National Center for Rural Health Works

Economic Loss to Community from Primary Care Practitioner Shortage

Feasibility of Additional Primary Care Practitioners in Noble County, Oklahoma

Noble County has lost several primary care practitioners in the last few years. In order to assist the community in determining the appropriate number of primary care practitioners for Noble County, the need for primary care practitioners will be illustrated. To show the community what it costs economically if the community does not provide necessary primary care locally, the economic impact of the shortage of primary care physicians will be illustrated.

To evaluate a community's ability to support an additional primary care practitioner, the demand for additional practitioners needs to be determined by estimating potential local office visits. The number of total physician office visits is estimated by using specific service area population data in conjunction with data from state and national research.[1,2,3] The medical service area (MSA) must be delineated in order to determine population. The medical service area for this study includes all of Noble County. The latest population estimates by age and gender for Noble County are for the year 2009 and can be obtained from the U. S. Census Bureau website.[4] According to the 2009 Census population estimates, the total population of the Noble County was estimated to be 10,950. **Table 1** presents the estimated populations by age group and gender.

Table 1
Population of Medical Service Area of Noble County, OK

Age	Male	Female	Total
< 15	1,133	1,069	2,202
15-24	696	681	1,377
25-44	1,323	1,216	2,539
45-64	1,531	1,496	3,027
65-74	427	491	918
75+	359	528	887
Total	5,469	5,481	**10,950**

[1] Source: U. S. Census Bureau, 2009 population estimates (www.census.gov [July 2010]).

Table 2 presents these same age groups with their corresponding estimated number of annual office visits by gender. The National Ambulatory Medical Care Survey updates the office visits by age and gender annually with the latest data for 2006 provided in August 2008.[3] For instance, for males under age 15, the average number of annual office visits is 2.6 visits per year. For females age 75 and older, the average number of annual office visits is 7.3 visits per year.

Table 2
Annual Primary Care Physician Office Visits Generated in Noble County, Oklahoma

Male

Age	2009 Population	Visit Rate	Total Visits
< 15	1,133	2.6	2,946
15-24	696	1.1	766
25-44	1,323	1.6	2,117
45-64	1,531	3.0	4,593
65-74	427	5.5	2,349
75+	359	7.1	2,549
Total	5,469		**15,320**

Female

Age	2009 Population	Visit Rate	Total Visits
< 15	1,069	2.6	2,779
15-24	681	2.4	1,634
25-44	1,216	3.0	3,648
45-64	1,496	3.9	5,834
65-74	491	6.0	2,946
75+	528	7.3	3,854
Totals	5,481		**20,695**
Combined Totals	10,950		**36,015**
Total - Primary Care	58.3%		**20,997**

Source: U. S. Census Bureau, 2009 population estimates (www.census.gov [July 2010]); Annual visit rates by gender and age groups, U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center of Health Statistics, "National Ambulatory Medical Care Survey: 2006 Summary," No. 3, August 2008.

Table 2 illustrates the total physician office visits for Noble County, Oklahoma. The average annual visit rates were applied to Noble County data to estimate the number of physician office visits. For example, the 1,133 males under age 15 will generate 2,946 office visits (2.6 x 1,133). The total

annual physician office visits were 15,320 for males and 20,695 for females, for a grand total for Noble County of 36,015. These office visits are for visits to all types of practitioners, both primary and specialty care. To determine the number of office visits to primary care practitioners, the National Ambulatory Medical Care Survey data indicate that 58.3 percent of the total physician office visits are to primary care practitioners. The total office visits to primary care practitioners in Noble County are estimated to be 20,997 visits. These total annual primary care office visits were made to physicians or mid-level practitioners (i.e., physician assistants, nurse midwives, or nurse practitioners) actively providing primary care patient care. The remaining 15,018 annual office visits were made to specialists.

The total number of primary care office visits given various usage rates is presented in **Table 3**. If the residents in Noble County exercised a 75 - 80 percent usage rate of primary care practitioners, the estimated annual primary care office visits would be between 15,748 and 16,798. The national average for the number of annual office visits serviced by each primary care physician is 5,000.[5]

Table 3
Primary Care Physician Office Visits & Shortage for Different Local Usage Levels for Noble County, OK

Usage Level	70%	75%	80%	85%
Office Visits	14,698	15,748	16,798	17,847
No. Needed	2.9	3.1	3.4	3.6
Current No.	2.0	2.0	2.0	2.0
SHORTAGE	0.9	**1.1**	**1.4**	1.6

If 75% to 80% usage in Noble County,
primary care office visits total 15,748 to 16,798.

