and the RC 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,"[16] 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 2020 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.

[16] "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 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 2 illustrates the history of the NHSC field strength from FY 1972 through FY 2020.

Figure 2: NHSC Field Strength, FYs 1972 – 2020



The NHSC estimates that the FY 2021 field strength will be approximately 18,534 clinicians. This increase over the FY 2020 level reflects the 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.[17] Many racial and ethnic minority groups are underrepresented nationally within the major health professions,[18] and the NHSC is working to bolster clinician diversity. As a result, in FY 2020, the share of racial and ethnic minority NHSC providers exceeded their share in the national workforce, as shown in the following instances:

Primary Care

- Black or African American physicians represented 15.6 percent of the NHSC LRP and SP participants, exceeding their 5.0 percent share in the national physician workforce.[19]

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[17] 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).

[18] 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).

[19] 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).

- Hispanic or Latino physicians represented 15.8 percent of the NHSC LRP and SP participants, exceeding their 5.8 percent share in the national physician workforce.[20]
- American Indian and Alaska Native physicians represented 1.8 percent of the NHSC LRP and SP participants, exceeding their 0.3 percent share in the national physician workforce.[21]
- Black or African American nurse practitioners represented 18.5 percent of the NHSC LRP and SP participants, exceeding their 12.2 percent share in the national health care workforce averages of nurse practitioners.[22]
- Hispanic or Latino nurse practitioners represented 8.7 percent of the NHSC LRP and SP participants, exceeding their 2.6 percent share in national health care workforce averages of nurse practitioners.[23]

Mental and Behavioral Health

- Asian health services psychologists represented 5.8 percent of the NHSC LRP participants, exceeding their 3.7 percent share in the national health care workforce averages of health services psychologists.[24]
- Black or African American health services psychologists represented 8.3 percent of the NHSC LRP participants, exceeding their 5.8 percent share in the national health care workforce averages of health services psychologists.[25]
- Hispanic or Latino licensed clinical social workers represented 15.7 percent of the NHSC LRP participants, exceeding their 14.3 percent share in the national health care workforce averages of licensed clinical social workers.[26]

Oral Health

- Black or African American dentists represented 13.6 percent of the NHSC LRP and SP participants, exceeding their 0.8 percent share in the national health care workforce averages of dentists.[27]
- Hispanic or Latino dental hygienists represented 20.5 percent of the NHSC LRP participants, exceeding their 11.3 percent share in the national health care workforce averages of dental hygienists.[28]

Based on self-reports of the 1,527 NHSC scholars (i.e., those in school, pursuing post-graduate training, or awaiting placement in an NHSC-approved service site), 20.8 percent are Black or African American, 16.5 percent are Asian or Pacific Islander, and 2.1 percent are American Indian or Alaska Native. Moreover, 14 percent of NHSC scholars self-reported as Hispanic or Latino. Black or African American NHSC scholars exceeded national student enrollment averages in

[20] *Ibid.*
[21] *Ibid.*
[22] U.S. Department of Labor, Bureau of Labor Statistics Labor Force Characteristics by Race and Ethnicity, 2019, December 2020, Report 1088.
[23] *Ibid.*
[24] *Ibid.*
[25] *Ibid.*
[26] *Ibid.*
[27] *Ibid.*
[28] *Ibid.*

dentistry, medicine, physician assistant, and nursing disciplines.[29] Hispanic or Latino NHSC scholars exceeded student enrollment averages in dentistry, representing 18.4 percent of the Corps' dental participants, compared to their 9.0 percent share of the national student enrollment.[30] American Indian and Alaska Native NHSC scholars exceed national student enrollment averages in dentistry, medicine, physician assistant, and nursing disciplines.[31]

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.

HRSA continues to bolster its efforts to recruit for and increase awareness of all NHSC programs. In response to follower (social media, web, and email correspondence) and content engagement data, NHSC communications vehicles continue to evolve and implement best practices resulting in more focused and effective outreach activities.

NHSC Communications Strategy

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

The 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, the 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 support to extend our message. The result is an increase in high-quality applicants across all programs and an increase in NHSC-approved health care sites.

