Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONAL HEALTH SERVICE CORPS: A SURVEY OF PROVIDERS, FACILITIES, AND STAFF

JUNE GIBBS BROWN
Inspector General

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EXECUTIVE SUMMARY

PURPOSE

This inspection assesses the impact of the National Health Service Corps' policies, practices, and requirements on health care providers and the facilities where they serve.

BACKGROUND

After years of sharp budget reductions, Congress and the Department of Health and Human Services have initiated a revitalization of the National Health Service Corps program (hereafter referred to as "the Corps"). As part of this revitalization, the Office of the Secretary asked the Office of Inspector General (OIG) to provide information on Public Health Service (PHS) and Corps policies and how they affect health care providers, such as physicians, nurse practitioners, and dentists, and the facilities where they serve. In addition, the Assistant Secretary for Legislation, the Assistant Secretary for Planning and Evaluation, and the Assistant Secretary for Management and Budget requested that the OIG provide information on the Corps' ability to expand in the future.

The Corps is a Federal program designed to reduce or eliminate health professional shortages in local communities. Congress created the Corps in 1970 to "improve the delivery of health services to communities where health personnel and services are inadequate to meet the health needs of the residents of such communities and areas." The Corps grew rapidly until budget constraints and predictions of physician surpluses led to reductions during the 1980s. As a result, the number of newly awarded scholarships declined from a high of 2,380 single-year awards in 1979 to 40 multi-year awards in 1988.

Despite the continued prediction of a national physician oversupply, there is a shortage of primary care providers. Approximately 22 million Americans lack adequate access to medical care, and millions more lack adequate access to dental and/or mental health care. Physician availability in counties with small populations is less than a third of the national average. Inner cities face similar problems. Drug abuse and the AIDS epidemic have made practicing medicine more dangerous and have driven providers into safer neighborhoods.

Congress took two major actions to address these ongoing problems. In 1987, it established the loan repayment program to attract providers who could serve immediately in medically needy areas. Then in 1990, it enacted the Revitalization Amendments which increased the Corps' appropriation from $51 million to $91 million. Since then, expansion has continued. According to PHS, the Corps will offer approximately 400 scholarships and 600 loan repayments in 1994, as contrasted to 49 and 112 in 1989.

We conducted telephone and in-person interviews with a national random sample of 302 providers from 13 strata. We asked them about recruitment, matching to a facility, retention, defaulting, communication with PHS, and suggestions for improvement. We also conducted telephone and in-person interviews with a random sample of 30 directors from facilities where a Corps provider has served during the last 7 years. In addition to the provider and facility director interviews, we conducted interviews with PHS central and regional office staff. We asked the staff to address specific comments, concerns, and problems that were reported by providers and facility directors, as well as recent efforts to revitalize the Corps, the Corps' expansion strategy, and its ability to expand in the future.

FINDINGS

Health facilities depend on the Corps for quality providers

Ninety percent of facility directors believe that their facilities could not adequately serve patients without Corps providers.

According to providers, directors, and PHS staff, more frequent and better communication is essential for Corps morale and expansion

The PHS officials do not routinely initiate contact, and providers and facilities do not know whom to call with questions or concerns. Both PHS and related agencies do not provide enough outreach and technical assistance to existing and potential facilities.

Providers and directors are dissatisfied with the matching process

Providers believe PHS gave them inadequate information and assistance before and during the matching process. In addition, the vacancy lists do not contain complete and current information.

Although many factors affect retention, facilities and PHS play key roles

More than one-third of scholars and loan repayers stay at Corps facilities more than a year after their obligation has ended. Crucial factors affecting retention include facilities' treatment of providers, family concerns, financial incentives, and professional support.

PHS policies are not flexible enough to address providers' needs and preferences

More than 50 percent of providers cited problems with inflexible Corps policies and/or suggested that PHS policies should be more flexible.

Competition, availability, and site limitations may hinder the expansion of the loan repayment program

Three factors limit the number of people who enter the loan repayment program:

(1) the small number of primary care providers overall, (2) competition from group practices and managed care organizations, and (3) the limited number of attractive, available sites approved for loan repayers.

Nurse practitioners, physician assistants, and certified nurse midwives frequently face practice barriers

Almost three-fourths of nurse practitioners, physician assistants, and certified nurse midwives reported facing barriers to providing medical care.

The check disbursement process could be improved

More than one-third of loan repayers and a few scholars described problems related to their financial disbursements from PHS.

RECOMMENDATIONS

PHS should improve its communication with and support for providers and facilities

Good communication, adequate support, and outreach are essential to maintain and increase provider morale and satisfaction.

PHS should consider more flexible matching and practice policies

Increased flexibility would improve retention and provide better solutions to the shortage of health care providers.

PHS should develop more accurate, complete, and up-to-date vacancy lists

Insufficient, inaccurate, and outdated information hamper the matching process.

PHS should use direct deposit to pay providers

Loan repayers and scholars have difficulties receiving their checks on time and at the correct address.

AGENCY COMMENTS AND OIG RESPONSE

In written comments on the draft report, PHS concurred fully or in part with all of the report's recommendations and described the actions they already have taken or plan to take. The full text of PHS' comments appears in Appendix B. In response to PHS' comments, we have made some technical corrections. We recognize and support the numerous improvements that PHS has made and plans to make to improve communication and support, flexibility, vacancy list accuracy, and monetary disbursement.

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INTRODUCTION

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BACKGROUND

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History

The National Health Service Corps is a Federal program designed to reduce or eliminate health professional shortages in local communities. Congress created the Corps in 1970 by enacting the Emergency Health Personnel Act. This legislation enabled PHS to send volunteers and Federal health care providers to "improve the delivery of health services to communities where health personnel and services are inadequate to meet the health needs of the residents of such communities and areas." In 1972, Congress established a scholarship program that allowed PHS to offer scholarships to medical students in exchange for service in the Corps.

The Corps grew rapidly until budget constraints and predictions of physician surpluses led to reductions during the 1980s. As a result, the number of newly awarded scholarships declined from a high of 2,380 single-year awards in 1979 to 40 multi-year awards in 1988.

Millions of Americans Lack Adequate Access to Health Care

Despite the continued prediction of a national physician oversupply, PHS estimates that approximately 22 million Americans lack adequate access to medical care, and millions more lack adequate access to dental and/or mental health care. Physician availability in counties with small populations is less than a third of the national average. Inner cities face similar problems with physician access. Drug abuse and the AIDS epidemic have made practicing medicine more dangerous and have driven providers into safer neighborhoods.

A major factor in this shortage is the lack of "primary care" providers.[1] Primary care providers, in contrast to non-primary care specialists, provide a broad range of services to meet patients' health needs. In an area with few health care professionals, a primary care provider may serve all of the public's health care needs. Although the total number of physicians has grown over the past several decades, the percentage who are primary care physicians has declined.