Based on two current primary care physicians,
SHORTAGE of 1.1 to 1.4 Primary Care Physicians

SOURCE: Current number of primary care physicians from local sources; Average annual number of primary care physician office visits of 5,000, 2001 data, American Medical Association, Center for Health Policy Research, "Physician Socioeconomic Statistics, 2003 Edition."

Therefore, Noble County needs an estimated 3.1 to 3.4 primary care practitioners at the 75 - 80 percent usage rate. Given that Noble County currently has primary care coverage with two full-time primary care physicians, the assumption could be made that Noble County is underserved by 1.1 to 1.4 primary care practitioners. The number of mid-level practitioners should also be included in the number of primary care practitioners providing health care; however, the number of annual office visits provided by mid-level practitioners is typically 50.0 percent of the physician; (5,000 x 50% = 2,500); therefore, mid-level practitioners are calculated as servicing 2,500 office visits annually. Estimates of the usage rates should be used in conjunction with the current number of primary care practitioners in Noble County to determine the next steps for the community.

Utilization rates and office visits per physician might vary slightly with rural primary care practitioners. Research suggests that utilization per person in rural areas might be lower than the national average due to lower patient incomes and lower rates of insurance coverage.[5] Increased patient visits and longer work hours for rural practitioners has also been documented.[6] However, in the absence of specific rural data, national coefficients serve as the best available approximations. Rural medical service areas have a higher proportion of elderly, making age analysis critical for estimating the number of rural visits.

Higher usage levels would indicate that more practitioners could be supported, while lower usage levels would indicate fewer practitioners could be supported. All assumptions and local conditions, including the actual usage levels in the county, must be taken into consideration by decision-makers before determining if additional primary care practitioners could successfully locate in Noble County. Primary care practitioners include family practitioners, internal medicine physicians, OB-GYN, and pediatricians, as well as mid-level practitioners providing primary care health services. All of these types of physicians and mid-level practitioners should be considered when analyzing the primary care medical needs in Noble County.

Economic Contribution of a Rural Primary Care Physician in Oklahoma

Many people have little idea of the economic importance of the health care system to the local community. Primary care physicians are a major part of the health care system. In most rural communities, they are the principal provider of local health care services.

Economically, primary care physicians hire and pay staff to operate a clinic and also contribute to the local hospital through inpatient admissions and outpatient services.[6] A large portion of the revenues generated by a primary care physician practice will be returned to the local community. Local expenditures support jobs, create additional wages and salaries and provide tax revenues that are vital to the local economy. As these dollars continue to be spent in the community, the multiplier effect generated by the physician becomes clear.

Table 4 presents the direct and total impacts of the physician clinic and the business that the typical primary care physician brings to the local hospital. In addition to the physician, new employment opportunities for the physician's medical staff will be created, along with the corresponding wages, salaries, benefits, and proprietor income. A typical primary care physician practice employs a nurse, a medical technician and a receptionist. The clinic generates revenues of $394,275 and wages, salaries, benefits, and proprietor income of $286,925 from the four clinic employees.

Revenues to the hospital from physician activity will also support employment and generate payroll. An additional 12.6 jobs and $434,627 in wages, salaries and benefits will be created at the hospital from patient visits, with total hospital revenues of $751,949.

Average multipliers for six Oklahoma Critical Access Hospital communities were applied to estimate the total impact. This additional impact is the result of the physician office, hospital and the medical staff of both purchasing goods and services from the local community.

Table 4
Economic Impact of Rural Primary Care Physician in Oklahoma

	Direct Impact	Secondary Impact	Total Impact
Revenue			
Clinic	$394,275	$145,882	$540,157
Hospital	$751,949	$240,624	$992,573
TOTAL	**$1,146,224**	**$386,506**	**$1,532,730**
Income [1]			
Clinic	$286,925	$45,908	$332,833
Hospital	$434,627	$121,696	$556,323
TOTAL	**$721,552**	**$167,604**	**$889,156**
Employment			
Clinic	4	1.5	5.5
Hospital	12.6	4.8	17.4
TOTAL	**16.6**	**6.3**	**22.9**

SOURCE: "The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-Migrating Health Care Services," National Center for Rural Health Works, January 2007 (www.ruralhealthworks.org [July 2010]).
[1] Income includes wages, salaries, and benefits, and proprietor income.

