Overall Work and Practice Satisfaction of Licensed Clinical Social Workers in the National Health Service Corps Loan Repayment Program

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Little is known about the job satisfaction of licensed clinical social workers (LCSWs) participating in the National Health Service Corps (NHSC) federal Loan Repayment Program (LRP). Employee satisfaction in organizations is important for organizational well-being and to decrease turnover. A satisfied NHSC LCSW workforce is also important given the array of services it provides, especially in rural and underserved areas. This study examined the work satisfaction of 386 LCSWs participating in the NHSC LRP in 21 states. Rural upbringing, being older than 40 years, and a higher salary were significantly associated with overall work and practice satisfaction. In addition, satisfaction with administration, staff and the practices' linkages to other health providers, the mission of the practice, and connection with patients were strongly associated with overall work and practice satisfaction. To our knowledge, this is the first study to examine the work and practice satisfaction of LCSWs participating in the NHSC LRP, and our findings have the potential to inform the NHSC's strategies in managing and retaining LCSWs.

KEY WORDS: *job satisfaction; Loan Repayment Program; National Health Service Corps; social work; workplace psychology*

The National Health Service Corps (NHSC) is a federal program that aims to improve access to health care practitioners in Health Professional Shortage Areas (HPSAs), principally by providing educational loan repayment incentives to clinicians who practice in areas of need (Bird, Dempsey, & Hartley, 2001). Fully trained health professionals in qualifying disciplines and working in NHSC Loan Repayment Program (LRP) designated sites can have from $15,000 to $50,000 in educational loans repaid for an initial two-year NHSC contract. The amount of these contracts varies by the site's HPSA severity score, full- or part-time employment, and amount of educational loans (Health Resources and Services Administration [HRSA], 2019). One-year renewal contracts are also available. NHSC sites include federally qualified health centers (FQHCs), Indian Health Service and tribal clinics, federal and state correctional facilities, community mental health facilities, health departments, school-based health programs, and other settings.

The NHSC LRP supports a workforce of roughly 10,000 clinicians in disciplines within primary care, dental health, and mental and behavioral health. The latter group, which makes up one-third of the NHSC's LRP workforce (HRSA, 2018), includes psychiatrists, psychologists, master's-level licensed clinical social workers (LCSWs), licensed professional counselors, marriage and family therapists, psychiatric nurse specialists, and nurse practitioners and physician assistants in mental health specialties. The proportion of the NHSC's mental and behavioral health workforce that each discipline constitutes is not reported, but earlier work by Pathman and Konrad (2012) noted that LCSWs make up about one-quarter of the behavioral health practitioners in the NHSC LRP.

Little is known about the job satisfaction of NHSC LCSWs, but employee satisfaction in behavioral health organizations is important for organizational well-being (Glisson, Green, & Williams, 2012) and to limit turnover (Mor Barak, Nissly, & Levin, 2001). A satisfied NHSC LCSW workforce is also important given the array of services social workers can provide in integrated health settings—crisis management, behavioral health care, client

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education, and referrals (Fraser et al., 2018; Zerden, Lombardi, Fraser, Jones, & Rico, 2018)—for rural and underserved areas with limited behavioral health services (Friedberg et al., 2014) and in addressing the opioid epidemic (Lombardi, Zerden, Guan, & Prentice, 2019).

Moreover, with the expansion of Medicaid-funded services under the Patient Protection and Affordable Care Act and the growing integration of physical and behavioral health care (Stanhope, Videka, Thorning, & McKay, 2015), social workers play an increasingly important role as providers of integrated health and behavioral health care (Fraher, Richman, Zerden, & Lombardi, 2018; Fraser et al., 2018). Currently, nearly 160,000 social workers work in health care settings within the United States (Bureau of Labor Statistics [BLS], 2016), and the workforce is projected to increase by 20 percent over the next decade (BLS, 2017). However, where social workers are employed, and how this aligns with behavioral health shortage areas, is not well understood as there is no national data set of social workers. Although there remains a paucity of data available regarding the number, scope, and roles of social workers in health care settings (Fraher et al., 2018), it is well understood that the shortage of behavioral health care providers generally compromises access to local services and increases health disparities (Probst, Moore, Glover, & Samuels, 2004; Substance Abuse and Mental Health Services Administration, 2007).

