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Executive Office of Health and Human Services
Department of Public Health
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July 14, 2017

Steven T. James
House Clerk
State House Room 145
Boston, MA 02133

William F. Welch
Senate Clerk
State House Room 335
Boston, MA 02133

Dear Mr. Clerk,

Pursuant to Sections 25L and 25N of Chapter 111 of the Massachusetts General Laws, please find enclosed a report from the Department of Public Health entitled the *Massachusetts Health Care Workforce Center Annual Report*.

Sincerely,

Monica Bharel, MD, MPH
Commissioner
Department of Public Health

Charles D. Baker
Governor

Karyn Polito
Lieutenant Governor



Marylou Sudders
Secretary

Monica Bharel, MD, MPH
Commissioner

Massachusetts Health Care Workforce Center Annual Report

July 2017



Legislative Mandate

The following report is hereby issued pursuant to Section 25L and 25N of Chapter 111 of the Massachusetts General Laws as follows:

Chapter 111 M.G.L., Section 25L

(a) There shall be in the department a health care workforce center to improve access to health and behavioral, substance use disorder and mental health care services. The center, in consultation with the health care workforce advisory council established by section 25M and the secretary of labor and workforce development, shall: (1) coordinate the department's health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention, including with the activities of the Health Care Workforce Transformation Fund; (2) monitor trends in access to primary care providers, and nurse practitioners and physician assistants practicing as primary care providers, behavioral, substance use disorder and mental health providers, and other physician and nursing providers, through activities including (i) reviewing existing data and collection of new data as needed to assess the capacity of the health care and behavioral, substance use disorder and mental health care workforce to serve patients, including patients with disabilities whose disabilities may include but are not limited to intellectual and developmental disabilities, including patient access and regional disparities in access to physicians, nurses, physician assistants, and behavioral, substance use disorder and mental health care professionals and to examine physician, nursing and physician assistant, behavioral, substance use disorder and mental health professionals' satisfaction; (ii) reviewing existing laws, regulations, policies, contracting or reimbursement practices, and other factors that influence recruitment and retention of physicians, nurses, physician assistants, behavioral, substance use disorder and mental health professionals; (iii) projecting the ability of the workforce to meet the needs of patients over time; (iv) identifying strategies currently being employed to address workforce needs, shortages, recruitment and retention; (v) studying the capacity of public and private medical, nursing, physician assistant, behavioral, substance use disorder and mental health professional schools in the commonwealth to expand the supply of primary care physicians and nurse practitioners and physician assistants practicing as primary care providers and licensed behavioral, substance use disorder and mental health professionals; (3) establish criteria to identify underserved areas in the commonwealth for administering the loan repayment program established under section 25N and for determining statewide target areas for health care provider placement based on the level of access; and (4) address health care workforce shortages through the following activities, including: (i) coordinating state and federal loan repayment and incentive programs for health care providers; (ii) providing assistance and support to communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (iii) maximizing all sources of public and private funds for recruitment initiatives; (iv) designing pilot programs and making regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; and (v) making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain physicians, nurses, physician assistants and behavioral, substance use disorder and mental health professionals.

(b) The center shall maintain ongoing communication and coordination with the health

disparities council, established by section 16O of chapter 6A.

(c) The center shall annually submit a report, not later than March 1, to the governor, the health disparities council, established by section 16O of chapter 6A; and the general court, by filing the same with the clerk of the house of representatives, the clerk of the senate, the joint committee on labor and workforce development, the joint committee on health care financing, and the joint committee on public health. The report shall include: (1) data on patient access and regional disparities in access to physicians, by specialty and sub-specialty, and nurses, physician assistants, behavioral, substance use disorder and mental health professionals; (2) data on factors influencing recruitment and retention of physicians, nurses, physician assistants, and behavioral, substance use disorder and mental health professionals; (3) short and long-term projections of physician, nurse, physician assistant and behavioral, substance use disorder and mental health professionals supply and demand; (4) strategies being employed by the council or other entities to address workforce needs, shortages, recruitment and retention; (5) recommendations for designing, implementing and improving programs or policies to address workforce needs, shortages, recruitment and retention; and (6) proposals for statutory or regulatory changes to address workforce needs, shortages, recruitment and retention.