NHSC Stakeholder Engagement and Conferences/Exhibits

In FY 2020, the 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 seven virtual conferences. By fostering relationships with national health organizations, state primary care offices, and primary care associations, the 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: the Association of American Medical Colleges, Association of Clinicians for the Underserved, National Medical Association, Hispanic Medical Association, Black Nurses

[29] American Dental Association, 2018-2019 Survey on Dental Education: Academic Programs, Enrollments, and Graduates. Association of American Medical Colleges, 2020-2021. American Association of Colleges of Nursing, 2020. 35th Physician Assistant Education Association Annual Report, 2019.
[30] *Ibid.*
[31] *Ibid.*

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. 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, American Dental Education Association, National Dental Association, American Dental Association, Hispanic Dental Association, American Dental Hygienist Association, Indian Dental Association, Chinese American Dental Association, and the Association of State and Territorial Dental Directors.

In addition to professional associations, HRSA promoted NHSC program opportunities to eligible health professions schools through regional outreach and visits, when possible. HRSA engaged with medical, dental, nursing, and behavioral and mental health students at 35 health professions schools throughout the United States and its territories in FY 2020. Due to the COVID-19 pandemic, direct outreach was reduced from previous years. Large scale communications/e-blasts are also sent to over 19,000 professional and academic institutions promoting the 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. The Division of Regional Operations in 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 2020, 972 ITUs were NHSC-approved and 932 clinicians from those sites were in an NHSC commitment. This is an increase of 25 percent of clinicians over the previous year (743 clinicians in 2019), and is due in part to a $15 million congressional set-aside for applicants serving in ITUs in the FY 2020 appropriation.

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 these recruitment tools are 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.

Despite the challenges of COVID-19, HRSA continued to use both recruitment resources to support health professionals and health centers. HRSA hosted three separate VJFs, with one targeted toward rural regions in the United States. VJFs in 2020 resulted in the promotion of over 3,000 job postings to more than 2,000 job seeking health care professionals in attendance. There was a 10 percent increase in the number of NHSC sites that committed to formally present their

site and job opportunities during the two general VJFs and an over 20 percent increase for the rural communities VJF, resulting in the highest number of participating sites for both a VJF and a rural-focused VJF to date. VJF events and promotions contributed to over 13,000 new health clinician and site administrator profiles on the Health Workforce Connector. The three FY 2020 HRSA VJFs included over 300 participating sites representing all 50 states, the District of Columbia and the Northern Mariana Islands, with pre-registration participation interest from the U.S. Virgin Islands, Guam, and Puerto Rico.

NHSC Recruitment Activities

The NHSC, to ensure successful recruitment outcomes, queries potential members via their application submissions and receives program feedback through content engagement metrics and anecdotal information collected for analysis. HRSA then uses this data to develop cohesive communications plans and 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 and exceeded eligible application award pool needs for all programs.

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 2020, the NHSC website had more than 1.3 million visitors (up from 1.2 million during the previous year) and more than 3.5 million page views, with the NHSC loan repayment programs among the site's most-visited pages.

In March 2020, in response to the rapid onset of the COVID-19 crisis, HRSA strengthened FY 2020 recruitment and retention efforts by implementing flexibilities to extend deadlines for application submissions and employment start dates at NHSC-approved sites. Additionally, HRSA incorporated mechanisms to help clinicians meet service compliance requirements.

NHSC program expansion has increased patient access to qualified SUD providers. The NHSC continues to align its recruitment activities with guidance from the U.S. Department of Health and Human Services' Five-Point Strategy to Combat the Opioid Crisis.[32] Adding to its focused communications campaigns during program application cycles, NHSC recruitment efforts now include pre-launch messaging targeting qualified, eligible Tier 1 applicants to the NHSC SUD Workforce LRP and Tier 2 applicants to the NHSC Rural Community LRP.[33]
Through a continued partnership with Substance Abuse and Mental Health Services Administration's (SAMHSA) Providers Clinical Support System, clinicians receive information

[32] In 2017, the Department of Health and Human Services launched a comprehensive 5-Point Strategy to empower local communities on the frontlines (see 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 (see https://www.performance.gov/health_and_human_services/APG_hhs_2.html).