Furthermore, job satisfaction of LCSWs also warrants attention. To date, job satisfaction of LCSWs supported by the NHSC has not been examined. Studies of the NHSC have principally addressed physicians (Pathman, Konrad, & Ricketts, 1994), physician assistants and nurse practitioners (Pathman, Konrad, & Hooker, 2014), and dentists (Bhatavadekar, Rozier, & Konrad, 2011). Prior research evaluating the job satisfaction of non-NHSC LCSWs has shown that workplace civility (Yanchus, Periard, & Osatuke, 2017), respect from other disciplines (Marriott, Sexton, & Staley, 1994), adequate pay (Acker, 2004; Jerrell, 1983), promotional opportunities (Siefert, Jayaratne, & Chess, 1991), clinical autonomy (Gleason-Wynn & Mindel, 1999), and supervisory support (Ulrich et al., 2007; Yanchus et al., 2017) all play a role in job satisfaction. These studies have generally been limited by small sample sizes and typically combine several mental health professionals, obscuring any issues unique to social workers.

To better understand LCSWs working in areas of need, this study assessed the overall satisfaction with work and the practice of LCSWs participating in the NHSC LRP. Specifically, this study examined LCSWs' satisfaction with various facets of their work lives and their practices and evaluated how overall work and practice satisfaction differs by demographic characteristics, practice settings, and community features.

METHOD

Design

A cross-sectional study design was used to examine overall satisfaction with work and practice within a large, geographically dispersed sample of LCSWs serving in communities in nearly half of all U.S. states. The University of Chapel Hill Office of Human Research Ethics deemed this study, which used deidentified survey data gathered principally for administrative purposes, exempt from human research subjects review (Study #12-0626; February 15, 2017).

Study Sample

Subjects were LCSWs participating in the NHSC LRP in the 21 states participating in the Practice Sights Retention Collaborative, a group of states' primary care offices collaborating to gather information on clinicians in the NHSC and in states' own LRPs and other clinician recruitment incentive programs (Rauner et al., 2015). A total of 453 LCSWs in 21 states were asked to complete questionnaires at the end of their first or second years of an initial two-year LRP contract ($n = 155$) or at the end of a one-year extension contract ($n = 231$), during the 32-month period from July 1, 2015, through December 31, 2017. This resulted in 386 LCSWs who responded, including 358 who were at the end of a contract and 28 who were one year into their first contract, for a response rate of 85.2 percent. For analyses, we used only one questionnaire per respondent. In cases where a respondent completed both an end-of-year and an end-of-contract questionnaire, we used end-of-contract data.

Demographics and Background

Demographic information and practice characteristics were drawn from NHSC roster data and

verified by respondents. Individual clinician information included age, gender, race (White, Hispanic, Black, Native American or Alaskan Native, Asian, other), relationship status (single, married, divorced, engaged, has significant other, widowed), number of children living at home, type of community lived in before college (urban, suburban, small town or rural, no principal place), current educational debt, and contract type (first NHSC LRP contract versus renewal contract). A survey item querying current educational debt was only asked in the end-of-contract questionnaire.

For practice and job characteristics, respondents reported their principal practice setting while serving their NHSC contracts. Site types included FQHCs or community health centers, Indian Health Services or tribal sites, mental health facilities, and several other less common practice types. Respondents also reported their salaries; the number of hours they worked per week; whether they taught students; the proportion of their patients or clients who were non-Hispanic White; and the proportion of their patients who were covered under the Indian Health Service, Medicaid, or had no insurance coverage. Community characteristics included the proportion of the local population below 100 percent of the federal poverty line and whether practice sites were in rural or urban counties. Poverty rates were obtained by matching the practice site ZIP code to ZIP Code Tabulation Areas (U.S. Census Bureau, 2018). These, in turn, were used to obtain poverty-level percentages from the American Community Survey and U.S. Census Bureau data (American Academy of Family Physicians, 2019).