Chapter 111 M.G.L., Section 25N

(a) There shall be a health care workforce loan repayment program, administered by the health care workforce center established by section 25L. The program shall provide repayment assistance for graduate and medical school loans to participants who: (1) are graduates of medical, nursing, or physician assistant schools or accredited graduate schools; (2) specialize in family health or medicine, internal medicine, pediatrics, obstetrics/gynecology, psychiatry, behavioral health, mental health or substance use disorder treatment; (3) demonstrate competency in health information technology, at least equivalent to federal meaningful use standards as set forth in 45 C.F.R. Part 170, including use of electronic medical records, computerized physician order entry and e-prescribing; and (4) meet other eligibility criteria, including service requirements, established by the board.

Each recipient shall be required to enter into a contract with the commonwealth which shall obligate the recipient to perform a term of service of not less than 2 years in medically underserved areas as determined by the center.

(b) The center shall promulgate regulations for the administration and enforcement of this section which shall include penalties and repayment procedures if a participant fails to comply with the service contract.

The center shall, in consultation with the health care workforce advisory council and the public health council, establish criteria to identify medically underserved areas within the commonwealth. These criteria shall consist of quantifiable measures, which may include the availability of primary care medical services or behavioral, substance use disorder and mental health services within reasonable traveling distance, poverty levels and disparities in health care access or health outcomes.

(c) The center shall evaluate the program annually, including exit interviews of participants to determine their post-program service plans and to solicit program improvement recommendations.

(d) The center shall file an annual report, not later than July 1, with the governor, the clerks of the House of Representatives and the senate, the house and senate committees on ways and

means, the joint committee on health care financing, the joint committee on mental health and substance abuse and the joint committee on public health. The report shall include annual data and historical trends of: (1) the number of applicants, the number accepted and the number of participants by race, gender, medical, nursing, physician assistant, behavioral health, substance use, and mental health specialty, graduate, physician assistant, medical or nursing school, residence prior to graduate, medical, nursing, or physician assistant school and where they plan to practice after program completion; (2) the service placement locations and length of service commitments by participants; (3) the number of participants who fail to fulfill the program requirements and the reason for the failures; (4) the number of former participants who continue to serve in underserved areas; and (5) program expenditures.

Executive Summary

The Health Care Workforce Center (the Center) was established by Chapter 305 of the Acts of 2008 and expanded by Chapter 224 of the Acts of 2012. The Center's mission is to improve access to health care in the Commonwealth by supporting programs that assure an optimal supply and distribution of primary care and other health care professionals. The Center is supported by the Health Workforce Transformation Fund through an Interdepartmental Service Agreement with the Executive Office of Labor and Workforce Development. Support is also received by grant funding from the federal Health Resources and Services Administration (HRSA). The Center strives to fulfill its mandate and to further the goals of Chapter 224 by focusing its work in three areas:

- Collection and analysis of data on the Commonwealth's licensed health care workforce to support development of targeted strategies for addressing workforce gaps;
- Administration of federal and state programs that encourage recruitment and retention of primary care providers; and
- Coordination of Department of Public Health (DPH) health care workforce activities with those of other public and private primary care workforce development efforts.

Health Care Workforce Data Collection

The [*Health Professions Data Series*](#) was developed by the Center in 2009 following a state mandate to monitor the composition and distribution of health care providers in order to identify solutions to potential health care workforce shortages. A core dataset was developed to facilitate the monitoring of workforce trends in seven licensed health care provider disciplines: physicians, physician assistants, nurses, licensed practical nurses, dentists, dental hygienists and pharmacists. The core dataset contains data elements such as provider name, specialty, licensing, education and educational status, languages, employment characteristics, (e.g., location, practice type, provider role, planned work hours) and training for patients with disability. Data collection includes discipline-specific questions that are related to emerging practice and regulations.

Biennial Data Series reports help inform policy and program development of DPH initiatives such as the Massachusetts Loan Repayment Program, the State's Oral Health Equity Project, and initiatives within the Office of Health Equity and the State Office of Rural Health.