This clearly documents the importance of a rural physician. One primary care physician generates approximately $1.5 million in revenue, $0.9 million in income (wages, salaries, benefits, and proprietor income) and creates 23 jobs in both the physician clinic and the hospital. This assessment underestimates the total value of a rural primary care physician, as their impact on other sectors such as pharmacy and nursing homes is not included. Thus, the physician's *economic* contributions are as important to a community as their medical contributions. As our nation faces a growing physician shortage, it is absolutely critical that rural leadership across the United States understands that rural communities are at risk of losing much more than the opportunity to receive local medical care.

Economic Impact of Shortage of Primary Care Physicians in Noble County, Oklahoma

A primary care physician (PCP) shortage exists in many rural areas. Frequently, this local shortage occurs even when the statewide averages do not suggest this. Too often, the statewide distribution of PCPs is the real issue. Obviously, this local shortage is made worse when there is a statewide shortage. In addition to the impact on the health status of the local population, a shortage of health professionals can significantly impact the local economic activity.[6] A PCP shortage in a community leads to residents purchasing their primary care health services in nearby communities. In addition, out-of-town trips to obtain health care naturally offer opportunities to spend dollars out-of-town that may have been spent locally. With this out-migration of health services, businesses and the overall local economy lose these primary care dollars.

To assume that a community can expect to capture all of the PCP visits is unrealistic due to personal preferences and available alternatives, but the goal should be to capture as much of this activity as possible. Local decision makers and health care providers should be involved in determining the usage rate appropriate for the service area.

An additional PCP and/or part-time PCP would increase the number of local visits and recapture the dollars leaving the area. Noble County would require an additional 1.1 to 1.4 full-time equivalent PCPs to achieve a target rate of 75 - 80 percent of total patient visits from the community; therefore, the impact of one additional PCP and the impact of 1.25 additional PCPs will be illustrated.

The addition of one PCP will be the same as **Table 4** above. One additional PCP will generate $1.1 million in direct revenue from the clinic and the hospital, for a total revenue impact of $1.5 million throughout the economy of Noble County. The recaptured activity will generate a total impact of 22.9 jobs and $889,156 in income including the PCP net earnings and medical staff wages, salaries and benefits at both the clinic and hospital.

The second illustration shows the impact of 1.25 additional PCPs in **Table 5**. The results presented show that the addition of even a part-time PCP can have a significant impact on the economy of a rural community. For many rural communities, this impact will make a noticeable difference through increased services and the opportunity to keep their hospital from closing. The addition of 1.25 PCPs results in total revenue impact of $1.9 million, total income impact of $1.1 million, and total employment impact of 28.7.

Table 5
Impact of 1.25 FTE Primary Care Physician in Noble County, Oklahoma

	Direct Impact	Secondary Impact	Total Impact
Revenue			
Clinic	$492,844	$182,352	$675,196
Hospital	$939,936	$300,780	$1,240,716
TOTAL	**$1,432,780**	**$483,132**	**$1,915,912**
Income [1]			
Clinic	$358,656	$57,385	$416,041
Hospital	$543,284	$152,120	$695,404
TOTAL	**$901,940**	**$209,505**	**$1,111,445**
Employment			
Clinic	5	1.9	6.9
Hospital	15.8	6.0	21.8
TOTAL	**20.8**	**7.9**	**28.7**

SOURCE: "The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-Migrating Health Care Services," National Center for Rural Health Works, January 2007 (www.ruralhealthworks.org [July 2010]).

[1] Income includes wages, salaries, and benefits, and proprietor income.

The lost income from a PCP shortage has a negative impact on potential sales tax collections which affects a community's ability to fund other important services. All recaptured dollars can be regarded as new revenue that comes into the community. New revenues stimulate growth and economic development and are further amplified by the multiplier effect that comes with them. Local decision makers should exercise caution when estimating local spending, particularly when utilizing national coefficients. Spending patterns and income levels vary across regions and from state to state.

In addition to the impact on health status, a PCP shortage has a dramatic economic effect on a community by reducing employment and income in other sectors. These impacts should be considered when assessing local health services.