[33] 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 opioid treatment program or an office-based opioid 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 opioid treatment program or at an office-based opioid treatment facility. See https://www.hrsa.gov/rural-health/rcorp for more information about the Rural Communities Opioid Response Program.

for free medication-assisted treatment training that can assist them with obtaining the DATA 2000 Waiver. As a result, during the FY 2020 award season, the number of DATA 2000 Waiver-certified clinicians awarded loan repayment funds increased by 63 percent and the number of NHSC members completing the medication-assisted treatment training increased to more than 360 clinicians, about a 220 percent increase from the previous FY (from 113 to 362). Further, the medication-assisted treatment training webpage was viewed more than 19,000 times, an increase of 92 percent, during the FY 2020 promotional campaign as compared to FY 2019 numbers. In FY 2020, NHSC's social media audience grew to more than 58,000 followers, up by almost 2 percent from FY 2019. The FY 2020 efforts also included increased, focused outreach on digital platforms and the development of innovative content.

Additionally, the recruitment campaign for NHSC-approved sites resulted in 1,006 new site applications, an increase of 9 percent over the FY 2019 application cycle's 924 total applications. These new sites are vital to the NHSC's ability to increase distribution of a qualified health workforce and increase access to quality health care across the nation.

The NHSC conducted direct email outreach to potential program participants to announce the opening of the FY 2020 NHSC application cycles via GovDelivery. The current GovDelivery opt-in email lists for NHSC programs include more than 797,000 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 Primary Care Offices. As summarized in the table below, these efforts resulted in more than 2,200 applications to the NHSC Scholarship Program and over 8,600 new applications to the NHSC LRP Programs (including NHSC SUD Workforce LRP and NHSC Rural Community LRP). In early 2020, NHSC also hosted its second-largest Facebook chat to date to answer questions about the three LRPs. More than 1,000 potential applicants, site administrators, and program staff members attended/participated in the Facebook chat. The reach for this event was more than 10,000 individuals.

Table 1: New Applications and Awards, FY 2020

Program	*Applications*	*New Awards*
NHSC SP	2,250	251
NHSC LRPs	8,684	5,963
S2S LRP	199	148

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 2020 saw more than 17 million patients and generated 68 million patient visits. The NHSC estimates that primary care NHSC clinicians saw 7.4 million patients and generated 29.6 million patient visits. Dental health NHSC clinicians saw 2.1 million patients and generated 8.4 million patient visits, and behavioral and mental health NHSC clinicians saw 7.5 million patients and generated 30 million patient visits.

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

The NHSC continues to monitor the retention rates of NHSC scholars and loan 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

The 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 (2,536 of 3,125 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.[34]

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 85 percent of those who fulfilled their service commitments between 2012 and 2019 (of 21,590 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.

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

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). 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 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 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.

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.

The 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. The 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, 2019, through September 30, 2020, 11,558 new vacancies were created and 667 vacancies were filled. As of September 30, 2020, there were 4,560 vacancies listed. The Health Workforce Connector is located at https://connector.hrsa.gov/.

V. Conclusion

The achievements of NHSC in 2020 reflect the increased promotion and outreach of the program and the greater collaboration with partners, which was made possible by the enhanced resources provided to the NHSC. These resources allowed the NHSC to achieve record field strength levels and serve the health care needs of approximately 17 million patients across the United States.

The NHSC will continue its focus on ensuring that NHSC providers are serving in the nation's high-need areas and 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 the NHSC to continue to address the nationwide shortage of health care providers in underserved communities.

One of the critical activities of the NHSC in 2020 was the continued expansion of the NHSC RC LRP and the NHSC SUD Workforce LRP. Funding provided through the FY 2018, 2019, and 2020 appropriations 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 2020 Field Strength

National Health Service Corps – Overall Field Strength (as of 9/30/2020)