Responding to the Primary Care Shortage

During the late 1980s and early 1990s, Congress took several steps to respond to the shortage of primary care providers. Specifically, Congress:

- established a loan repayment program in 1987 to complement the Corps' scholarship program by attracting health care providers who could serve immediately in medically needy areas and

- enacted the National Health Service Corps Revitalization Amendments of 1990 which almost doubled the Corps' appropriation from $51 million to $91 million.

Since then, expansion has continued. According to PHS officials, the Corps will offer approximately 400 scholarships and 600 loan repayments in 1994, as contrasted to 49 and 112 in 1989.

Program Oversight

Depending on the region and State, a number of agencies are responsible for overseeing, assisting, and supporting Corps providers and facilities. Within PHS, the Division of National Health Service Corps and regional offices oversee most aspects of the program. The Division of Scholarships and Loan Repayments, Division of Shortage Designation, and Division of Fiscal Services also oversee and administer the program at the central office level. At the regional, State, and local levels, PHS has cooperative agreements with all 50 States and works with numerous primary care associations to help administer the program. While their duties vary by region and State, these agencies generally help facilities apply for Corps providers, help recruit and retain providers, and provide continuing assistance. They also help providers obtain further training and education and establish linkages with other health professionals.

HOW THE NATIONAL HEALTH SERVICE CORPS WORKS

The PHS helps match Corps providers to needy facilities in both rural and urban areas. All providers must serve 1 year for each year they receive Corps support, with a

[1] The Corps' list of primary care fields includes family practice, osteopathic general practice, pediatrics, internal medicine, general psychiatry, obstetrics/gynecology, dental general practice, nurse practitioner practice, physician assistant practice, and certified nurse midwifery.

minimum 2-year commitment. Scholarship and loan repayment applicants experience different application and site matching processes. Facilities undergo a separate application process and are responsible for encouraging providers to remain in the community after they complete their obligations.

How do providers enter the Corps?

Students planning to enter primary care fields may compete to receive scholarships to pay for their training. Students apply to PHS' Division of Scholarships and Loan Repayments which scores each application. The PHS central and regional offices interview applicants who receive high scores to ensure that they are aware of the program's requirements and the unique demands of serving a medically needy population. The PHS scores all interviews and awards scholarships based on the combined score of the written application and interview.

Loan repayment applicants enter the program when they finish their training and are ready to start working. For the most part, providers either (1) obtain a list of eligible facilities and complete the paperwork upon reaching an agreement to work for a facility or (2) apply for and receive loan repayment through eligible facilities that use the Corps' loan repayment program as part of a benefit package. In general, applicants automatically receive loan repayment as long as they are qualified, licensed to practice in that State, and match to an eligible facility. In addition to receiving salaries from facilities, loan repayers receive lump-sum or quarterly checks from PHS to repay their loans. Loan repayers are eligible to receive up to $35,000 per year.

How do facilities apply for providers, and how does PHS rank their need for assistance?

Individual facilities submit applications for providers to PHS. To be eligible for assistance, the facility must be located in a federally-designated "Health Professional Shortage Area" (HPSA). The criteria that PHS uses to designate HPSAs include (1) the ratio of providers to area residents, (2) low birthweight, infant mortality, and poverty rates, and (3) access to primary care services, taking into account the distance to such services. Sites must be in the neediest HPSAs to be eligible for Corps assistance. The PHS scores applications from facilities located within these high need areas and places them on one of three vacancy lists:

- *Health Professional Shortage Area Placement Opportunity List (HPOL):* Scholarship recipients must fulfill their obligation at these facilities which are located in communities with the greatest need for providers. The PHS develops separate HPOLs for each medical specialty. The number of facilities on each HPOL is set by law--three facilities per available scholarship recipient--in order to ensure that the neediest communities have a good chance to obtain a provider. For example, if 16 family practitioners were available for placement, their HPOL would consist of the 48 facilities that have the greatest need for family practitioners.

Although the three-to-one ratio was designed to ensure that providers were offered an adequate selection of sites, the small number of available scholarships limited their options. In response, PHS recently began using a questionnaire to assess providers' interests, spouses' needs, and geographic preferences to add facilities to the HPOL if a provider's placement there would result in a long-term solution to a community's primary care shortage.

- *Loan Repayment Vacancy List:* These facilities generally have less critical need for providers than facilities on the HPOL. This list offers loan repayers more options in matching to a facility than the HPOL.

- *Volunteer Vacancy List:* Many sites meet the minimum criteria for Corps assistance but are not as needy as the sites on the HPOL or loan repayment list. The PHS makes a list of these sites available to providers who do not receive scholarships or loan repayment but wish to serve in a needy community.

How do providers get assigned to facilities?

When scholarship recipients complete medical school and their residency, they must begin serving their obligation. The first step is "matching" to--or reaching an agreement to work for--an eligible site. The PHS provides scholarship recipients with the appropriate HPOL for their medical specialty. Providers can attempt to get hired by any facility on that list. The PHS may assign providers to facilities if they have not matched themselves after 9 months.

Loan repayers have more options than scholarship recipients during the matching process. The PHS provides copies of the HPOL and loan repayment vacancy lists to providers interested in receiving loan repayment. Upon matching to an eligible facility, the provider or facility submits the paperwork for loan repayment.

What are the requirements for providers who are serving their obligations?

Providers must meet certain requirements while serving at facilities. The PHS requires that providers are licensed in their assigned States and that they engage in "full-time" medical practice, defined as 40 hours per week. At least 32 hours per week (21 hours for obstetricians) must be spent providing clinical services at the facility.

In addition, providers must meet all normal State requirements regarding their practice. This is particularly an issue for nurse practitioners, physician assistants, and certified nurse midwives, whose ability to practice independently and write prescriptions depends on State law.

What happens to providers who experience problems while serving their obligations?

A difficult placement, poor relationship with the facility management, or any number of other professional or personal problems may pose barriers to providers completing their

obligations. The PHS conducts orientation sessions and makes efforts to familiarize providers with the staff they should contact if they have problems. The PHS is supposed to provide support and mediate disputes between providers and facilities. If the problems persist, however, providers may request transfers or subsequently default on their obligations. Generally, providers must serve at least 1 year at a facility before they are eligible for a transfer. Providers who fail to meet any of the Corps' requirements are placed into default status. The PHS imposes severe penalties to discourage providers from defaulting.

What happens after providers complete their obligations?

The PHS encourages facilities to develop effective plans to retain providers who are completing their obligation in order to eliminate health provider shortages permanently. Although the facility is primarily responsible for designing the retention package, PHS may offer assistance and guidance to the provider and/or facility.

METHODOLOGY

We interviewed a national random sample of 302 Corps providers drawn from a universe of 1,856. We selected providers from 13 strata. The strata were based on type of assistance, year, and timing in the program. We included special strata for (1) nurse practitioners, physician assistants, certified nurse midwives and (2) obstetrician/gynecologists. During telephone and in-person interviews during the Fall of 1992, we asked providers about recruitment, matching to a facility, retention, defaulting, communication with PHS, and suggestions for improvement. For a more detailed description of the sample selection methodology, please refer to the appendix.