Overall Work and Practice Satisfaction and Facet Satisfaction

Twenty-two items derived from the Physician Worklife Survey (PWS) assessed satisfaction with various aspects of LCSWs' jobs and their practices and their overall satisfaction with work and their practice setting (Williams et al., 1999). The PWS was developed by a team of researchers that included two of this study's coauthors (Thomas Konrad and Donald E. Pathman) and has been used in national surveys of physicians and adapted for other health professions (Pathman, Konrad, Sewell, Fannell, & Rauner, 2019; Williams et al., 1999). In the survey instrument, LCSWs indicated their level of agreement on a five-point Likert scale, ranging from 1 = strongly disagree to 5 = strongly agree, with statements such as, "My work leaves me enough time for my personal life," and "Staff in my practice support my professional judgment."

We grouped the 20 items about specific areas of satisfaction into six distinct facets of work and job satisfaction based on exploratory factor analysis with an oblique oblimin rotation (Acock, 2013). Six facet satisfaction scales were created by averaging responses to the two to five items that loaded on each scale: (1) administration (five items; Cronbach's alpha [α] = .83); (2) staff and service linkage (five items; α = .78); (3) mission orientation and patients (three items; α = .75); (4) community integration (two items; α = .79); (5) work–life balance (three items; α = .72); and (6) compensation (two items; α = .55). We averaged responses to the two global questions for a scale of overall work and practice satisfaction: "Overall, I am satisfied with my work" and "Overall, I am satisfied in my current practice" (α = .81).

Statistical Analysis

Descriptive statistics were used to characterize respondents, their practices, and their communities. We then described respondents' overall job satisfaction with their work and practice as well as satisfaction with the six distinct job facets. We dichotomized and trichotomized some continuous variables based on the distribution of the data and the need for group sizes large enough to allow for stable comparisons. Then two-way independent groups *t* tests and one-way analysis of variance were used to examine the relationships between overall job satisfaction and demographic and community characteristics. We used Pearson's correlations to measure the degree of association between individual, work and practice, and community continuous variables with overall work and practice satisfaction (Konrad, 2015).

We fit a linear regression model to determine adjusted relationships between overall work and practice satisfaction and the demographic, work and practice, and community variables after running a correlation matrix to identify and eliminate highly correlated variables. We then used backward elimination based on partial *F* tests to reduce variables in the model that did not contribute to overall model R^2. As a second approach for model reduction, we removed variables that had *p* values

greater than .20 in unadjusted bivariate analysis from the full set of variables: The final set of variables in the reduced form model were the same with the two approaches. To help interpretation, we used Stata's statistical software (Version 14.2) (StataCorp, 2016) margins command to calculate adjusted predicted means for the categorical variables in our final model.

Respondents who did not respond to either of the two overall satisfaction items or to more than one of the narrower satisfaction items were omitted from analysis ($n = 13$, 3.3 percent). We used deterministic imputation to impute the missing values for a single, facet-specific satisfaction item (Enders, 2010). In this sample, 70 LCSWs listed missing or illogical (for example, less than $10,000) approximate annual salary values; we assigned mean salary values for part-time (<35 hours a week) and full-time (>35 hours a week) LCSWs, as appropriate. We considered p values less than .05 statistically significant. All analyses were performed using Stata's statistical software (Version 14.2).

RESULTS

Most of the 386 respondents were female (85 percent), married (61 percent), and identified as non-Hispanic White (90 percent) (see Table 1). Just over half (51 percent) reported that they grew up in a rural community. Reported mean residual educational debt at the time questionnaires were completed, which was at the end of loan repayment contracts for many, was $17,486 ($SD$ = $26,500). The majority (92 percent) of respondents were completing or serving their first NHSC loan repayment contract when they completed the questionnaire that was included in these analyses. A comparable proportion of LCSWs worked in mental health facilities (38 percent) and FQHCs or community health centers (41 percent). Mean reported annual salaries were $56,716 ($SD$ = $13,572), and most LCSWs worked full-time (93 percent). Respondents reported that about 70 percent of their patients had insurance coverage through Medicaid or Indian Health Service tribal insurance or were uninsured. The communities in which LSCWs served were generally poor, with 20 percent of the population having incomes below 100 percent of the federal poverty level (FPL). Similar percentages of LCSWs worked at rural (52 percent) and urban (48 percent) sites.

