



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

REPORT TO CONGRESS

NATIONAL HEALTH SERVICE CORPS, 2024

Executive Summary

This report to Congress for 2024 details the program accomplishments of the National Health Service Corps (NHSC), which is charged with helping communities within health professional shortage areas (HPSAs) of greatest need by providing primary health care services through the recruitment and retention of primary care health professionals.

Significant findings in the report include the following:

- The NHSC field strength in fiscal year (FY) 2024 was 17,419.
- The NHSC invested in building primary care provider capacity, awarding 172 new scholarships and 235 Students to Service loan repayment awards to health professions students in FY 2024. In FY 2024, the NHSC was supporting 2,719 health professions students, helping to expand the pipeline of providers preparing to work in underserved communities.
- In FY 2024, NHSC clinicians provided care to more than 18 million people. Approximately 59.3 percent of NHSC clinicians served in health centers supported by Health Resources and Services Administration (HRSA) grants. The remaining clinicians provided patient care services at other sites, including Rural Health Clinics, Indian Health Service (IHS) facilities, tribal health programs,¹ urban Indian organizations, group or private practices, critical access hospitals with affiliated outpatient clinics, hospital-based outpatient clinics, and similar outpatient sites located in HPSAs.
- The NHSC and many federal and state workforce programs use HPSA designations for resource allocation. As of September 30, 2024, there were HPSA designations for geographic areas, population groups, and facilities² in primary care (7,543), dental health (6,888), and mental health (6,246).
- In FY 2024, HRSA continued using maternity care health professional target area (MCTA) scores, which are generated for primary care HPSAs using service areas, to distribute NHSC loan repayment awards to maternity care health professionals to serve in areas federally designated as having a shortage of maternity care providers. MCTA-eligible maternity care providers are defined in the NHSC as obstetricians and gynecologists, family practice physicians providing obstetric care, and certified nurse midwives.³ HRSA finalized criteria for determining MCTAs in FY 2022, and published

¹ An Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by IHS through, or provided for in, a contract or compact with IHS under the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 5301 *et seq.*).

² This data includes facilities automatically designated as HPSAs based on statute, including Health Center Program grantees, Federally Qualified Health Center Look-Alikes, IHS facilities, and Rural Health Clinic Program grantees that meet NHSC site requirements.

³ The NHSC uses either the designated MCTA score or the primary care HPSA score of an NHSC-approved site, whichever is higher, to distribute MCTA-eligible maternity care providers.

composite MCTA scores in the HRSA Data Warehouse HPSA Find tool.⁴ As of September 30, 2024, there were 7,387 MCTA designations within existing primary care HPSAs.

- Approximately 38.6 percent of FY 2024 NHSC placements were at sites that served rural areas.⁵
- The discipline mix of the NHSC field strength reflects the program’s efforts to respond to the demand for services in underserved communities as well as the program’s commitment to an interdisciplinary approach to patient care. The NHSC continues to expand the number of behavioral health clinicians in the program with ongoing congressional support for the Substance Use Disorder (SUD) Workforce and Rural Community (RC) Loan Repayment Program (LRP). In addition, registered nurses and pharmacists are included as eligible disciplines in the NHSC SUD Workforce LRP, the RC LRP, and the State LRP.
- In FY 2024, the NHSC made a total of 233 new and continuation scholarship awards as well as a total of 6,500 new and continuation loan repayment awards. Additionally, 235 new Students to Service LRP awards were made through the NHSC, providing loan repayment to medical students, dental students, and nursing students in their final year of school in return for providing health services in urban, rural, or frontier communities with limited access to care. These awards are vital recruitment tools for underserved communities in need of primary medical care, oral health, and behavioral health services.
- The NHSC made 582 new SUD Workforce LRP awards and 478 new RC LRP awards in FY 2024, expanding the health workforce caring for people with SUD. Additionally, NHSC funding designated by Congress in FY 2024 helped support 275 loan repayment awards to clinicians serving in IHS facilities, tribal health programs, and urban Indian organizations.
- Approximately 81 percent of NHSC participants who completed their NHSC service obligation in FY 2022 continued to serve in underserved areas 2 years later, and 87 percent of those who fulfilled their service commitments between FY 2012 and FY 2023 are either still working in a HPSA or have remained in the community where they served even if it no longer qualifies as a HPSA.

⁴ The Improving Access to Maternity Care Act (P.L. 115-320) amended the Public Health Service Act to direct HRSA to identify MCTAs within HPSAs for assigning maternity care health professionals.