Recruitment and Retention of Primary Care Physicians

Communities who desire to recruit a primary care physician have often taken a very proactive role to assist with this initial cash flow problem. Many communities assist new physicians by providing cash incentives to assist with covering these initial losses.[7] Typically, the community will require that the physician remain in the community for a specific number of years in order to receive the community assistance. The cash incentive can be provided by the local hospital, by other local health care providers, by local businesses or industries, by local civic groups, through local fundraisers, through grants or loans, through local Chambers of Commerce support, etc. Local community support groups have been formed to determine the best possible options for their specific community needs. A new physician can lower expenses by joining a physician practice or group and these local health care practitioners will often supplement the new physician temporarily until the practice is established and generating adequate revenues.

With the current shortage of primary care physicians in rural areas and with the impending ever-increasing shortage of primary care physicians for the future, rural communities are wise to be proactive and creative in their recruitment and retention of primary care physicians.[8] Since primary care practitioner shortages have reduced access to care for the rural areas which lead to poorer health outcomes, medical schools and state and federal agencies and programs are rising to the challenge by initiating incentive programs aimed at reducing these shortages.

Medical schools increasingly are placing students in rural rotations in an effort to introduce them to the rural practice experience. Several determinants have been identified that assist in predicting the successful placement of a graduate family practitioner in a rural area. These include: being selected for a rural preceptorship, growing up in a rural area, and attending college in a rural area. Programs are in place to increase the number of family practitioners in rural areas through grow-your-own initiatives where the brightest students with potential for medical school are fostered by rural communities throughout their studies. Then in return for the financial support and assistance, the resulting medical graduates repay the community through their service.[9] Along with these, Rabinowitz et al. identified a strong correlation between the background and early career plans that medical students had upon entering medical school and future rural primary care practice and retention.[10]

Interviews with primary care practitioners and health care administrators were conducted in six rural areas in California which culminated in an issue brief produced by the California Policy Research Center.[11] Their findings outlined some location considerations that primary care practitioners made. The interviewees considered:

- the financial solvency of clinics and group practices they might join,
- the competency of administrators and boards of directors,
- the presence of other primary care practitioners,
- the proximity to hospitals, and
- the relationships already established with specialists at regional referral centers.

Along with these location considerations, the interviewees found government programs such as the National Health Service Corps (NHSC) and NHSC/State Loan Repayment programs, Federally Qualified Health Center (FQHC), and Rural Health Clinic designations were needed to assist with recruitment in rural areas because of insufficient financial resources available from private firms.

Valid recommendations were also made by the surveyed group to the State of California to provide the following:

- expand the loan repayment program,
- provide placement services, leadership training and assistance with recruitment and retention strategies,
- encourage academic health centers to define areas in which clinical, educational and research partnerships would be conducted,
- develop undergraduate programs that are focused on preparing for rural, underserved-area practice,
- continue to maintain cost-based reimbursements where applicable, and
- encourage telemedicine initiatives through a technical service fee to reimburse rural

health care facilities for using new technologies and to encourage ISDN telephone lines usage for consultations with specialists at remote sites.

In Iowa, the Primary Care Recruitment and Retention Endeavor (PRIMECARRE)[12] was established in 1994 to address efforts there. PRIMECARRE currently supports the Iowa Loan Repayment Program with stipulations such as:

1) the program includes two-year grants for use in repayment of educational loans,

2) the loan program requires a two-year practice commitment in a public or non-profit hospital or clinic located in a health professional shortage area (HPSA),

3) the program provides up to $30,000 annually for primary care physicians, psychiatrists, and clinical psychologists; up to $20,000 annually for dentists, and up to $15,000 annually for physician assistants, registered nurse practitioners, certified nurse midwives, dental hygienists, clinical social workers, and psychiatric nurse specialists.

In summary, increasing demand for rural primary care physicians in the United States is a critical issue. Medical schools and their accreditation partners are placing emphasis on solutions to the shortage through increasing family practice graduates. State and federal government programs are striving to assist. And, rural communities are instituting other initiatives in an effort to preserve rural health care services for their residents.

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APPENDIX A
Rural Health Clinics and Federally Qualified Health Clinics: A Brief Overview

The **Rural Health Clinics (RHCs)** program is intended to increase primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, private, or non-profit. The main advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, underserved areas and must use midlevel practitioners.
A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.