We also conducted telephone and in-person interviews with a simple, random sample of 30 directors from the 2,284 facilities where a Corps provider has served during the last 7 years. We asked the directors about (1) the matching process, (2) recruitment and retention, and (3) the Corps' policies, staff, and providers.

In addition to the provider and facility director interviews, we conducted interviews with PHS central and regional office staff. We asked the staff to address specific comments, concerns, and problems that were reported by the providers and facility directors, as well as recent efforts to revitalize the Corps, the Corps' expansion strategy, and its ability to expand in the future.

FINDINGS

HEALTH FACILITIES DEPEND ON THE CORPS FOR QUALITY PROVIDERS

Ninety percent of facility directors,[2] hereafter called "directors," believe that their facilities could not adequately serve patients without Corps providers. Both directors and providers believe that the Corps' presence has led to new or expanded services, greater access to care, and improved financial stability.

Directors praise the overall quality of the providers. They are impressed with providers' technical expertise and personal commitment. Many of them believe that without the Corps they would not be able to attract the same quality of providers. Eighty percent of directors say they need at least one more provider to offer adequate health care in their communities. Because of their locations and inability to offer competitive salaries, two-thirds of directors believe they will always need the Corps to recruit providers for their communities.

However, approximately half of the loan repayers said they would have worked at the facility even if they had not received loan repayment. Most of these providers said they do not plan to stay at the facility just because the Corps repaid their loans.

ACCORDING TO PROVIDERS, DIRECTORS, AND PHS STAFF, MORE FREQUENT AND BETTER COMMUNICATION IS ESSENTIAL FOR CORPS MORALE AND EXPANSION

Early and continuing contact educates providers and facilities about procedures, agency responsibilities, and available assistance. Furthermore, communication helps avoid and mitigate problems among providers, facilities, and Federal officers. Poor communication can lead providers to default, request transfers, leave after their obligation, and/or discourage others from joining the Corps.

Providers and directors offered comments about the lack of regular contact, a specific contact person, outreach, technical assistance, and responsiveness of PHS. More than 35 percent of providers who call PHS with questions or concerns claim that PHS staff are not responsive to their needs. Providers described receiving inconsistent interpretations of policies and inadequate follow-up when they raised questions about problems they were having in their assigned facilities.

[2] We included the confidence intervals for all percentages in this report in the appendix.

PHS officials do not routinely initiate contact, and providers and facilities do not know whom to call with questions or concerns

According to providers, PHS regional and central office staff did not routinely contact them. More than one-quarter of all providers recalled no contact with PHS. Fifty-six percent of scholars and 42 percent of loan repayers placed in 1991 believe PHS does not contact them often enough.

Providers and directors often do not know whom to contact when they have questions or concerns. Depending on the question, they may have to contact the regional office, the primary care association, the State agency, or one of several divisions in the central office. In addition, the responsibilities of many offices and agencies vary by region and type of facility. Providers would prefer to have a single person to contact when they have questions.

PHS and related agencies do not provide enough outreach and technical assistance to existing and potential facilities

Although PHS officials acknowledge the importance of site development and recognize the need to work with facilities to ensure that providers receive adequate professional and financial support, site development has not been a PHS priority in recent years. As a result, many directors do not understand the roles and responsibilities of PHS and related agencies. Furthermore, many new directors did not know about the Corps' existence or were unaware that the Corps is expanding. The lack of knowledge is especially evident in facilities that do not receive Federal funds, facilities with high administrative turnover, and/or small rural facilities.

Directors commented on the need for outreach and clearly defined roles among PHS and related agencies. Directors rarely receive technical assistance from PHS, primary care associations, or State agencies. Twenty-five percent of directors did not know that PHS provides technical assistance, and 30 percent of directors recalled being offered technical assistance by regional offices. Some directors were not aware that primary care associations and State agencies help administer the Corps. Thirty percent of directors had no interaction with primary care associations and State agencies.

Directors want more on-going technical assistance in areas ranging from the application to provider retention. For example, approximately 50 percent of directors believe that the application process is burdensome. Lacking technical assistance, facilities have trouble collecting the data necessary for the Corps' application. Insufficient or problematic data can lead to denied applications for assistance.

PHS officials recognize the need for revised management practices to improve communication and accommodate expansion

Regional office staff predict that expansion will force them to reduce their recruitment, site development, and oversight activities. In response to these workload concerns, PHS central office plans to rely on agreements with State agencies and primary care associations to perform some of these vital functions. Both regional and central office staff caution that some States will not be able to assume more responsibilities and that specific guidance needs to be developed to define appropriate roles and responsibilities.

Expansion also will require greater communication and coordination among PHS components. Staff in 9 out of 10 regions believe that the Division of Scholarships and Loan Repayments and the Division of National Health Service Corps need to communicate better, coordinate their workplans, and develop and implement consistent policies and procedures. To address these concerns, program officials are examining ways to use their resources more efficiently by improving their data and information systems and simplifying reporting requirements.

PROVIDERS AND DIRECTORS ARE DISSATISFIED WITH THE MATCHING PROCESS

A majority of providers and one-third of directors were dissatisfied with the matching process. More than 60 percent of providers who participated in the matching process were dissatisfied with the number and variety of facilities available. Seventy percent of scholars placed in 1991 were dissatisfied with the matching process, and 60 percent of all providers who experienced a problem during their obligation attributed it to the matching process. Providers and directors are dissatisfied with the matching process because (1) they receive inadequate information from PHS and (2) the HPOL and loan repayment vacancy list lack complete and current information.

Providers believe PHS gave them inadequate information and assistance before and during the matching process

Almost 30 percent of providers believe that PHS does not adequately describe the matching process and the facilities available for placement. More than one-quarter of providers who matched to a facility commented that they had expected the HPOL and the loan repayment vacancy list to contain more facilities nationally or in specific areas. Some providers further indicated that PHS staff gave them incorrect information about the facilities that would be available.

Since 1989, PHS has made an effort to educate and prepare scholars better by interviewing top applicants. Our data reflect this effort. More 1989 and 1991 scholarship recipients mentioned that PHS is providing information about available locations and facilities and explaining how PHS develops the HPOL than prior scholars.

Many providers do not recall receiving adequate assistance from PHS during matching. More than half of the providers placed in 1991 recalled receiving only the list and no further assistance. Some providers said this is due partly to PHS' incomplete knowledge of the facilities and surrounding communities.

The vacancy lists do not contain complete and current information

Directors and providers suggest that PHS should provide more timely and complete information to facilitate matching. Twenty percent of directors believe that the information on the HPOL and loan repayment vacancy list is inadequate and that providers do not get a good picture of facilities. Providers further commented that the lists contained outdated and incomplete information and listed facilities without vacancies. Directors and providers suggested that an on-line, or otherwise continually updated, system of eligible facilities be available. Similarly, several PHS staff suggested on-line community profiles and tracking systems, which PHS is now developing on a pilot basis.

Directors also suggest that PHS provide additional information about the providers who are looking for vacancies, so they can better market their facilities. They suggest that the list of eligible providers include information such as language skills or providers' outside interests.