⁵ The NHSC uses the Federal Office of Rural Health Policy’s definition of rural for identifying NHSC-approved sites that are in rural areas; see http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

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Acronym List

ARP Act	American Rescue Plan Act of 2021
FQHC	Federally Qualified Health Center
FY	fiscal year
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
HWC	Health Workforce Connector
IHS	Indian Health Service
ITU	Indian Health Service, tribal, or urban Indian health clinic
LRP	Loan Repayment Program
MCTA	maternity care health professional target area
NHSC	National Health Service Corps
ODU	opioid use disorder
PHS Act	Public Health Service Act
PCO	primary care office
RC LRP	Rural Community Loan Repayment Program
SP	Scholarship Program
SUD	substance use disorder
S2S LRP	Students to Service Loan Repayment Program

I. Legislative Language

Section 336A of the Public Health Service (PHS) Act (42 U.S.C. § 254i) sets out the requirements for this report to Congress:

“The Secretary shall submit an annual report to Congress, and shall include in such report with respect to the previous calendar year—

- (1) the number, identity, and priority of all health professional shortage areas designated in such year and the number of health professional shortage areas which the Secretary estimates will be designated in the subsequent year;*
- (2) the number of applications filed under section 333 in such year for assignment of Corps members and the action taken on each such application;*
- (3) the number and types of Corps members assigned in such year to health professional shortage areas, the number and types of additional Corps members which the Secretary estimates will be assigned to such areas in the subsequent year, and the need for additional members for the Corps;*
- (4) the recruitment efforts engaged in for the Corps in such year and the number of qualified individuals who applied for service in the Corps in such year;*
- (5) the number of patients seen and the number of patient visits recorded during such year with respect to each health professional shortage area to which a Corps member was assigned during such year;*
- (6) the number of Corps members who elected, and the number of Corps members who did not elect, to continue to provide health services in health professional shortage areas after termination of their service in the Corps and the reasons (as reported to the Secretary) of members who did not elect for not making such election;*
- (7) the results of evaluations and determinations made under section 333(a)(1)(D) during such year; and*
- (8) the amount charged during such year for health services provided by Corps members, the amount which was collected in such year by entities in accordance with section 334, and the amount which was paid to the Secretary in such year under such agreements.”⁶*

This report includes updates and fiscal year (FY) data⁷ on each of these requirements and related National Health Service Corps (NHSC) program activities and initiatives and discusses how these activities and initiatives align with the mission of the program.

⁶ The Health Care Safety Net Amendments of 2002 amended section 334 of the PHS Act (42 U.S.C. § 254g) to eliminate the requirement that entities receiving NHSC assignees reimburse the agency for health services provided by those Corps members. Therefore, reporting element #8 is no longer relevant.

⁷ Generally, FY budget data are provided in this report in accordance with Congress’ appropriation of funding to the NHSC. Additionally, the Bureau of Health Workforce Management Information System Solution collects NHSC program data. The Bureau of Health Workforce Management Information System Solution is an IT system that replaced and/or retired several legacy systems that contained information collected from individual scholarship and loan repayment applications, recruitment and retention assistance applications, and monitoring data from individual sites. The Health Resources and Services Administration also collects State Loan Repayment Program data at the grantee level and reports them to the Bureau of Health Workforce.

II. Introduction

The Bureau of Health Workforce within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services manages the NHSC programs. The Emergency Health Personnel Amendments Act of 1972 (P.L. 92-585) established the NHSC. Congress has amended and reauthorized the Emergency Health Personnel Amendments Act several times over the past 50 years. More recently, the American Rescue Plan (ARP) Act of 2021 authorized and appropriated \$800 million to the NHSC, \$100 million of which was dedicated to the State Loan Repayment Program (LRP).⁸ In FY 2023, Congress appropriated \$417.9 million in mandatory and discretionary funding to the NHSC, and in FY 2024, Congress appropriated \$561.5 million in mandatory and discretionary funding to the NHSC.^{9,10}

Overall, in FY 2024, the NHSC made 172 new and 61 continuation scholarship awards, as well as 4,375 new and 2,125 continuation loan repayment awards. Within this award total, the NHSC's annual set-aside (\$16 million) and approximately \$1.9 million in additional NHSC funding, a total of \$17.9 million, enabled the NHSC to fund 275 awards for all eligible providers serving Indian Health Service (IHS), tribal, or urban Indian health clinic (ITU) organizations who applied to the NHSC loan repayment programs in FY 2024. Additionally, the NHSC made 235 new Students to Service (S2S) LRP awards to eligible students in their last year of medical, nursing, or dental school.