RHCs receive special Medicare and Medicaid reimbursement. Medicare visits are reimbursed based on allowable costs and Medicaid visits are reimbursed under the cost-based method or an alternative Prospective Payment System (PPS). Ordinarily, this will result in an increase in reimbursement. RHCs may see improved patient flow through the utilization of NPs, PAs and CNMs, as well as more efficient clinic operations.

A **Federally Qualified Health Center (FQHC)** is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHC's are also referred to as Community Health Centers (CHCs). An FQHC Look-Alike is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding. Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations. Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs.
There are location requirements for FQHCs. Each FQHC that receives PHS 330 grant funding must meet the requirements of that grant. Community Health Centers must serve a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). To determine if your area qualifies, you can search the MUA/MUP database. If an area does not have the MUA/MUP designation they can apply for it and can put in an application for a PHS Section 330 grant while the designation is being processed. For additional information regarding the MUA/MUP designation, contact the Shortage Designation Branch**:** sdb@hrsa.gov or 1-888-275-4772. Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care Programs do not need to meet the MUA/MUP restriction. FQHCs may be located in rural and urban areas.

FQHCs must provide primary care services for all age groups. FQHCs must provide preventive health services on site or by arrangement with another provider. Other requirements that must be provided directly by an FQHC or by arrangement with another provider include: dental services, mental health and substance abuse services, transportation services necessary for adequate patient care, hospital and specialty care.

SOURCE: Rural Assistance Center, Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (www.raconline.org).

Information provided by National Center for Rural Health Works, Oklahoma State University, Oklahoma Cooperative Extension Service, 405-744-6083. www.ruralhealthworks.org. May 2009.

APPENDIX B
National Health Service Corps: A Brief Overview

National Health Service Corps (NHSC) is committed to improving the health of the Nation's underserved, one community at a time. NHSC brings together communities in need with caring health professionals and supports their efforts to build better systems of care.

NHSC is a network of 7,000 primary health care professionals and 10,000 sites as of September 30, 2009, working in underserved communities across the country. To support their service, the NHSC provides clinicians with financial support in the form of loan repayment and scholarships.

NHSC members are required to practice full-time for at least two years in a NHSC-approved site. Approved sites are located across the country in Health Professional Shortage Areas (HPSAs). Corps members are required to engage in full-time clinical practice of the profession for which they were awarded a NHSC loan repayment award, at their approved site. Corps members may receive up to $145,000 in loan repayment for completing a five-year service commitment. The program starts with an initial award of $50,000 for two years of service.

Many types of health care facilities are NHSC-approved sites. About half of Corps members serve in federally-supported health centers. Other approved sites are described below.

Clinicians in NHSC practice where they are needed most. The communities NHSC serves are as widespread and varied as the landscape of our Nation. NHSC can be found in inner cities, farm towns, mountain villages, and migrant communities. NHSC recruits health professionals committed to serving underserved populations, wherever they are.

NHSC-Approved Sites

NHSC can make your community in a Health Professional Shortage Area (HPSA) healthier by helping you recruit and retain qualified health care clinicians who care about underserved people and choose to work where they are needed most. Federally qualified health centers, rural health clinics, and other sites that care for low-income and uninsured people can become NHSC-approved sites where dentists, dental hygienists, primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, and mental health professionals who are eligible for loan repayment funding or have received scholarships can fulfill their service obligation.

Eligibility to become NHSC-Approved Site

To become an NHSC-Approved Site, the following criteria must be met:

- ✓ Located in a HPSA
- ✓ Provides services on a discount fee schedule
- ✓ Accepts patients covered by Medicare, Medicaid, and the Children's Health Insurance Program
- ✓ Can document sound fiscal management
- ✓ Has capacity to maintain a competitive salary, benefits, and malpractice coverage package for clinicians
- ✓ Could be any of the following:
  - Federally Qualified Health Center
  - Center or Look-Alike Certified Rural Health Clinic
  - Indian Health Service Site (Federal or Tribal)
  - Solo or Group Partnership or Practice
  - Hospital-Affiliated Primary Care Practice
  - Managed Care Network
  - State or Federal Prison
  - U.S. Immigration, Customs and Enforcement Site
  - Public Health Department