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	234	106	13	11	8	0	96	89	145	19	119
AL	116	88	17	2	3	6	0	89	27	69	47
AR	102	87	8	5	0	2	0	42	60	53	49
AS	1	0	0	1	0	0	0	0	1	1	0
AZ	688	417	47	33	26	7	158	468	220	252	278
CA	1,441	995	99	16	85	44	202	1,210	231	953	286
CO	396	223	60	14	6	8	85	287	109	206	105
CT	378	265	91	7	13	2	0	353	25	243	135
DC	199	120	17	0	17	5	40	199	0	120	39
DE	57	19	9	3	4	1	21	40	17	19	17
FL	626	508	78	3	20	17	0	550	76	415	211
GA	333	254	41	15	12	8	3	192	141	177	153
GU	2	2	0	0	0	0	0	0	2	1	1
HI	93	55	10	2	3	1	22	54	39	60	11
IA	176	105	24	12	3	2	30	66	110	88	58
ID	267	178	47	9	4	9	20	147	120	123	124
IL	788	578	86	16	35	13	60	648	140	490	238
IN	249	142	35	6	4	4	58	158	91	139	52
KS	124	72	15	15	3	3	16	37	87	72	36
KY	262	123	37	42	4	4	52	58	204	106	104
LA	246	141	29	8	5	4	59	173	73	113	74
MA	382	157	97	1	10	14	103	359	23	262	17
MD	293	189	58	4	12	6	24	259	34	145	124
ME	108	48	31	12	6	2	9	31	77	70	29
MI	643	307	74	29	12	16	205	332	311	284	154
MN	320	203	60	22	6	10	19	147	173	86	215
MO	676	524	53	19	14	19	47	362	314	286	343
MP	24	11	0	0	0	0	13	13	11	1	10
MS	148	129	4	9	5	1	0	45	103	69	79
MT	204	149	24	13	4	2	12	45	159	79	113
NC	367	244	62	15	23	12	11	170	197	202	154
ND	97	25	15	7	1	0	49	24	73	13	35
NE	111	54	16	6	0	0	35	49	62	48	28
NH	26	12	7	7	0	0	0	10	16	17	9
NJ	84	40	20	0	3	4	17	77	7	62	5
NM	325	211	23	56	11	2	22	145	180	164	139
NV	154	66	28	6	6	1	47	100	54	40	67
NY	1,152	752	227	22	31	25	95	943	209	501	556
OH	394	224	82	27	12	10	39	258	136	291	64
OK	403	307	55	33	5	3	0	147	256	114	289
OR	474	269	103	22	26	20	34	258	216	278	162
PA	333	189	39	9	17	12	67	272	61	206	60
PR	113	71	41	0	0	1	0	103	10	108	5
RI	83	29	28	0	1	4	21	83	0	62	0
SC	208	146	23	16	14	9	0	114	94	171	37
SD	85	63	13	7	0	2	0	16	69	27	58
TN	252	137	6	8	9	7	85	153	99	107	60
TX	363	246	41	8	15	17	36	275	88	239	88
UT	185	103	54	8	7	1	12	110	75	56	117
VA	248	149	22	14	10	6	47	134	114	116	85
VI	6	6	0	0	0	0	0	0	6	6	0
VT	55	7	16	4	0	1	27	18	37	28	0
WA	608	416	68	13	39	23	49	428	180	356	203
WI	287	134	38	13	14	15	73	145	142	149	65
WV	171	113	36	4	4	1	13	92	79	114	44
WY	69	29	13	11	1	2	13	11	58	12	44
Total	**16,229**	**10,237**	**2,240**	**645**	**573**	**388**	**2,146**	**10,588**	**5,641**	**8,488**	**5,595**
Percentage of Total Field Strength		**63.08%**	**13.80%**	**3.97%**	**3.53%**	**2.39%**	**13.22%**	**65.24%**	**34.76%**	**60.27%**	**39.73%**

National Health Service Corps – Primary Care Field Strength (as of 9/30/2020)