To access published *Data Series* reports, please visit:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/primarycare-healthaccess/health-care-workforce-center/health-care-workforce-development-reports.html>

Center 2016 highlights include:

- Posted the first physician data reports on the data series website.
- Collaborated with the Office on Health Equity's Health and Disability Program to add core data set questions aimed at identifying clinician trainings that will improve care for persons with disability.
 - Preliminary findings were presented at the Health and Disability Partnership meeting in September 2016.
- Presented the most recent nursing data report to the Board of Registration in Nursing.
- Developed and presented a poster entitled *Geographic distribution and hotspot analysis of primary practice locations of registered nurses and advanced practice registered nurses in Massachusetts* at the [Massachusetts Action Coalition](#) (MAAC) summit, and the [New England Rural Health Roundtable](#) conference. The poster utilizes health series data to map primary practice settings of all practicing RNs and APRNs in the state and show the provider/population ratios by city/town.
- Participated on a workforce panel at the MAAC regarding the nursing workforce data.

Administration of Federal and State Programs

The Center plays a critical role in primary care recruitment and retention by implementing and promoting the following federal and state programs:

- Massachusetts Loan Repayment Program for Health Professionals
- J-1 Visa Waiver Program
- Shortage Designation

Massachusetts Loan Repayment Program for Health Professionals (MLRP)

The Massachusetts Loan Repayment Program (MLRP) supports employment of primary care clinicians in designated shortage areas by helping repay their education loans. The MLRP consists of two components:

- *Component A* is funded in part by a grant from the federal Health Resource and Services Administration (HRSA) that requires a dollar-for-dollar non-federal match. This federal funding also requires that awardees practice in a federally designated Health Professional Shortage Area (HPSA). The federal grant award is \$550,000 annually through 2019.
- *Component C* is funded by the Health Workforce Transformation Fund (\$20,000 in 2016) established by Chapter 224 of the Acts of 2012, which mandates an Inter-State Agreement between the Executive Office of Labor and Workforce Development and the Department.

Chapter 224 of the Acts of 2012 established the Health Care Workforce Transformation Fund, administered by the Executive Office of Labor and Workforce Development, and mandated that 20% (\$4,000,000 over a four-year period) of the fund be transferred to the DPH to support the work of the Center including the MLRP (Components A & C) and the Center data collection activities. In addition, DPH contracts with The Massachusetts League of Community Health Centers (the League) for a complementary loan repayment program focused on eligible primary care physicians, physician assistants, and nurse practitioners in community health centers, and for other activities. The League receives \$500,000 per year over four years. The remaining \$2,000,000 is retained by the DPH to support the MLRP and the Center. The Transformation Fund continues through state fiscal year 2017.

Engagement in the MLRP has grown substantially in the past ten years, from approximately 30 applications annually to more than 130 applications. This growth is due in part to our competitive federal grant award increase from \$350,000/year to \$550,000/year for the 5-year grant which supports Component A.

In response to this MLRP growth, the Department conducted an assessment of the MLRP operations and updated standard operating procedures which streamlined program administration. Resources for the MLRP are limited and the demand is high. Each year, the Department receives applications from two-to-three times more applicants than funding can support.

MLRP Eligibility and Award Process

Eligible applicants must have an employment commitment from an eligible employer (i.e., a public or non-profit entity) providing services in a geographic area or community that is identified as high need. Participants agree to provide the equivalent of two years full-time professional health services in clinical practice for that employer. Part-time practice must be at least 20 hours per week in exchange for a pro-rated increase in the service contract period (i.e., a 20-hour work week means a 4-year contract), for a minimum of 45 weeks per service year.