ALTHOUGH MANY FACTORS AFFECT RETENTION, FACILITIES AND PHS PLAY KEY ROLES

More than one-third of scholars and loan repayers stay at their assigned facilities more than a year after they complete their obligation. Although the data do not show any significant difference in actual retention between loan repayers and scholars, more loan repayers say they plan to stay at the facility after their obligation. That may be due to the fact that many loan repayers worked at the facility before joining the Corps.

Some providers credited personal satisfaction with their work as the reason for staying. On the other hand, some mentioned conflicts with the facility's administration as the reason for leaving. Physician assistants and certified nurse midwives appear to have higher retention rates than other providers. Furthermore, rural providers are more likely to remain after their obligation than urban providers.

Providers and directors offered a variety of ways that PHS and facilities could improve morale and retention. Increased flexibility of PHS policies is a common suggestion. We discuss flexibility in more detail in the finding on page 11. Other suggestions to improve provider morale and retention include (1) fair treatment of providers by facilities, (2) financial incentives, and (3) adequate support of providers in their settings.

Facilities' treatment of providers is crucial to retention

Almost two-thirds of directors believe their role in retention is to offer providers exciting and attractive work environments. Facilities with high retention rates cite fair treatment of providers as the key to their success. These directors treat the providers as equals, involve them in the decision-making process, and make them feel welcome in the community. They believe this approach helps providers grow "roots" that may prevent them from leaving.

Although providers also believe that fair treatment by facilities is essential for retention, many described negative experiences. Some providers believe facility administrators' lack of understanding results in overly ambitious patient loads, poor working conditions for all providers, and high turnover among medical staff. Some providers say they would be more likely to stay if the facility gave them greater responsibility and autonomy, managed workloads better, replaced incompetent administrators, and/or provided additional opportunities for professional training.

Financial incentives affect retention

Although factors such as family concerns and treatment by the facility are more important, almost half of providers and 80 percent of directors believe adequate compensation is crucial. Providers suggest that higher salaries and better benefits would make them more likely to stay. Some providers also are willing to sign extended commitments in exchange for repayment of additional educational loans. Others seek higher salaries because their spouses cannot earn enough income in underserved areas. Some facilities with high retention rates use incentive programs, in which salary bonuses are based on productivity. Directors also suggest that tax breaks, bonuses that are not tied to productivity, and Federal malpractice coverage for all facilities would increase retention.

Lack of professional support can hurt retention and morale

Providers stated that their inability to interact with other health professionals and the lack of clinical and administrative support frustrates their attempts to provide quality care and contributes to "burn-out." Twenty-three percent of directors agree with providers that professional support is essential for clinical success and retention. Both directors and providers suggested that PHS place providers in settings that can ensure an adequate level of support.

Provider "burn-out" is common in small practice settings. Several sampled providers defaulted on their obligations, while others stayed simply because the community's need for their services was so great.

Providers in the private practice option have a special need for support and assistance, because they are often in small practice settings and have the added responsibility of running a business. Only a small number of providers exercise the private practice

option, because most needy communities cannot support a financially viable private practice.

PHS POLICIES ARE NOT FLEXIBLE ENOUGH TO ADDRESS PROVIDERS' NEEDS AND PREFERENCES

More than 50 percent of providers cited problems with inflexible policies or suggested that PHS policies should be more flexible. Providers believe that greater consideration of individual situations in matching, transfer, and clinical practice policies would not hinder the Corps' ability to serve the neediest areas.

Many providers believe that inflexible matching policies hinder their productivity, long-term retention, and lifestyle. Providers wonder why they are not allowed to choose an area where they are more likely to stay permanently. Some providers leave their families behind because of poor employment opportunities for their spouses or educational opportunities for their children. Many providers reported that their placement choices consisted solely of communities where they face discrimination or bigotry based on race, gender, sexual orientation, or religion.

In an effort to address providers' needs and wishes, PHS began using the Professional Training Information Questionnaire in 1992. Most providers we interviewed had no experience with this questionnaire, because they were already assigned to a Corps facility or still in training.

Some providers want more flexible transfer policies so they can move if they encounter problems at a Corps facility. By transferring, they could continue serving instead of defaulting or leaving at the end of their obligation. Approximately one-quarter of providers who attempted to transfer experienced difficulties. They stated that PHS offered little or no assistance and discouraged their attempts to transfer.

Several PHS officials suggested that greater flexibility would bolster both recruitment and retention. They specifically suggested that PHS offer (1) scholars more choices of facilities during the matching process and (2) part-time options with extended payback periods for all providers. Providers echoed these suggestions and said they would be willing to extend their obligations in exchange for these options.

COMPETITION, AVAILABILITY, AND SITE LIMITATIONS MAY HINDER THE EXPANSION OF THE LOAN REPAYMENT PROGRAM

The PHS may encounter difficulties attracting enough providers into an expanded loan repayment program. Three factors limit the number of people who enter the loan repayment program: (1) the small number of primary care providers overall, (2) competition from group practices and managed care organizations, and (3) the limited number of attractive, available sites approved for loan repayers.

The loan repayment program recruits from the limited pool of approximately

11,500 primary care providers and general dentists who complete their training and enter practice each year.[3] Some of these primary care providers are not available for loan repayment service, because they already have service obligations to Federal, State, or local governments or private organizations. Many additional internal medicine and pediatrics residents are not available for loan repayment recruitment, because they choose to specialize further in non-primary care fields.

Group practices and managed care organizations hire large numbers of primary care providers to keep their costs down. Compared to most of the facilities where Corps providers serve, group practices and managed care organizations offer higher salaries, fewer on-call assignments, and better benefits. Furthermore, they are located in more desirable communities. Recently, managed care organizations increased salaries and financial incentives, such as fringe benefits and improved support services, to recruit and retain primary care providers.[4]

At least half of the loan repayment applicants withdraw their applications because they cannot find an approved facility that (1) has a current vacancy, (2) can support them financially or professionally, and/or (3) they find attractive. Fewer than 43 percent of the 1,164 providers who submitted applications and sought placements in fiscal year 1993 found a placement.

NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE MIDWIVES FREQUENTLY FACE PRACTICE BARRIERS

Almost three-fourths of nurse practitioners, physician assistants, and certified nurse midwives reported facing barriers to providing medical care. The most commonly mentioned barriers are physicians' attitudes and the lack of prescriptive authority and hospital admitting privileges. Several complained about their inability to receive payment from Medicare and Medicaid for their services.

Providers offered suggestions on how to eliminate these barriers. Some suggested that regional offices act as problem-solving resources for providers by knowing the State laws and by working closely with the professional associations. Others believe PHS should teach facility administrators and doctors about the services that these providers are trained to perform and the type of support they need. The PHS staff agreed that facility administrators should be educated better.