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	139	63	7	0	69	50	30	26	5	13	15	55	84	13	57
AL	63	55	2	6	0	22	34	5	2	0	0	47	16	49	14
AR	32	31	0	1	0	9	22	1	0	0	0	12	20	28	4
AS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AZ	377	244	16	4	113	113	173	60	13	0	18	246	131	159	105
CA	738	480	68	29	161	228	274	208	16	0	12	636	102	494	83
CO	149	87	5	6	51	52	38	43	12	0	4	113	36	87	11
CT	79	68	10	1	0	14	45	16	4	0	0	77	2	67	12
DC	104	64	12	4	24	55	33	8	7	1	0	104	0	68	12
DE	30	11	3	1	15	14	12	3	0	0	1	22	8	13	2
FL	364	335	19	10	0	116	183	46	19	0	0	318	46	270	94
GA	196	182	7	4	3	55	118	15	8	0	0	114	82	129	64
GU	1	1	0	0	0	0	0	0	1	0	0	0	1	1	0
HI	42	19	3	0	20	16	20	4	2	0	0	28	14	19	3
IA	58	39	1	0	18	12	37	4	1	0	4	27	31	31	9
ID	89	62	2	7	18	33	23	31	0	1	1	31	58	53	18
IL	407	316	29	11	51	139	174	78	16	0	0	330	77	302	54
IN	97	64	3	2	28	28	57	7	4	1	0	66	31	67	2
KS	52	38	2	0	12	9	27	10	0	6	0	18	34	31	9
KY	109	62	3	2	42	32	60	10	1	1	5	20	89	38	29
LA	101	69	4	3	25	25	70	5	1	0	0	65	36	54	22
MA	154	94	5	5	50	37	89	22	3	0	3	138	16	104	0
MD	94	56	10	6	22	41	31	15	7	0	0	80	14	65	7
ME	24	13	1	1	9	10	9	5	0	0	0	4	20	13	2
MI	288	131	7	9	141	87	110	87	4	0	0	122	166	115	32
MN	58	43	1	6	8	18	21	15	4	0	0	29	29	31	19
MO	284	247	7	8	22	104	155	24	1	0	0	127	157	105	157
MP	15	7	0	0	8	1	2	4	0	2	6	8	7	1	6
MS	90	85	5	0	0	15	71	4	0	0	0	29	61	55	35
MT	73	60	3	1	9	19	26	23	0	5	0	13	60	26	38
NC	183	156	17	10	0	58	67	54	4	0	0	83	100	106	77
ND	44	16	0	0	28	4	19	12	0	6	3	3	41	8	8
NE	53	26	0	0	27	16	14	16	1	0	6	21	32	21	5
NH	5	5	0	0	0	2	2	1	0	0	0	4	1	5	0
NJ	32	16	1	2	13	15	14	2	1	0	0	29	3	19	0
NM	125	106	5	1	13	45	59	16	5	0	0	56	69	62	50
NV	70	31	4	1	34	11	29	23	0	2	5	37	33	25	11
NY	543	435	27	21	60	234	187	94	28	0	0	436	107	294	189
OH	145	111	7	5	22	52	86	5	2	0	0	121	24	101	22
OK	142	138	4	0	0	25	93	18	6	0	0	55	87	74	68
OR	168	106	19	12	31	65	49	51	0	0	3	77	91	107	30
PA	144	96	11	7	30	49	68	24	3	0	0	128	16	96	18
PR	30	29	0	1	0	30	0	0	0	0	0	29	1	29	1
RI	22	11	0	3	8	8	8	2	0	4	0	22	0	14	0
SC	123	105	12	6	0	45	59	19	0	0	0	65	58	110	13
SD	28	28	0	0	0	4	16	7	1	0	0	6	22	16	12
TN	149	71	5	3	70	33	94	17	5	0	0	87	62	58	21
TX	156	133	10	13	0	47	78	27	4	0	0	119	37	129	27
UT	53	42	1	0	10	17	8	28	0	0	0	27	26	22	21
VA	90	61	6	2	21	28	36	19	2	1	4	44	46	59	10
VI	5	5	0	0	0	1	0	3	1	0	0	0	5	5	0
VT	21	0	0	0	21	10	7	4	0	0	0	7	14	0	0
WA	220	143	30	17	30	85	56	62	8	3	6	145	75	146	44
WI	102	40	3	7	52	41	39	18	4	0	0	49	53	43	7
WV	73	60	2	0	11	17	40	15	0	0	1	25	48	48	14
WY	27	13	1	2	11	8	10	8	1	0	0	6	21	7	9
Total	**7,060**	**5,009**	**400**	**240**	**1,411**	**2,304**	**3,082**	**1,324**	**207**	**46**	**97**	**4,560**	**2,500**	**4,092**	**1,557**
Percentage of Primary Care Field Strength		**70.95%**	**5.67%**	**3.40%**	**19.99%**	**32.63%**	**43.65%**	**18.75%**	**2.93%**	**0.65%**	**1.37%**	**64.59%**	**35.41%**	**72.44%**	**27.56%**
Percentage of Total Field Strength		**30.86%**	**2.46%**	**1.48%**	**8.69%**	**14.20%**	**18.99%**	**8.16%**	**1.28%**	**<1%**	**<1%**	**28.10%**	**15.40%**	**29.06%**	**11.06%**