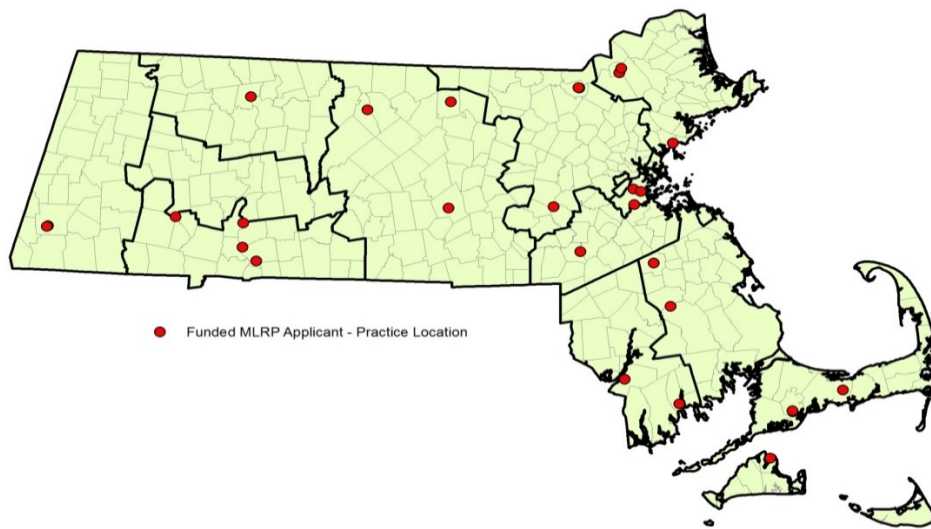
Award amounts vary by profession. The highest award amount is \$40,000 for a two-year contract (maximum of \$20,000 per year) for physicians, psychologists (PhD.), and nurse practitioners. All other qualified health professionals are eligible for a total award of up to \$30,000 over two years (maximum of \$15,000 per year). In the event of a breach of contract, the MLRP can recoup all loan repayment funds provided to the individual, with penalty. There have been no contract breaches since 2009, which we credit to our rigorous information dissemination during the application and contracting process which ensures that each applicant fully understands the contract obligations.

The 2016 MLRP application cycle was July – September. MLRP applications were reviewed using a multilevel deliberative process designed to select awardees that are most likely to provide quality care and continue service beyond their contracted commitment. The review committee included individuals with expertise in behavioral health, epidemiology, oral health, substance use, reproductive health, rural health, adolescent health, and representation from the Department of Mental Health and the League.

In this 2016 application cycle the program received 131 applications and made 32 awards: 31 through Component A and 1 through Component C. A list of the 2016 cycle of MLRP awardees, and a full description of the current MLRP funding sources is presented in the appendix.

The map below shows the distribution of awards in 2016 (SFY 2017)

2017 Massachusetts Loan Repayment Program - Funded Applicants



Related Evaluation and Retention Activities

The MLRP functions as an investment in the state's primary care infrastructure. To ensure that the "return" on that investment extends beyond the two-year service requirement, the Center devotes considerable attention to program evaluation – with respect to participants' experience with the application process and their experience with placement.

In our previous report we noted efforts to seek ways to support our findings of low-cost high-impact tools and incentives that can be used to further support program goals. Our research and literature reviews indicate that engaging MLRP participants in research, training, mentoring, or other activities that support clinician growth and development also support retention in underserved areas. Despite the value of site-specific recruitment and retention plans, most provider sites do not have such plans in place. We are coordinating with the State Office of Rural Health to develop a pilot project that can be used as a model for supporting recruitment and retention planning. Our survey data also showed that hospital affiliation increased the recruitment and retention capacity of community based agencies. However community-based agencies find it difficult to compete with neighboring hospitals' salaries and benefits packages. Our survey data continues to show that access to loan repayment adds significant value as a recruitment and retention tool.

The Center continues *Welcome Surveys* and *Exit Surveys* to improve MLRP administration and to identify ways to increase participant satisfaction and retention rates. This past year we revised survey questions in order to link pre-and-post-survey results so that we may better assess potential for applicant retention after the contracted obligation. We have found Center's recruitment and retention are consistent with national trends.

Welcome Packet

A *Welcome Packet* is provided for MLRP awardees with relevant program information and a welcome survey to obtain feedback on Center performance in the application process and gather information aimed at helping practice sites retain their MLRP participants.