The NHSC LCSWs had high mean overall satisfaction levels for their work and practices (4.0 on a 1–5 scale) (see Table 2). They were most satisfied with the mission orientation of their practice and their connection with patients and least satisfied with their compensation. Of the items comprising satisfaction with their practices' mission and their connectedness with patients, 99 percent of LCSWs agreed that they were "doing important work" and 96 percent agreed that they "valu[ed] the mission of [their] practices." Of the items addressing compensation, LCSWs were overall neutral in agreeing with the statement, "I am not well compensated given my training and experience" ($M = 3.0$) and only weakly agreed with the item, "My total compensation package including benefits is fair" ($M = 3.4$). Relationships with staff and how their practice was linked to the broader health system was another area of relative satisfaction for these NHSC LCSWs ($M = 4.1$). Two other areas of relatively low satisfaction were with work–life balance ($M = 3.3$) and with the administration of their practices ($M = 3.5$).

In unadjusted bivariate analysis, two clinician characteristics, age > 40 and having a rural or small-town upbringing, were associated with higher overall satisfaction ($p < .05$, for both). Among practice and job characteristics, salary was positively correlated with overall job satisfaction ($r = 0.13$, $p = .02$). Of the community characteristics, there were no significant bivariate associations with either poverty level or rurality and overall work and practice satisfaction (see Table 3).

The full model that adjusted simultaneously for individual clinician, work and practice, and community characteristics had borderline statistical significance ($p = .054$) and low explanatory power ($R^2 = 0.053$) (see Table 4). Anticipating that the full model contained too many variables for the size of the sample's relatively narrow distribution of overall satisfaction values, we used backward elimination to remove variables that did not contribute to explanatory power (that is, they could be omitted with no significant loss of R^2). In the reduced model, LCSWs age 40 years and greater had an adjusted mean overall work and practice satisfaction score of 4.12 versus 3.95 for those less than 40 ($p = .03$). LCSWs with a rural upbringing versus nonrural upbringing had adjusted mean overall work and practice satisfaction scores of 4.12 and 3.93, respectively ($p = .01$). Furthermore, every

Table 1: Individual Clinician, Work and Practice, and Community Characteristics ($N = 386$)

Variable	*n*	%	*M* (*SD*)
Individual clinician factors			
Age	386		42 (9.6)
Gender			
Male	60	16	
Female	326	84	
Race[a]			
White	349	90	
Hispanic	33	9	
Black	11	3	
Indian	6	2	
Asian	12	3	
Hawaii	6	2	
Other	6	2	
Relationship status			
Single	77	20	
Married	235	61	
Divorced	49	13	
Engaged	6	2	
Significant other	18	5	
Widowed	1	0	
Children			
0	199	53	
1–5	179	46	
Rural upbringing			
Small town or rural	210	57	
Urban, suburban, no principal place	161	43	
Current educational debt[b]	216		$17,486 ($26,500)
Type of contract			
First contract	356	93	
Renewal	28	7	
Practice and job characteristics			
Practice type			
FQHC or community health center	158	41	
Health department	4	1	
Hospital-based site	9	2	
Indian Health Service or tribal site	20	5	
Mental health facility	145	38	
Migrant health center	2	1	
Correctional facility	7	2	
Rural health center	14	4	
Other	27	7	
Salary from service practice	316		$56,716 ($13,572)
Full-time	353	93	
Teach	67	17	
Proportion of non-Hispanic White patients			
0 to 25th percentile	101	28	

(Continued)