National Health Service Corps – Oral Health Field Strength (as of 9/30/2020)

State	Total	NHSC LRP Total	NHSC SP Total	S2S LRP Total	SLRP Total	DD	RDH	Non-Rural	Rural	BPHC Grantee	Non-BPHC Grantee
AK	23	9	0	0	14	18	5	6	17	2	7
AL	8	7	1	0	0	8	0	6	2	8	0
AR	13	12	0	1	0	11	2	7	6	12	1
AS	0	0	0	0	0	0	0	0	0	0	0
AZ	73	44	8	2	19	68	5	50	23	29	25
CA	260	201	16	14	29	239	21	227	33	191	40
CO	49	37	1	2	9	24	25	38	11	39	1
CT	33	32	0	1	0	18	15	31	2	32	1
DC	29	19	3	0	7	20	9	29	0	18	4
DE	3	0	1	0	2	3	0	3	0	1	0
FL	64	56	1	7	0	52	12	55	9	61	3
GA	28	22	3	3	0	21	7	22	6	20	8
GU	0	0	0	0	0	0	0	0	0	0	0
HI	18	17	0	1	0	14	4	11	7	17	1
IA	31	20	1	2	8	24	7	16	15	23	0
ID	21	17	2	2	0	16	5	9	12	21	0
IL	50	36	4	1	9	44	6	41	9	41	0
IN	30	27	1	2	0	21	9	28	2	29	1
KS	25	18	1	3	3	16	9	11	14	20	2
KY	28	18	0	2	8	21	7	11	17	18	2
LA	25	12	1	1	11	22	3	16	9	13	1
MA	37	11	5	7	14	26	11	35	2	22	1
MD	17	15	2	0	0	11	6	11	6	17	0
ME	14	9	4	1	0	10	4	1	13	11	3
MI	89	68	4	7	10	66	23	55	34	65	14
MN	33	22	4	4	3	19	14	22	11	18	12
MO	103	62	7	11	23	83	20	56	47	76	4
MP	3	3	0	0	0	2	1	0	3	0	3
MS	5	4	0	1	0	3	2	3	2	5	0
MT	16	12	0	1	3	11	5	5	11	9	4
NC	34	27	5	2	0	31	3	16	18	27	7
ND	7	5	1	0	1	6	1	2	5	2	4
NE	19	17	0	0	2	15	4	16	3	16	1
NH	1	1	0	0	0	0	1	0	1	1	0
NJ	16	9	2	1	4	14	2	16	0	12	0
NM	52	41	5	1	5	36	16	27	25	33	14
NV	13	9	2	0	2	10	3	10	3	4	7
NY	114	99	4	3	8	94	20	93	21	91	15
OH	61	40	4	5	12	44	17	43	18	47	2
OK	34	30	1	3	0	26	8	13	21	13	21
OR	57	44	5	8	0	33	24	45	12	47	10
PA	59	34	5	4	16	43	16	47	12	39	4
PR	9	9	0	0	0	9	0	8	1	9	0
RI	17	10	1	1	5	15	2	17	0	12	0
SC	19	14	2	3	0	13	6	15	4	19	0
SD	9	7	0	2	0	7	2	2	7	3	6
TN	24	14	4	2	4	18	6	18	6	14	6
TX	54	45	5	4	0	41	13	35	19	53	1
UT	20	12	6	1	1	19	1	13	7	12	7
VA	34	23	4	4	3	30	4	19	15	31	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	118	98	6	6	8	92	26	87	31	102	8
WI	76	39	9	8	20	61	15	40	36	48	8
WV	14	10	1	1	2	13	1	8	6	11	1
WY	1	1	0	0	0	1	0	0	1	0	1
Total	**1,996**	**1,449**	**142**	**136**	**269**	**1,568**	**428**	**1,395**	**601**	**1,466**	**261**
Percentage of Oral Health Field Strength		**72.60%**	**7.11%**	**6.81%**	**13.48%**	**78.56%**	**21.44%**	**69.89%**	**30.11%**	**84.89%**	**15.11%**
Percentage of Total Field Strength		**8.93%**	**<1%**	**<1%**	**1.66%**	**9.66%**	**2.64%**	**8.60%**	**3.70%**	**10.41%**	**1.85%**