Welcome Survey highlights:

- More than 81% of respondents indicated they planned to continue practicing at their site beyond the MLRP commitment
- The top four factors that were important to participants in choosing their work site, were:
 - Working with underserved populations
 - Opportunities for professional growth
 - Site's reputation
 - Site's qualification for the MLRP

We note that neither the salary nor the benefit package was identified in the top 4 determinants for practicing at the site.

- Regarding rural experience, 21% of respondent practice sites were in less urban or rural areas and 44% of respondents had lived at least 1 year in a rural setting and 39% had practiced in a rural setting.
- Regarding MLRP evaluation, 93% of respondents indicated they would very likely refer a friend or colleague to the program; and 90% were satisfied with their overall program experience.

Exit Survey

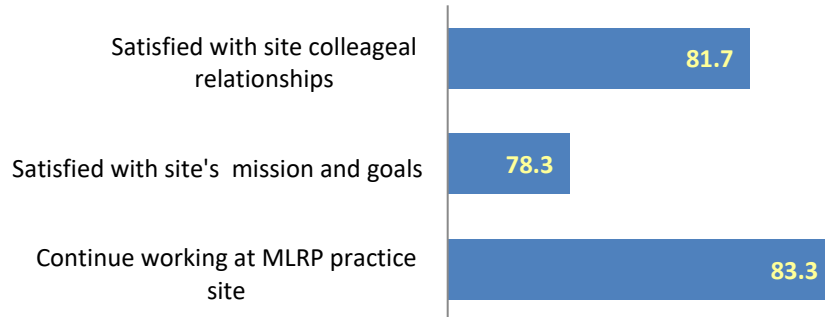
Since 2009 the Center has conducted an exit survey prior to MLRP participants completing their term of service.

Exit Survey Highlights:

Exit survey responses of health professionals ending their MLRP contract obligation period included the following: Most respondents were satisfied with their practice site mission, collegial relationships, and benefits package and did not consider leaving their site. Over half agreed that there was adequate site and community orientation, training, leadership support, encouragement of teamwork, and recognition for work done well.

The results shown in the chart below suggest that the MLRP supports health professionals who will or are being retained at their practice sites.

**Upon exiting the program, most providers
were satisfied with the MLRP and their
practice site**



Survey Summary

The Center continues to find (from both the welcome and the exit surveys) that MLRP participants have both an initial and ongoing commitment to working with underserved populations; and that the financial support they receive from the MLRP makes it possible for them to pursue those practice goals. Research also indicates that while the loan repayment program is an essential tool, other initiatives are also important to maintain long-term retention beyond a 5-year period. The Center staff is also exploring ways to implement post-participation follow-up strategies to track over time health professionals' practice in a high need area after their loan repayment contract obligation is met.

J-1 Visa Waiver Program

Another important resource for primary care capacity-building in underserved areas is the Conrad-30 / J-1 Physician Visa Waiver program. J-1 visas are non-immigrant visas issued by the United States to visitors participating in programs that promote cultural exchange, with a focus on individuals who want to obtain medical or business training within the U.S. The J-1 Visa allows international medical graduates to come to the United States under an educational exchange program for up to seven years. When the visa expires, they must return home for at least two years before applying for a permanent visa in the United States. A J-1 Visa Waiver eliminates the two year home residency requirement and allows the physician to remain and practice medicine in the United States if they agree to practice in a federally designated shortage or underserved area for at least 3 years. State government agencies can sponsor up to 30 J-1 Physician waiver requests annually.

The Center application review process focuses on DPH priorities including geographic need and behavioral health (e.g. mental health and substance use).

J-1 Visa Waiver Totals - 2016

In 2016 the Center received 39 applications, recommended 30 to practice in Massachusetts and did not support 9 applications. Supported applications included primary care physicians, psychiatrists, and specialty physicians. Massachusetts has 92-J-1-Visa Waiver physicians who remain obligated as of December 2016, and 23 physicians completed their 3-year obligation in CY2016.

Related Evaluation and Retention Activities

In 2016 the Department conducted an assessment of the related Visa Waiver program activities and processes to identify possible improvements. The assessment resulted in an expanded program FAQ and posting of additional program information to encourage applications that are closely aligned with Center priorities.