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[3] Estimate based upon data from (1) Third Report of the Council on Graduate Medical Education, October 1992; (2) Health Personnel in the United States, Eighth Report to Congress, 1991, September 1992; (3) the American Osteopathic Association; (4) the Association of American Medical Colleges; (5) the American College of Obstetrics and Gynecology; (6) the American Dental Association; (7) the American Academy of Physician Assistants; (8) the National Organization of Nurse Practitioners; and (9) the American College of Nurse Midwives.

[4] Palsbo and Sullivan, The Recruitment Experience of Health Maintenance Organizations for Primary Care Physicians, The Group Health Association of America, Inc., May 1993, pp. i and 11.

Some facility administrators have changed their attitudes and are making better use of nurse practitioners, physician assistants, and certified nurse midwives. Because facilities must reduce their overhead and provide care to more people, they are realizing the value of these providers. One-third of directors seek more of these caregivers, and some facilities are striving to use them more effectively. One facility is part of an innovative statewide pilot project that utilizes nurse practitioners in a system called "telemedicine." A nurse practitioner serves multiple counties in a fully equipped mobile unit and keeps in direct contact with primary care and specialty physicians through the use of cellular phones, video, and computers.

THE CHECK DISBURSEMENT PROCESS COULD BE IMPROVED

More than one-third of loan repayers and a few scholars described problems related to financial disbursements from PHS. The most significant problems involved late checks and checks with incorrect addresses, names, and/or amounts. Many providers also reported difficulty when trying to rectify the problems. They stated that they did not know whom to call, had to call multiple times, and received inadequate responses from PHS.

The regional PHS staff echoed loan repayers' concerns about the check distribution process. Staff said check problems undermine their efforts to build professional relationships with providers and unnecessarily increases their workload. The Division of Scholarships and Loan Repayments recently instituted a toll-free number to alleviate the situation.

RECOMMENDATIONS

PHS SHOULD IMPROVE ITS COMMUNICATION WITH AND SUPPORT FOR PROVIDERS AND FACILITIES

Providers, directors, and PHS staff believe good communication, adequate support, and outreach are essential to maintain and increase provider morale and satisfaction. To improve communication and strengthen the Corps, PHS should consider:

- exploring new and creative approaches, such as (1) conducting national orientation of each year's new providers and (2) providing on-site support for both providers and facilities;
- assigning each provider and facility a contact person and establishing a minimum level of contact;
- increasing outreach and educational activities for all new and existing facilities;
- increasing technical assistance to facilities about (1) the application, (2) recruitment and retention methods, and (3) clinical and management practices;
- educating facilities about the value of nurse practitioners, physician assistants, and certified nurse midwives; and
- assuring that each provider clearly understands and is fully aware of all aspects of the Corps program prior to signing the contract.

PHS SHOULD CONSIDER MORE FLEXIBLE MATCHING AND PRACTICE POLICIES

Providers, directors, and PHS staff believe increased flexibility would improve retention and provide better solutions to the shortage of health care providers. Among other things, PHS should consider:

- part-time options with extended repayment periods,
- deferments or time off for continued education, and
- more site choices.

PHS SHOULD DEVELOP MORE ACCURATE, COMPLETE, AND UP-TO-DATE VACANCY LISTS

Providers and directors complained about the insufficient, inaccurate, and outdated information available for matching. To solve these deficiencies, PHS should consider:

- developing a matching information system that can be continually updated (such as an on-line computer system);
- issuing quality assurance reports and descriptive profiles of facilities; and
- providing facilities with more information about individual providers, such as their language skills and outside interests.

PHS SHOULD USE DIRECT DEPOSIT TO PAY PROVIDERS

Participants in the loan repayment program and a few scholars have difficulties receiving their checks on time and at the correct address. The PHS could alleviate these problems and save money if it deposits payments directly into providers' accounts.

AGENCY COMMENTS

In written comments on the draft report, PHS concurred fully or in part with all of the report's recommendations and described the actions they have already taken or plan to take. The PHS expressed concern that the report does not reflect the program improvements PHS has made since 1990, because most of the providers interviewed were placed under policies developed prior to the 1990 legislation. The PHS also included several technical comments. The full text of PHS' comments appears in Appendix B.

OIG RESPONSE

In response to PHS' comments on the draft report, we have made some technical corrections. We recognize and support the numerous improvements that PHS has made and plans to make to improve communication and support, flexibility, vacancy list accuracy, and monetary disbursement. Although the majority of the providers we interviewed were placed under policies that were developed prior to the 1990 legislation, more than two-thirds of providers interviewed were still serving or not yet serving their obligations. These providers expressed concerns about communication and support at the time of our interview in late 1992. Their concerns are indicative of current communication deficiencies despite the fact that they were placed under pre-1990 policies.

APPENDIX A

SAMPLE SELECTION METHODOLOGY, ESTIMATES, AND CONFIDENCE INTERVALS

Provider Sample Selection Methodology

We conducted telephone and in-person interviews with a random sample of 302 Corps providers between September 1992 and January 1993. Working from prepared discussion guides, we asked providers about their experiences with the Corps' recruitment, placement, and retention efforts. In order to analyze the impact of Corps policies on specific providers, we selected our sample based on 13 separate strata. We based the strata on the type of assistance the provider received (scholarship, loan repayment, or volunteer) and the year in which the provider was placed or received the assistance (1986, 1989, or 1991). We established two additional strata to collect the individual experiences of obstetrician/gynecologists, nurse practitioners, physician assistants, and certified nurse midwives. A discussion of the strata follows:

- **Scholars--Awarded.** Scholars may be awarded their scholarship up to 7 years before they enter the placement process. We selected samples of 30 providers each from 3 different years based on when the scholarship was awarded. We asked these providers in greater detail about their experiences with Corps recruitment efforts.

- **Scholars--Placed.** To determine the impact of changes in placement policies, we selected samples of 30 providers each from 3 different years based on when the scholar was placed. We asked these providers in greater detail about the level of assistance they received in finding a site, their satisfaction with placement choices, and how available choices met with their expectations.

- **Volunteers.** Volunteers are providers who do not receive financial assistance. They want to practice in underserved areas and request Corps assistance in finding a facility. We selected samples of volunteer providers. We excluded their responses from our analysis, however, because the PHS universe was incomplete.

- **Loan Repayers.** Loan repayers enter the program and are placed in the same year. Since the loan repayment program was established in 1987, we sampled 30 providers each from 1989 and 1991.

- **Obstetricians.** Due to the need for obstetric services in certain underserved areas, PHS officials and health care professionals told us that obstetricians face greater hardships than other Corps providers. To determine if this was true, we selected a separate sample of all 10 obstetricians who were placed in 1991.

- **Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives.** These providers may be hindered in their practice of medicine by current laws, regulations, and practice policies. We sampled the 44 nurse practitioners, physician assistants, and certified nurse midwives who entered the Corps in 1991.