National Health Service Corps – Mental and Behavioral Health Field Strength (as of 9/30/2020)

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	RN MH	PHARM MH	Non-Rural	Rural	BPHC Grantee	Non-BPHC Grantee
AK	72	34	13	11	1	0	13	9	8	0	0	9	28	4	4	0	0	7	1	2	28	44	4	55
AL	45	26	17	2	0	0	0	6	4	0	0	9	8	4	1	0	0	11	0	2	36	9	12	33
AR	57	44	8	5	0	0	0	0	12	0	0	16	28	1	0	0	0	0	0	0	23	34	13	44
AS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0
AZ	238	129	47	33	2	1	26	9	71	5	1	42	58	21	6	1	0	8	3	13	172	66	64	148
CA	443	314	99	16	1	1	12	36	61	16	0	133	4	88	90	1	0	8	4	2	347	96	268	163
CO	198	99	60	14	0	0	25	11	15	9	2	55	65	13	2	1	0	22	3	0	136	62	80	93
CT	266	165	91	7	3	0	0	14	37	2	0	91	55	21	23	0	0	13	10	0	245	21	144	122
DC	66	37	17	0	2	1	9	9	6	2	0	23	19	3	0	0	0	3	1	0	66	0	34	23
DE	24	8	9	3	0	0	4	1	4	1	0	3	4	6	0	0	0	5	0	0	15	9	5	15
FL	198	117	78	3	0	0	0	19	32	4	0	48	38	22	7	0	0	18	6	4	177	21	84	114
GA	109	50	41	15	2	1	0	3	27	2	0	16	34	5	3	0	0	17	2	0	56	53	28	81
GU	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1
HI	33	19	10	2	0	0	2	3	5	1	0	6	1	17	0	0	0	0	0	0	15	18	24	7
IA	87	46	24	12	1	0	4	2	23	3	0	22	18	6	3	0	0	7	1	2	23	64	34	49
ID	157	99	47	9	0	0	2	12	19	10	0	52	33	11	3	1	0	14	1	1	107	50	49	106
IL	331	226	86	16	2	1	0	17	32	7	0	125	100	22	2	1	0	17	5	3	277	54	147	184
IN	122	51	35	6	0	0	30	8	18	1	0	34	29	12	2	3	0	11	1	3	64	58	43	49
KS	47	16	15	15	0	0	1	1	12	3	0	9	5	3	1	0	0	6	2	5	8	39	21	25
KY	125	43	37	42	1	0	2	12	35	0	0	26	33	7	1	0	0	10	0	1	27	98	50	73
LA	120	60	29	8	0	0	23	8	15	0	0	31	52	5	0	0	0	4	2	3	92	28	46	51
MA	191	52	97	1	0	2	39	17	52	5	3	63	14	7	1	3	0	10	16	0	186	5	136	16
MD	182	118	58	4	0	0	2	10	37	1	0	57	36	22	0	0	0	15	4	0	168	14	63	117
ME	70	26	31	12	1	0	0	9	22	5	0	21	7	2	0	0	0	4	0	0	26	44	46	24
MI	266	108	74	29	1	0	54	10	18	8	0	142	26	16	2	0	0	33	4	7	155	111	104	108
MN	229	138	60	22	1	0	8	5	25	10	1	60	45	23	15	1	0	36	5	3	96	133	37	184
MO	289	215	53	19	0	0	2	11	44	3	0	84	103	26	2	1	0	11	4	0	179	110	105	182
MP	6	1	0	0	0	0	5	1	0	0	0	2	2	1	0	0	0	0	0	0	5	1	0	1
MS	53	40	4	9	0	0	0	0	10	1	0	6	31	2	0	0	0	2	1	0	13	40	9	44
MT	115	77	24	13	1	0	0	6	13	4	0	34	35	3	0	0	0	15	1	4	27	88	44	71
NC	150	61	62	15	1	0	11	15	24	10	2	44	24	7	2	0	0	9	7	6	71	79	69	70
ND	46	4	15	7	0	0	20	3	7	1	0	8	4	1	0	1	0	11	7	3	19	27	3	23
NE	39	11	16	6	0	0	6	1	11	2	0	3	11	3	0	0	0	6	1	1	12	27	11	22
NH	20	6	7	7	0	0	0	1	5	4	0	0	5	3	0	0	0	2	0	0	6	14	11	9