Benefits of Becoming NHSC-Approved Site

- ➢ List clinician vacancies on NHSC Job Opportunities
- ➢ Recruit clinicians dedicated to working where they are needed most
- ➢ Recruit students and residents
- ➢ Develop linkages with academic institutions and other organizations
- ➢ Receive community and site development assistance
- ➢ Network with other NHSC sites
- ➢ Maximize revenue from Federal programs such as the Rural Health Clinic and Federally Qualified Health Center programs

- Identify ways to support uncompensated care through other grant programs (State and/or Federal) to ensure that your site remains fiscally sound
- Establish an integrated system of care that includes the uninsured and underinsured

NHSC Scholarship Program

NHSC scholarships pay tuition, required fees, and some other education costs, tax free, for as many as four years. Education costs may include books, clinical supplies, laboratory expenses, instruments, two sets of uniforms and travel for one clinical rotation. Recipients also receive a monthly living stipend ($1,289 in 2010-2011). The stipend is taxable.

Who is Eligible?

- ✓ U.S. Citizen or national
- ✓ Enrolled or accepted for enrollment
- ✓ Pursuing an eligible degree in an accredited program located in the U.S. (joint programs that provide dual degrees are not eligible):
  - Physician: MD or DO
  - Dentist: DDS or DMD
  - Family Nurse Practitioner: master's degree or post-master's certificate
  - Certified Nurse-Midwife: master's degree or post-master's certificate
  - Physician Assistant: associate, bachelor's or master's degree

What is the Service Commitment?

NHSC scholars are committed to serve one year for each year of support (minimum of two years service) at an approved site in a high-need Health Professional Shortage Area soon after they graduate, serve a primary care residency (family medicine, general pediatrics, general internal medicine, obstetrics/gynecology or psychiatry for physicians and general or pediatric for dentists) and are licensed. Scholars compete for employment at the approved service sites of their choice from a listing of job vacancies in their discipline and specialty. The NHSC helps scholars select a compatible service site and pays for travel to and from interviews.

Where do Scholars Serve?

Many types of health care facilities are approved NHSC sites. About half of NHSC scholars fulfill their service commitment at Federally-supported health centers. Health center clinicians can be granted medical malpractice liability protection through the Federal Tort Claims Act. Other types of NHSC approved sites are discussed in detail in the above section "Eligibility to Become a NHSC-Approved Site."

Scholars negotiate their salaries with the employing site, but the NHSC requires that they be paid at least as much as they would in an equivalent Federal civil service position. A few scholars serve in an established private practice in a high-need Health Professional Shortage Area. These arrangements must be approved by the NHSC and scholars working in them are not protected by the NHSC minimum salary requirement.

All NHSC approved sites accept Medicare, Medicaid and provide services on a sliding fee scale or other method that enables poor and uninsured patients to receive care whether or not they are insured or able to pay.

Sites that have applied to and been approved by the NHSC post vacancies on NHSC Job Opportunities. Sites that list vacancies for scholars must be located in the neediest Health Professional Shortage Areas (this year, a HPSA score of 17 or higher, depending on discipline and specialty).

Scholars fulfill their service commitments by providing full time clinical care (at least 40 hours each week), with at least 32 of those hours in the ambulatory care setting. (Except obstetricians/gynecologists, certified nurse-midwives, and family practitioners who practice obstetrics on a regular basis, who must work in outpatient clinical practice at least 21 hours per week with delivery and other clinical hospital-based duties making up the remaining 19 hours).

Ambassadors

Ambassadors help recruit students and clinicians to the NHSC. Ambassadors serve as a catalyst to motivate students and clinicians to provide primary health care in underserved communities across the country where many Americans lack adequate access to care.

If you are a faculty member or a health care professional interested in educating students and

clinicians about the benefits of the NHSC and the rewards that come with providing services to those most in need, become an NHSC ambassador.

If you are interested in knowing more about being a NHSC ambassador or would like an ambassador to speak at an event please send a message to nhscAmbassador@hrsa.gov and a NHSC representative will contact you.

For more information on how you can get involved, call the NHSC toll-free help line or visit the NHSC website.

National Health Service Corps
Toll-Free Help Line:
1-800-221-9393
http://www.nhsc.hrsa.gov/

SOURCE: The National Health Service Corps, U. S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) (http://www.nhsc.hrsa.gov/ [September 2010]).

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