Table 1: Individual Clinician, Work and Practice, and Community Characteristics ($N = 386$) (Continued)

Variable	*n*	%	*M* (*SD*)
25th to 75th percentile	147	41	
75th to 100th percentile	109	31	
Proportion of patients uninsured or with Indian Health Service or Medicaid coverage	371		0.70 (0.28)
Community characteristics			
Poverty			
Proportion of population below 100% of the federal poverty level	386		0.20 (0.09)
Rurality			
Rural	200	52	
Urban	185	48	

Note: FQHC = federally qualified health center.
[a]Sum of numbers for race do not equal 386 because respondents marked all races with which they identified.
[b]Items asking about current educational debt were only included in end-of-contract questionnaires, which comprised 231 of the 386 questionnaires in our sample.

$10,000 increase in salary was associated with an adjusted mean increase of 0.06 points in overall work and practice satisfaction ($p = .03$).

Satisfaction levels of all six facets (scales) of satisfaction were significantly associated with LCSWs' overall satisfaction with their work and practice (see Table 5). Satisfaction with staff and service linkage and satisfaction with mission orientation and relationship with patients had the strongest associations with overall satisfaction, while satisfaction with work–life balance and compensation had the weakest associations. The model including all six satisfaction facets explained 55 percent of the variance in overall work and practice satisfaction.

DISCUSSION

This study of the overall satisfaction with work and practice of NHSC LCSW LRP participants found that NHSC LCSW LRP participants are generally satisfied, with 86 percent reporting that they are satisfied or very satisfied. Among specific aspects of satisfaction, LCSWs' level of satisfaction with organizational features explained the greatest portion of overall work and practice satisfaction. Among individual clinician, work and practice, and community characteristics, a rural upbringing, being older than 40, and higher salary explained a smaller proportion of overall work and practice satisfaction than the specific aspects of satisfaction. Notably, lower satisfaction levels were not associated with arguably more challenging settings, including practices with fewer privately insured clients and communities with greater levels of poverty and more racial–ethnic minorities.

The associations in multivariate analysis between overall work and practice satisfaction and satisfaction with staff and service linkage, as well as mission orientation and patient satisfaction, may also reflect the values that social workers bring to their work. Specifically, the overall work and practice satisfaction of NHSC LCSWs may relate to how their work lives resonate with the core values of their profession as a whole—service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (National Association of Social Workers, 2017). Previous literature has also reported how social workers' job satisfaction has been linked to altruism and sense of connection to clients (Stalker, Mandell, Frensch, Harvey, & Wright, 2007). From this perspective, satisfaction with staff and service linkages may indicate satisfaction with an organization's ability to promote the well-being of individual patients.

The strong association between overall satisfaction and satisfaction with administration, staff and service linkages, and mission orientation and patient satisfaction could suggest that the fit between the LCSW and the position matters more for job satisfaction than demographic, practice, or community characteristics. As was previously highlighted in earlier research, job satisfaction was higher for those working in an environment that was more collaborative and team based (Jerrell, 1983), and more civil (Yanchus et al., 2017). Given that integrated care offers both physical and behavioral health services, likely through multiple providers, it could be that the

Table 2: Satisfaction Items and Facets and Overall Satisfaction ($N = 386$)