The Center is also reviewing the Visa Waiver exit survey process that was initiated in 2015. The exit surveys are sent to Visa Waiver program participants who have either completed or will be completing their 3-year commitment. For the year ending 2016 there are 23 Visa Waiver program participants who will be surveyed. The Center anticipates the Visa Waiver exit surveys will resume in spring 2017.

In January 2015, 24 Visa Waiver participants completing their 3-year commitment were emailed the survey (21 responded), the results are as follows:

- Most respondents planned to continue practicing in a federally designated HPSA or Medically Underserved Area or Population (MUA/MUP) after their 3-year commitment.
- Most participants said they would recommend the J-1 program to others.
- Most participants had prior professional experience with medically underserved populations.
- Principal reasons for leaving their site included family needs, professional opportunities, and salary/benefits.

Shortage Designation

The Center is responsible for managing federal Health Resources and Services Administration (HRSA) shortage designation assessments and applications for Massachusetts. These federal designations provide access to federal grant funding and other program benefits for Massachusetts communities, health care facilities, and providers. The overall purpose is to identify areas of greatest need, so that limited resources can be prioritized and directed to the people in those areas. This need is evaluated based on a complex set of statistical criteria, as well as population demographics and geographic factors.

Some federal shortage designation benefits include: eligibility for National Health Service Corps (NHSC) supported clinicians and the Medicare Physician Bonus and the Medicare Surgical Bonus programs, which can amount to millions of dollars annually, and eligibility for educational and other grants.

2016 Accomplishments

Health Access and Status Needs Assessment

The Center has conducted an overall statewide community health needs assessment in 2016. The statewide needs assessment incorporated data from a wide array of sources with guidance and input from programs within the Bureau of Community Health and Prevention in DPH.

The statewide community health needs assessment is a process that is used to help identify and quantify potential health care needs at the community level, specifically focusing on primary care. The primary goals of the needs assessment are to:

- Identify communities with the greatest unmet health care needs, health disparities, and workforce shortages
- Identify the key barriers to accessing health care for the communities of highest need
- Help develop strategies to improve health outcomes and health care access for high need communities

The needs assessment goals align with the Center mission. The results inform priority setting and developing recommendations for initiatives to improve health outcomes and access to care for identified high need communities and groups. The needs assessment will also provide both our community partners and other programs within DPH with community level data to aid in their own program planning. The needs assessment is in final review and a copy will be available on our webpage (www.mass.gov/dph/hcworkforcecenter).

Federal Shortage Designation Management System

In 2016 the majority of our federal designation activity focused on: 1) changes to the federal HRSA-Shortage Designation Management System (SDMS) an electronic shortage designation application and review system, and 2) a planned impact analysis and report that the federal HRSA has scheduled for mid-2017.

The federal HRSA initiated a Shortage Designation Project with the goal of modernizing the shortage designation process for one aspect of shortage designation, the Health Professional Shortage Area designation and scoring process. One component of the project is to update

existing geographic, population, and some facility HPSA designations using national, standardized data sets and data provided by states. In order to meet the requirements of this project the Center has been reviewing, correcting and updating provider data in the federal SDMS in order to ensure an accurate assessment of Massachusetts' primary care providers for dental, behavioral/mental health and medical care. An accurate assessment will help Massachusetts's neediest communities qualify for federal funding and other resources. This work will continue into 2017.

Coordinating Primary Care Workforce Development Activities

A key Center mandate is to coordinate public and private health care workforce activities with those of the Department. The Center is pleased to report the following:

- The Center is to be advised by a 19 member Health care Workforce Advisory Council appointed by the Governor.
 - The Council consists of representatives of various disciplines and affiliations, as mandated in the legislation, each serving a three-year term, and designed to give wide ranging and detailed perspectives in regards to issues facing health care workforce development and retention.
 - While several member slots remain unfilled, a quorum has been established. The Council will formally meet in 2017.
- The Center is represented on the Health Workforce Transformation Fund Advisory Board. The Director of the Division of Health Access represents the DPH Commissioner on this Board and the Center Director provides program support.
- The Center Director participates on the University of Massachusetts Medical School - Learning Contract Advisory Group.
- The Center Director continues monthly meetings with the Commonwealth Corporation which represents the Executive Office of Labor and Workforce Development, and includes the Massachusetts Area Health Education Center (MassAHEC) and others depending upon topic. Each of the entities represents a unique perspective of health care workforce.
- The Center collaborates with the MassAHEC and the Mass League of Community Health Centers on several initiatives relating to health centers and rural health care.
 - The work includes health workforce assessment and development and information sharing on various partner initiatives including the Rural Scholars program.
- The Center Director participates on the Community Health Worker Advisory Group.
- The Center is represented on the Health and Disability Partnership.
- Center is represented on the Massachusetts Rural Council on Health and the New England Rural Health Roundtable.
- The Center is represented on the Massachusetts of Massachusetts Medical School – Rural Scholars Program.
- The Center Director participates on the Massachusetts League of Community Health Center workforce retention and loan repayment program review committee.

Next Steps for the Center in 2017

- Continue efforts with the Division of Professional Licensure to gather data on additional health workforce disciplines including behavioral health, allied health, and others.
- Continue work with the DPH Bureau of Substance Abuse Services (BSAS) to initiate reports on those substance use providers licensed through BSAS.
- With our Board of Registration in Nursing we are considering an in-depth report on advanced practice registered nurses. We will identify a partner at one of the nursing schools to work with us to develop a report with the next iteration of nursing data.
- Refine MLRP surveys to include a sample of non-awardees.
- Add a 1-year follow up survey post-contract-commitment for MLRP and the Visa Waiver program.
- Refine Massachusetts-specific high need or shortage designation criteria using the needs assessment.
- Post results of our MLRP Welcome and Exit surveys on our Center webpage.

We will continue internal partnerships with our offices of Health Equity, Oral Health, Rural Health, the Office of Community Health Planning and Engagement, licensing boards, and relevant sister state agencies such as the Department of Mental Health, Labor and Workforce Development, Higher Education, Developmental Disability, MassHealth and the Massachusetts Center for Information and Analysis. We will continue monthly meetings with the Commonwealth Corporation and Massachusetts Area Health Education Centers to maintain communication about and support for work toward shared goals. Finally, we will continue relationships with academic training centers and with the New England Rural Health Roundtable.

Conclusion

Massachusetts is nationally recognized for its robust, high-performing primary care workforce and for its extraordinary health care access, services and strong health outcomes. The capacity to collect and monitor health professions workforce data and support workforce development is critical to ensuring that the health care needs of Massachusetts residents are adequately addressed. The Health Care Workforce Center continues to diligently support a strong health care workforce that provides highly accessible quality care to Massachusetts residents.

Appendix

Massachusetts Loan Repayment Program for Health Professionals: State Fiscal Year 2017 Overview of Funding and Awards

Funding and Sources

\$1,120,000 was available to fund contracts for qualifying health professionals in state 2016 (State FY'17). These funds are 48% federal, 31% state monies, and 21% trust fund (the Healthcare Transformation Fund through chapter 224).

Federal HRSA	4500-1069	\$550,000
State Match	4510-0110	\$350,000
ISA Trust Fund	7003-1224	\$220,000
(Includes The League <i>through ISA-contracted funds of \$50,000</i>)		

Component A:

Federal HRSA	4500-1069	\$550,000
State Match	4510-0110	\$350,000
ISA Trust Fund	7003-1224	\$150,000
Subtotal available for Component A awards		<u>\$1,100,000</u>

Component C

ISA Trust Fund for 1 awardee	\$20,000
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The chart below lists the profession and the number of awards for 2016 (SFY 2017)

Profession	Number of Awards
Certified Nurse Midwife (CNM)	0
Dentist (DDS or DMD)	4
Registered Dental Hygienist	1
Health Service Psychologist	0
Licensed Independent Clinical Social Worker (LICSW)	4
Licensed Alcohol and Drug Counselor (LADC-1)	1
Licensed Professional Counselor	0
Mental Health Counselor	2
Nurse Practitioner	13
Physician Assistant	0
Clinical Pharmacist	0
Physician – DO	1
Physician – MD	5
Psychiatric Nurse Practitioner	1
TOTAL	32