We could not interview all sampled providers because some (1) had relocated, (2) refused to participate, (3) were involved in cases that were being reviewed by the Department of Justice, or (4) had not completed their medical training. In addition, we interviewed three providers twice based on their being awarded a scholarship in one year and placed in another. The following chart summarizes the interviews that we conducted:

	1986	1989	1991	TOTALS
Scholars--Awarded	29	29	30	88
Scholars--Placed	26	29	30	85
Volunteers	6	6	10	22
Loan Repayers	NA	30	30	60
Obstetricians	NA	NA	9	9
Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives	NA	NA	41	41

Upon completion of the interviews, we coded all provider responses and entered the data into a computerized database. Within each stratum, we weighted each provider's responses based on his/her representation of an equal share of the universe.

Estimates and confidence intervals

The chart below summarizes the estimated proportions and the 95 percent confidence intervals for the statistics presented in the report.

Statistic		
	Point Estimate	**95% Confidence Interval**
Proportion of directors who believe their facilities could not adequately serve patients without Corps providers		
	90.0%	79.3% - 100%
Proportion of directors who say they need at least one more provider to offer adequate health care		
	80.0%	65.7% - 94.3%

Statistic		
	Point Estimate	**95% Confidence Interval**
Proportion of directors who believe they will always need the Corps to recruit providers		
	66.7%	49.8% - 83.5%
Proportion of loan repayers who say they would have worked at the facility even if they had not received loan repayment		
	59.5%	50.8% - 68.2%
Proportion of those loan repayers who would have worked at the facility without loan repayment who do not plan to stay at the facility just because of loan repayment		
	67.7%	55.7% - 79.6%
Proportion of providers who called PHS with questions who claim that PHS staff are not responsive to their needs		
	35.7%	23.0% - 48.3%
Proportion of providers who recall no contact with PHS		
	27.1%	17.2% - 37.1%
Proportion of scholars placed in 1991 who believe PHS does not contact them often enough		
	56.2%	44.0% - 68.3%
Proportion of loan repayers placed in 1991 who believe PHS does not contact them often enough		
	41.9%	30.2% - 53.7%
Proportion of directors who did not know that PHS provides technical assistance		
	26.7%	10.8% - 42.5%
Proportion of directors who recall being offered technical assistance by regional offices		
	30.0%	13.6% - 46.4%
Proportion of directors who had no interaction with primary care associations and State agencies		
	30.0%	13.6% - 46.4%
Proportion of directors who believe the application process is burdensome		
	48.3%	30.1% - 66.5%
Proportion of directors who were dissatisfied with the matching process		
	33.3%	16.5% - 50.2%
Proportion of those providers who participated in the matching process who were dissatisfied with the number and variety of facilities available		
	60.6%	48.9% - 72.4%

Statistic		
	Point Estimate	**95% Confidence Interval**
Proportion of scholars placed in 1991 who were dissatisfied with the matching process		
	70.4%	59.2% - 81.6%
Proportion of providers who had a problem who attribute it to the matching process		
	60.2%	48.5% - 71.8%
Proportion of providers who believe that PHS does not adequately describe the matching process and the facilities available for placement		
	29.1%	20.7% - 37.4%
Proportion of providers matched to a facility who expected the HPOL or the loan repayment vacancy list to contain more facilities nationally or in specific areas		
	28.1%	18.4% - 37.8%
Proportion of 1991 scholarship recipients who say PHS provided information on available facilities and how the list is made		
	76.7%	62.1% - 91.3%
Proportion of 1989 scholarship recipients who say PHS provided information on available facilities and how the list is made		
	75.9%	67.3% - 84.4%
Proportion of 1986 scholarship recipients who say PHS provided information on available facilities and how the list is made		
	38.5%	28.5% - 48.5%
Proportion of providers placed in 1991 who recall receiving only the list and no further assistance		
	52.1%	43.0% - 61.2%
Proportion of directors who believe the information on the HPOL and loan repayment vacancy list is inadequate and that providers do not get a good picture of facilities		
	20.0%	5.7% - 34.3%
Proportion of providers who stay at facilities more than a year after they complete their obligation		
	37.9%	21.4% - 54.5%
Proportion of loan repayers who stayed at their facility after they completed their obligation		
	49.4%	33.7% - 66.3%
Proportion of scholars who stayed at their facility after they completed their obligation		
	47.1%	31.0% - 63.4%
Proportion of loan repayers who plan to stay at the facility after they complete their obligation		
	50.5%	38.8% - 61.7%

Statistic		
	Point Estimate	**95% Confidence Interval**
Proportion of scholars who have started serving their obligation who plan to stay at the facility after they complete the obligation		
	18.9%	8.4% - 28.9%
Proportion of providers placed in rural areas who stayed or plan to stay at the facility after they complete their obligation		
	39.7%	28.8% - 50.8% (90% Confidence)
Proportion of providers placed in urban areas who stayed or plan to stay at the facility after they complete their obligation		
	18.6%	10.6% - 26.4% (90% Confidence)
Proportion of directors who believe their retention role is to offer attractive work environments		
	63.3%	46.1% - 80.6%
Proportion of providers who believe adequate compensation is crucial to retention		
	44.6%	37.0% - 52.2%
Proportion of directors who believe adequate compensation is crucial to retention		
	80.0%	65.7% - 94.3%
Proportion of directors who agree professional support is essential to clinical success and retention		
	23.3%	8.2% - 38.5%
Proportion of providers who cite problems with inflexible policies or suggest more flexible policies		
	51.7%	43.7% - 59.8%
Proportion of those providers who attempted to transfer who experienced difficulties		
	24.8%	13.8% - 35.6%
Proportion of nurse practitioners, physician assistants, and certified nurse midwives who reported facing barriers to providing medical care		
	71.1%	67.1% - 75.0%
Proportion of directors who seek more nurse practitioners, physician assistants, and certified nurse midwives		
	36.7%	19.4% - 53.9%
Proportion of loan repayers who described problems with financial disbursements from PHS		
	33.5%	24.7% - 42.3%

APPENDIX B

PHS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Rockville MD 20857

MAR 14 1994

MEMORANDUM

From: Assistant Secretary for Health

Subject: Office of Inspector General (OIG) Draft Report "National Health Service Corps: A Survey of Providers, Facilities, and Staff," OEI-09-91-01310

To: Inspector General, OS

Attached are the Public Health Service comments on the subject draft report. We concur fully or in part with all of the report's recommendations and our comments describe the actions we have taken or plan to take to implement them. We have also included several technical comments for your consideration.

Philip R. Lee, M.D.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT "NATIONAL HEALTH SERVICE CORPS: A SURVEY OF PROVIDERS, FACILITIES, AND STAFF" OEI-09-91-01310

GENERAL COMMENTS

The report examined the Health Resources and Services Administration's National Health Service Corps (NHSC) placement cycles for Fiscal Years 1986, 1989, and 1991. Although these placements were made over a five year span, all cohorts studied by the OIG were placed under policies consistent with the previous (pre-1990) NHSC legislation. This is important to stress because all of the areas of concern expressed in this OIG report regarding the cohorts of 1986, 1989, and 1991 were recognized by the program administrators and corrective plans were implemented to improve the NHSC.