Variable	*M* (*SD*)	% Satisfied[a]	% Not Satisfied	Cronbach's Alpha
Overall satisfaction	4.0 (0.7)	86	14	.81
Overall, I am pleased with my work	4.1 (0.6)	88	12	
Overall, I am satisfied in my current practice	3.9 (0.9)	78	22	
Satisfaction facets				
Administration satisfaction	3.5 (0.8)	52	48	.83
My practice/organization is financially stable	3.8 (1.0)	67	33	
The staffing of my practice is stable—not much recent turnover	3.0 (1.3)	44	56	
The administrator of my practice/organization is effective	3.7 (1.0)	64	36	
I have a good relationship with the practice administrator	4.0 (0.9)	75	25	
I have real input into administrative decisions	3.0 (1.2)	37	63	
Staff and service linkage satisfaction	4.1 (0.7)	83	17	.78
My practice is well linked with the broader medical, mental, and dental health care systems	4.0 (0.9)	78	22	
I have good backup from partners or supervising clinicians	4.0 (1.0)	79	21	
I am able to provide the full range of services for which I was trained and wish to perform	4.1 (0.9)	85	15	
Staff in my practice support my professional judgment	4.4 (0.7)	93	7	
Staff in my practice are a major source of personal support	3.9 (1.0)	70	30	
Mission orientation and patient connection satisfaction	4.5 (0.5)	97	3	.75
I feel a strong personal connection with my patients	4.3 (0.7)	89	11	
I feel that I am doing important work	4.7 (0.5)	99	1	
I fully value the mission of my practice	4.6 (0.6)	96	4	
Community integration satisfaction	3.9 (0.8)	81	19	.79
I feel a sense of belonging to the community	4.0 (0.9)	77	23	
I am involved in community issues important to me	3.8 (0.9)	70	30	
Work–life balance satisfaction	3.3 (0.9)	43	57	.72
Work rarely encroaches on my personal time	3.0 (1.1)	39	61	
My work leaves me enough time for my personal life	3.4 (1.0)	57	43	
I have the needed flexibility in my work hours	3.4 (1.1)	57	43	
Compensation satisfaction	3.2 (0.9)	46	54	.55
I am not well compensated given my training and experience (reversed)	3.0 (1.2)	40	60	
My total compensation package including benefits is fair	3.4 (1.0)	51	49	

[a]Percentage satisfied for individual items calculated using the sum of scores > 4. Percentage satisfied for composite items calculated using the sum of scores > 3.5.

team-based, collaborative care contributes to overall satisfaction.

Team-based approaches to primary care have been shown to improve satisfaction among physicians, improve clinical outcomes, and increase patient satisfaction (Grumbach & Bodenheimer, 2004). However, the extent to which respondents of this study worked in collaborative models remains unknown. Previous studies have found that professional respect from other disciplines (Marriott et al., 1994) and autonomy (Arches, 1991) are associated with job satisfaction (Ulrich et al., 2007). In addition, a study of British behavioral health staff showed that higher satisfaction was associated with "working with people" and "management" (Prosser et al., 1997). Thus, the match between organizational variables and overall satisfaction resonates with the quadruple aim of health care transformation—improving care, improving population health outcomes, reducing costs, and preventing provider burnout (Bodenheimer & Sinsky, 2014).

Findings also showed that LCSW's satisfaction with their compensation was significantly associ-

Table 3: Unadjusted Associations between Demographics, Practice and Job Characteristics, and Community Characteristics with Overall Job Satisfaction ($N = 386$)

Variable	*n*	Overall Satisfaction or Correlation *M* (*SD*)	*p*
Individual clinician factors			
Age (continuous variable)	386	$r = 0.07$	.20
Age (dichotomous using 40 as cutoff)			
At least 40 years old	187	4.12 (0.67)	.03
Less than 40 years old	199	3.96 (0.75)	
Gender			
Male	60	4.03 (0.69)	.97
Female	326	4.04 (0.72)	
Race			
Non-Hispanic White	314	4.01 (0.71)	.21
Other	72	4.13 (0.76)	
Relationship status			
Married, engaged, have significant other	259	4.02 (0.70)	.46
Single, divorced, widowed	127	4.07 (0.75)	
Children			
Yes	179	4.07 (0.72)	.29
No	199	3.99 (0.71)	
Rural upbringing			
Rural or small town	210	4.10 (0.66)	.04
Urban, suburban, or no principal place	161	3.95 (0.77)	
Type of contract			
First contract	356	4.04 (0.71)	.90
Renewal	28	4.02 (0.66)	
Practice and job characteristics			
Practice type			
Mental health facility	145	4.01 (0.66)	.58
Other types of facilities[a]	241	4.05 (0.75)	
Salary from service practice[b] (per $10,000)	316	$r = 0.13$	.02
Full-time			
Yes	353	4.04 (0.72)	.87
No	25	4.06 (0.74)	
Teach			
Yes	67	3.97 (0.66)	.41
No	319	4.05 (0.73)	
Proportion of non-Hispanic White patients			
0 to 25th percentile	101	4.06 (0.81)	.88
25th to 75th percentile	147	4.02 (0.68)	
75th to 100th percentile	109	4.06 (0.65)	
Proportion of patients uninsured or with Indian Health Service or Medicaid coverage	371	$r = -0.01$	.91
Community characteristics			
Poverty			
Proportion of population below 100% of the FPL	386	$r = 0.08$	.14