NJ	36	15	20	0	0	1	0	4	7	2	0	15	0	3	0	1	0	2	0	2	32	4	31	5
NM	148	64	23	56	1	0	4	10	27	2	0	31	42	4	4	0	1	3	1	23	62	86	69	75
NV	71	26	28	6	0	0	11	0	5	1	0	20	10	4	10	0	0	20	0	1	53	18	11	49
NY	495	218	227	22	0	1	27	35	74	17	0	130	92	37	6	1	0	83	18	2	414	81	116	352
OH	188	73	82	27	1	0	5	7	58	1	0	47	34	4	0	0	0	16	7	14	94	94	143	40
OK	227	139	55	33	0	0	0	12	17	9	1	38	112	1	8	0	0	13	3	13	79	148	27	200
OR	249	119	103	22	2	0	3	13	44	13	4	64	50	7	9	0	0	27	14	4	136	113	124	122
PA	130	59	39	9	1	1	21	7	20	11	0	48	29	6	0	0	0	3	4	2	97	33	71	38
PR	74	33	41	0	0	0	0	3	0	0	0	14	11	24	0	0	0	5	3	14	66	8	70	4
RI	44	8	28	0	0	0	8	4	15	2	0	12	5	2	0	0	0	1	3	0	44	0	36	0
SC	66	27	23	16	0	0	0	2	15	1	0	10	19	6	0	0	0	7	2	4	34	32	42	24
SD	48	28	13	7	0	0	0	0	10	0	0	11	14	2	1	0	0	8	0	2	8	40	8	40
TN	79	52	6	8	0	2	11	4	19	2	0	11	17	10	4	10	0	1	1	0	48	31	35	33
TX	153	68	41	8	0	0	36	6	27	2	0	28	60	13	2	4	0	9	0	2	121	32	57	60
UT	112	49	54	8	0	0	1	5	11	8	0	50	21	6	2	0	0	5	1	3	70	42	22	89
VA	124	65	22	14	0	0	23	4	18	0	0	27	56	8	2	2	0	5	2	0	71	53	26	75
VI	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0
VT	28	6	16	4	0	0	2	4	7	1	0	3	5	0	0	0	0	6	2	0	11	17	26	0
WA	270	175	68	13	3	0	11	22	39	8	1	34	89	26	17	0	0	30	2	2	196	74	108	151
WI	109	55	38	13	2	0	1	6	14	0	0	20	33	13	6	1	0	6	3	7	56	53	58	50
WV	84	43	36	4	1	0	0	7	22	2	0	10	17	19	0	0	0	3	1	3	59	25	55	29
WY	41	15	13	11	0	0	2	1	4	1	0	8	14	4	2	0	0	3	0	4	5	36	5	34
Total	**7,173**	**3,779**	**2,240**	**645**	**31**	**12**	**466**	**425**	**1,157**	**204**	**15**	**1,905**	**1,686**	**586**	**243**	**33**	**1**	**591**	**159**	**168**	**4,633**	**2,540**	**2,930**	**3,777**
Percentage of Mental Health Field Strength		**52.68%**	**31.23%**	**8.99%**	**0.43%**	**0.17%**	**6.50%**	**5.92%**	**16.13%**	**2.84%**	**<1%**	**26.56%**	**23.50%**	**8.17%**	**3.39%**	**<1%**	**<1%**	**8.24%**	**2.22%**	**2.34%**	**64.59%**	**35.41%**	**43.69%**	**56.31%**
Percentage of Total Field Strength		**23.29%**	**13.80%**	**3.97%**	**0.19%**	**0.07%**	**2.87%**	**2.62%**	**7.13%**	**1.26%**	**<1%**	**11.74%**	**10.39%**	**3.61%**	**1.50%**	**<1%**	**<1%**	**3.64%**	**<1%**	**1.04%**	**28.55%**	**15.65%**	**20.81%**	**26.82%**

Acronyms and Abbreviations Used in Appendix A

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
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

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