Significant positive changes in program direction, management and oversight have occurred in the last 4 1/2 years beginning with program input into legislative changes resulting in a new law, the NHSC Revitalization Amendments of 1990 (Public Law 101-597). In addition, new leadership in HRSA's Bureau of Primary Care, Division of National Health Service Corps, and Division of Scholarships and Loan Repayments (DSLR), and a staff reorganization in both divisions have improved program management and focused the organization to better meet the needs of the medically underserved populations.

It is important to recognize, however, that changes in program administration may take several years to be realized in terms of impact on providers in the field and on retention. The scholarship program, in particular, spans an average of nine years for physicians and four years for other providers from initial award to completion of service. Substantial progress has been made in improving the overall operation of the NHSC. Examples of the improvements are indicated in our responses to the OIG's recommendations. The NHSC staff continuously listens to its customers, underserved people and communities, and primary care providers, and adjusts its policy to better serve those most in need of primary care services.

OIG Recommendation

1. The PHS should improve its communication with and support for providers and facilities.

PHS Comment

We concur and note that the NHSC has already taken and will continue to take significant actions to improve the levels of

communication and support to providers and facilities. Early and continuing contact is one of the "new" NHSC's main goals. Therefore, the NHSC is continually examining its marketing and recruiting efforts to assure that information provided about the programs is current and accurate, and evaluating ways to improve interaction with students in training and providers in the field. Program managers are in the process of standardizing the technical assistance and oversight activities that are provided through the PHS Regional Offices, cooperative agreements, primary care associations and contractors.

The NHSC has designed and implemented strategies to communicate program requirements and benefits to new providers and facilities, and to prospective providers. This spring the NHSC will conduct the fourth round of individual interviews for all scholars. The scholars will be provided with detailed information about the nature and requirements of NHSC service, financial and service obligations, the site selection process, and a sampling of current NHSC sites. In addition, for the past three years the NHSC has been conducting annual orientation seminars for new scholars and providers on a nationwide basis. The PHS Regional Offices have been an integral part of these orientation activities. Finally, at least annually the NHSC conducts conferences with new providers including scholars, loan repayers, volunteers, and non-obligated providers serving through the NHSC.

The NHSC has implemented procedures to ensure continuing contact with providers once they are on site. Providers are being advised of whom they need to contact with respect to different questions or problems. Since the nature of the provider's questions and concerns will vary depending upon whether they are still in school, beginning service, or seeking continuing professional education, the program is working to assure that each provider knows the first point of contact during all stages of the relationship with the NHSC.

In addition, the NHSC continues to work with sites to assure that providers have salary and benefit packages comparable with their peers in the community, and has provided clinical support funding and locum tenens support which offer providers opportunities to pursue educational activities on and off-site. When new providers are placed at a site they are encouraged to serve at least one year before transferring to a new site. The initial placement is the result of a documented need for primary care services in that community. The NHSC is concerned about continuity of care, and the impact on the community of the loss of a new provider through a transfer. When it is not possible for both site and provider to resolve their differences, transfer to another needy community is

facilitated. Providers who default on their service obligation incur financial damages under the statutory formula of three times principal plus interest, less any credit prorated for actual service.

The NHSC's technical assistance activities address the application process, recruitment, retention, clinical and management practices. With respect to the nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs), we are working with the PHS Regional Offices, State associations and professional organizations to educate everyone involved on the team approach to primary care, the full utilization of all primary care health professionals, and how to reduce practice barriers.

OIG Recommendation

2. The PHS should consider more flexible matching and practice policies.

PHS Comment

We concur with the general thrust of this recommendation, but recognize that the program must operate within statutory limitations. The program has made many positive efforts to increase the flexibility of the matching process, while assuring that the primary mission of serving those most in need is maintained. The program now has expanded the number of vacancies available per scholar, as compared with earlier cohorts, and has increased the number of vacancies available for providers interested in loan repayment.

However, the number of choices available to scholars is provided for by statute: three vacancies for each scholar in a given discipline and/or specialty, up to a maximum of 500 vacancies. For example, if there are 10 pediatricians available for service, the Health Professionals Opportunity List (HPOL) for that group would contain 30 sites (10 times 3). If there are 15 family nurse practitioners available, there would be 45 sites on the list. The program provides scholarship recipients with the appropriate HPOL for their specialty while they are still in training, one year prior to their targeted service date.

Recognizing that there are frequently more vacancies of highest need than would be permitted by the 3 to 1 statutory limit, the program began to collect placement preferences of scholars using the Professional Training Information Questionnaire (PTIQ), to be used for consideration in the development of the HPOL. This will be the third year in which the PTIQ is used to select high priority sites that may more

closely meet providers' preferences. This permits the program to meet our primary mission, serving people of greatest need, while considering the needs of our other important customers, primary care providers.

During the early decision alternative (EDA) phase of the placement cycle, providers have approximately nine months to choose a site from the HPOL that will best meet their personal and professional needs. It is only after the EDA, when a scholar has not chosen a site, that the program assigns the individual to a high priority site, as required by law.

Over 85 percent of providers are hired by individual community organizations. The communities receive notification that they have been placed on the vacancy list at the beginning of the placement cycle. The communities know that they have a one-in three chance of recruiting an NHSC scholar, since there are three times as many vacancies as scholars. As the hiring authority, they are recruiting scholars as well as others who may wish to serve in their communities. As a result, some sites will fill their vacancies with providers other than NHSC scholars. For this reason, scholars are encouraged to pursue their options as soon as they get the HPOL. NHSC's goal is to help fill all of the vacancies in the neediest communities, while matching all obligated scholars.

The program has continued to expand the number of sites that are available through loan repayment, enhancing efforts to target communities of greatest need. For the last three years, there have been approximately three vacancies available for each NHSC loan repayment contract. Loan repayment applicants are not obligated until they match to a site and have a loan repayment contract approved by DSLR. While loan repayment sites may be less needy than scholar sites, they are still in underserved communities and may be less "ideal" than many candidates would prefer. Loan repayers may also match to HPOL sites.

The loan repayment program is an important retention and recruitment program. Many providers, who are already on site view loan repayment as the "carrot" that will entice them to stay. In addition, the loan repayment program has been a significant recruiting tool for NHSC service. Loan repayers have already made a commitment to primary care by virtue of their chosen discipline. The loan repayment program has, in most cases, provided the incentive that was needed to attract these providers to underserved areas. The retention rate for loan repayers is about double that of scholars. Based on data from focus groups, the NHSC believes that loan repayment is a critical consideration in site selection. Once on-site, providers become integrated into the community, which is a

critical factor in any decision to remain beyond an obligation period.

The OIG report's characterization of the scholarship and loan repayment programs as being respectively more competitive and less rigorous does both programs a disservice. The programs are complementary. In the case of scholars, the application and interview process attempts to assure that the student has a clear understanding of what embarking on a career in primary care service in underserved areas means, and what the obligation he/she is about to incur entails. The scholar will incur the obligation several years prior to completing his/her education and beginning service. In the case of loan repayers, they are not obligated until they match to a site and sign an agreement with DSLR.