(Continued)

Table 3: Unadjusted Associations between Demographics, Practice and Job Characteristics, and Community Characteristics with Overall Job Satisfaction ($N = 386$) (Continued)

Variable	*n*	Overall Satisfaction or Correlation *M* (*SD*)	*p*
Rurality			
Rural	200	4.10 (0.69)	.12
Urban or suburban	185	3.98 (0.73)	

Note: FPL = federal poverty level.
[a]The category of other types of facilities includes federally qualified health centers or community health centers, health departments, hospital-based sites, Indian Health Service or tribal sites, migrant health centers, prisons, rural health centers, and sites classified as other practice site types.
[b]We calculated the correlation between overall satisfaction and annual approximate salary using nonimputed values. The correlation between overall satisfaction and annual approximate salary (per $10,000) using imputed values was 0.11 ($p < .03$).

ated with their overall satisfaction, ranking fourth among six satisfaction facets in its strength of association. Similarly, the association between actual salary and overall job satisfaction was significant. These results were consistent with previous research showing salary's positive association with job satisfaction (Acker, 2004), but contrary to other studies that found no such association for social workers (Vinokur-Kaplan, Jayaratne, & Chess, 1994). In addition, our sample had substantially higher mean average salaries ($44,000 versus $56,716) than reported elsewhere for recent MSW social worker graduates who worked in a variety of settings including mental health, health care, children and families, and school social work (Salsberg et al., 2019). Furthermore, the average total educational loan amount of our participants ($17,486) was slightly less than the average noninflated adjusted loans for social and behavioral graduate students in 2008 ($17,700) (U.S. Department of Education, National Center for Education Statistics, 2010) and less in total debt average ($30,000) derived from a related but dated study (Yoon, 2012). The differences in educational debt and mean salary likely stemmed from the greater age of our participants relative to the NASW survey respondents who were more than 10 years younger than our sample (mean age 42 versus 31 years old) and because many of our participants had already had some portion of their debt paid by the NHSC LRP at the time of survey completion.

The finding that LSCWs over age 40 were more satisfied than younger LCSWs mirrors the finding of other studies that age correlates with satisfaction among social workers (Jayaratne & Chess, 1986) and among social worker supervisors (Poulin, 1996). We also found that job satisfaction was not associated with the proportion of patients insured under Medicaid, Indian Health Service or tribal coverage; or who were uninsured, nor with the proportion who were below the FPL. These patient characteristics can arguably be assumed to be associated with greater workload, which has been negatively associated with job satisfaction (Hooper, 2016).

Study limitations include the cross-sectional and observational nature of the data, which precludes the determination of causality. Although the survey's response rate was high, the significant portion of the sample with missing or illogical salary values makes our findings related to salary less reliable. Also, how much our findings apply to non-NHSC LRP LCSWs in safety net organizations and underserved areas, or to LCSWs generally, is not clear. Generalizability to social work graduates nationally also needs to be taken into consideration. For example, compared with data on 2018 social work graduates by Salsberg et al. (2019), our sample had a smaller proportion of females (84 percent versus 91 percent), more participants who identify as White (90 percent versus 73 percent), and fewer participants who identify as African American (3 percent versus 12 percent).

As social work becomes increasingly imbedded within integrated primary care settings (Fraser et al., 2018), social workers will fill more roles (Fraher & Ricketts, 2016) and will be called on to expand available culturally appropriate care. Therefore, it is disappointing that, compared with MSWs nationally, this study's NHSC LRP participants, despite working with particularly diverse and socially needy patient populations, were less often themselves under represented minorities. This suggests that the NHSC needs to find new ways to increase the diversity of its LRP participants. Recruitment of LRP par-

Table 4: Adjusted Associations between Clinician Demographics, Work and Practice Characteristics, Community Characteristics, and Overall Work and Practice Satisfaction: Results of Full and Reduced Multiple Regression Models

	Full Model		Reduced Form Model	
Variable	***B***	***p***	***B***	***p***
Individual clinician factors				
Age				
Less than 40 years old	–0.146	.06	–0.164	.03
(At least 40 years old)				
Gender				
Female	0.038	.71		
(Male)				
Race				
Other	0.099	.33		
(Non-Hispanic White)				
Relationship status				
Single, divorced, widowed	0.122	.16		
(Married, engaged, have significant other)				
Children				
No	–0.061	.45		
(Yes)				
Rural upbringing				
Urban, suburban, or no principal place	–0.150	.06	–0.185	.01
(Rural or small town)				
Practice and job characteristics				
Practice type				
Not mental health facility	0.009	.91		
(Mental health facility)				
Salary from service practice[a] (per $10,000 increase)	0.057	.07	0.066	.03
Teach				
No	0.062	.53		
(Yes)				
Community characteristics				
Proportion of population below 100% of the FPL	0.421	.34		
Rurality				
Urban or suburban	–0.110	.17		
(Rural)				
Number of observations	363		371	
R^2	0.053		0.040	
F value *p*	0.054		0.002	
Root-mean-squared error	0.697		0.701	

Note: FPL = federal poverty level. Reference categories are in parentheses.
[a]We calculated the correlation between overall satisfaction and annual approximate salary using imputed values.

ticipants occurs principally among practicing clinicians who have already completed training; nevertheless, better outreach to students of historically Black colleges or universities and schools with large minority student populations can help ensure that minorities are aware of the NHSC LRP. The NHSC could also target students who are the first in their families to attend college and who will have more in common with and more to offer patients or clients of the safety net sites where LRP clinicians serve.

Table 5: Adjusted Associations between Satisfaction Facets and Overall Work and Practice Satisfaction

Satisfaction Facet	Adjusted *B*	*p*
Administration satisfaction	0.184	<.001
Staff and service linkage satisfaction	0.348	<.001
Mission orientation and patient satisfaction	0.284	<.001
Community integration satisfaction	0.038	.299
Work–life satisfaction	0.107	.001
Compensation satisfaction	0.125	<.001
Number of observations	386	
R^2	0.546	
F value *p*	<.0001	
Root-mean-squared error	0.486	

The NHSC could also advertise its LRP to students of social work programs that have received recent federal funding through the HRSA's Behavioral Health Workforce Education and Training (Kepley & Streeter, 2018) and Leadership in Public Health and Social Work Education (Pecukonis et al., 2019) programs, as well as other programs that expand the public health social work workforce. These federal mechanisms have already invested substantially in the social work profession as a key workforce to address behavioral health and population health needs of communities. MSWs who participate in these programs are likely well equipped to work in collaborative settings and with the at-risk populations of the study sample.

Future studies should explore how aware MSWs are of the NHSC LRP and other LRP options, of which subgroups of MSWs are less often aware and require additional outreach, and the reasons why some MSWs opt to participate in these programs and others do not.

In conclusion, LCSWs are overall quite satisfied with their work and jobs while serving in the NHSC LRP. Learning their areas of greatest and least satisfaction may help federal and state agencies like the NHSC better recruit, manage, and retain a social work workforce in areas of need. To make NHSC LRP participation maximally satisfying for LCSWs and perhaps thereby enhance their retention, the NHSC should support ways to strengthen social workers' relationships with clinic administration and increase their salaries. Ideally, the NHSC will also be able to build in a more diverse LCSW workforce in its LRP. HSW

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