The NHSC has noted a progressive increase in retention rates over the last few years. Of the universe of scholars and loan repayers who have completed their obligations, increasing numbers have agreed to continue service to the underserved beyond their obligation period at their current site: 39 percent in FY 1991, 52 percent in FY 1992, and 58 percent in FY 1993. In FY 1993, of the 58 percent which were retained, 43 percent of the scholars and 73 percent of the loan repayers stayed on at their site after completing their obligation. There were others who were "retained" in service to the underserved, moving into another underserved community, taking a public health position, or teaching primary care in an academic setting.

The way in which providers are treated, or perceive to be treated, by the programs in which they are serving is crucial to retention. Improving employer-employee relationships is critical in any profession. The NHSC is taking steps to prepare providers and community organizations to facilitate retention, and will delete sites from the vacancy lists which routinely do not manage their practices appropriately.

The statute mandates "full-time clinical practice." The intent was based on the belief that underserved communities required full-time providers to improve the health of the community. Any change to the requirement would necessitate a change in legislation. Full-time practice is defined as a minimum of 45 weeks a year in practice. Obligated providers are permitted up to 7 weeks a year off-site for vacation, sick leave, and/or continuing professional education. The NHSC has provided more than $1 million annually for continuing professional education for the last several years. Deferments are provided for residency training, and all NHSC providers are now required by statute to be fully qualified in their professional specialty before they start service.

During 1993 the NHSC matched 193 scholars and placed 477 loan repayers. In addition, 406 scholarships were awarded. The NHSC expects its site development contract and other ongoing technical assistance efforts to improve the matching process in future placement cycles, while remaining true to the mission of serving those most in need.

The OIG report notes that PHS allows only a small number of providers to exercise the private practice option (PPO). The reason that there are not more PPO sites is that NHSC providers generally work in areas which cannot currently support an economically viable practice. It is the NHSC's mission to locate primary care providers in areas where other providers have chosen not to go, and where health care services would not otherwise be available. It should not come as a surprise to providers to find that the communities in which they are serving are frequently economically and educationally disadvantaged. However, the NHSC believes that it can continue to attract primary care providers who want to go where they are most needed to serve where they can truly make a difference.

As noted in our comments to recommendation number 1 above, NPs, PAs, and CNMs frequently face licensure, community acceptance, and site practice barriers. The NHSC is working with professional organizations, States and State licensing boards, and communities to remove these practice barriers and allow for the full utilization of these health providers as members of interdisciplinary practice teams. The NHSC is also working with PHS Regional Offices and primary care associations to ensure that all providers are placed in situations where they can practice the full scope of their professions.

OIG Recommendation

3. The PHS should develop more accurate, complete, and up-to-date vacancy lists.

PHS Comment

We concur. The NHSC has improved and will continue to improve the vacancy list development and updating process. Currently, NHSC recruiters in the field are using laptop computers to access information in a community profile program.

The NHSC continues to enhance the computerization of vacancy lists to ensure that they are as up-to-date as possible. It is planning to provide descriptive profiles of sites which would not only describe the community, but also reflect the staffing and system of care in that site. The NHSC is also

exploring alternative ways to have profiles of scholars available to sites to assist them in the matching process. On a pilot basis, the NHSC is looking at developing an on-line, continuously updated file of available, eligible facilities.

The basis for these improvements is to assure that all customers of NHSC's services are as informed as possible regarding vacancy data. The better information potential providers and sites have prior to the beginning of the site selection process, the more successful the match. The program welcomes additional suggestions for improving customer satisfaction.

OIG Recommendation

4. The PHS should use direct deposit to pay providers.

PHS Comment

We concur and, as noted at the exit conference with staff from OIG, actions have already been taken to address this issue. For NHSC scholars, the DSLR has the fiduciary responsibility for the allocation of funds to pay schools for tuition and fees, and stipends for students. The HRSA Division of Fiscal Services handles the actual payments for the tuition and fees to educational institutions upon receipt and verification of invoices. The PHS Division of Commissioned Personnel processes the monthly stipends for students. A test program to implement direct deposit of stipend checks is currently under development. It is expected that this system will be fully implemented in the first half of 1994.

Concerning loan repayments, DSLR prepares computerized payment work sheets that account for what is due to each participant at the point of contract between the NHSC and the participant. These work sheets include information on the loan repayment amount, appropriate interest, and tax payments. The Division of Fiscal Services handles the actual disbursements. These procedures have resulted in a better accuracy rate in loan repayments than ever experienced before.

It is the program's experience that most complaints from providers about not receiving payments can be traced to the providers' failure to report their correct address to the program. In nearly all cases of payment complaints reviewed by the program staff, the check was not delivered because of an incorrect or old address and had been returned to the Treasury Department.

The NHSC believes that it has taken appropriate actions to assure accurate and timely payments to loan repayment program

participants. However, they will continue to seek better and more accurate methods of payment.

Technical Comments

Page 1, third paragraph

To present a more complete picture, we suggest that this paragraph mention the shortage of primary care providers.

Page 2, first paragraph

This paragraph does not fully recognize the important contributions that NPs, PAs, and CNMs make as a part of the primary care interdisciplinary team. Indeed, individuals in these disciplines are the providers of choice in some communities.

Page 2, "Program Oversight" first paragraph

The Office of State Activities is not a formalized organizational unit in HRSA's Bureau of Primary Health Care and does not have any responsibility for NHSC activities.

Page 3, first paragraph

While PHS is required to place those with a scholarship obligation, each individual is given a nine month period in which to select a site from the Health Professionals Opportunity List which has been approved for NHSC assignment. These individuals then negotiate with the site facilities over possible assignment. If an obligated scholar fails to find a site during this nine month period, he/she is then assigned to a site.

Page 5, first paragraph

The NHSC makes concerted efforts to ensure that providers and facilities get started on the right foot. The first year at the site is the most critical in that regard. We provide orientation sessions for new providers, and are expanding efforts to assure that field assignees know who their first contact is for questions or concerns.

Page 7, first sentences of the first and second paragraphs

These statements confuse the older program and cohorts studied by the OIG, from the current efforts of the revitalized NHSC. Increasing contact with field providers is one of the cornerstones of the "new" NHSC.

Page 8, second paragraph

We agree that NHSC expansion will require greater communication and coordination among PHS components and have taken some significant steps to improve communication and coordination. Through work planning processes, the NHSC is clearly defining responsibilities as NHSC expansion efforts are undertaken. Program officials are examining ways to economize, streamline and target our resources through improving our data and information systems, and simplifying reporting requirements. While new resources may be needed to handle a major expansion of the NHSC, we believe that current resources can be used more efficiently.

Page 9, second paragraph

Efforts are underway in the NHSC to improve the percentage of facility directors who are satisfied with the completeness and accuracy of information concerning their facilities that is contained in the HPOL and loan repayment vacancy list. Our comments on the OIG report's recommendations discuss actions taken or planned to provide more accurate and timely information to both providers and facilities.