In FY 2024, the NHSC field strength was 17,419 clinicians, serving in urban, rural, and frontier communities in all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.¹¹ The field strength includes clinicians recruited through the NHSC Scholarship Program (SP), the NHSC LRP, the NHSC S2S LRP, the NHSC Substance Use Disorder (SUD) Workforce LRP, the NHSC Rural Community (RC) LRP, and the State LRP who are currently working in communities to fulfill their service commitments.

There continues to be tremendous applicant interest in these programs and HRSA has maintained its robust online and in-person recruitment activities. Among other strategies, HRSA used social media, collaboration with stakeholders, and online visibility to recruit eligible NHSC applicants.

⁸ The 3-year State LRP grant cycle funded by the \$100 million appropriation in the ARP Act made its first grant awards in FY 2022. This grant cycle included two significant flexibilities derived from that Act: the dollar-for-dollar federal-state match is not required, and up to 10 percent of the federal grant funds may be used to administer the program at the state level.

⁹ The NHSC is subject to sequestration, across-the-board reductions in certain federal agency budgets triggered when action is not taken to reduce the federal deficit as required under the Budget Control Act of 2011. Sequestration distinguishes the authorization of mandatory appropriations for the NHSC from the actual mandatory funding level made available to the NHSC in FY 2023 for program administration and awards.

¹⁰ In FY 2024, Congress appropriated \$432.9 million in mandatory funding for the NHSC, extending the NHSC's mandatory authorization of appropriations through December 31, 2024. The total amount of mandatory and discretionary funding for the NHSC discussed here accounts for the FY 2024 mandatory appropriation provided to support NHSC programs from October 1, 2023, through December 31, 2024.

¹¹ In FY 2024, NHSC clinicians in the Pacific Basin served in American Samoa, Guam, and the Northern Mariana Islands.

HRSA used both online and in-person recruitment resources to support health professionals and health centers. HRSA also hosted virtual job fairs, which included 200 participating sites representing 38 states and territories; this resulted in over 7,600 newly created user profiles and more than 8,700 new job opportunities posted on the HRSA Health Workforce Connector.¹²

An important measure of the NHSC's success is the number of NHSC clinicians who continue to provide services to the underserved after fulfilling their NHSC commitments. In FY 2019, HRSA began using the Clinician Dashboard to calculate the retention rate for NHSC providers, using National Provider Identifier numbers from the Centers for Medicare & Medicaid Services in conjunction with other data sources to assist in determining the current practice locations of NHSC alumni. HRSA annually tracks short-term retention (Corps members who complete their service obligations and remain in a health professional shortage area (HPSA) for up to 2 years post-service) as well as long-term retention (Corps members who continue to provide care in underserved areas longer than 2 years after completing their NHSC service obligations). The Dashboard shows approximately 81 percent of those who fulfilled their NHSC commitments during FY 2022 remained in service in underserved communities 2 years after their commitments ended. Further, 87 percent of those who fulfilled their service commitments between 2012 and 2023 are either still working in a HPSA or have remained in the community where they served, even if it no longer qualifies as a HPSA (an alumni clinician measure referred to as "community retention").¹³

III. Overview

The NHSC directly operates five programs and administers one state grant program to place clinicians in underserved communities across the nation. NHSC-approved health care delivery sites must meet certain requirements, including using a sliding fee schedule to provide care to individuals regardless of their ability to pay.

NHSC SP: The NHSC Scholarship Program provides financial support through scholarships that cover tuition, other reasonable education expenses, and a monthly living stipend to health professions students committed to providing primary care in underserved communities with the greatest need. The NHSC SP provides a supply of clinicians who will be available over the next 1 to 8 years, depending on the length of their education and training programs. Upon completion of training, NHSC scholars become salaried employees of NHSC-approved sites in underserved communities. NHSC scholars will provide a 1-year service commitment for each year of scholarship support received, with a 2-year minimum service commitment. Scholars can receive a maximum of 4 years of scholarship support.

NHSC S2S LRP: The NHSC S2S LRP provides loan repayment assistance to health professions students in their last year of school in return for a 3-year commitment to provide primary health care in HPSAs of greatest need. Eligibility for the S2S LRP includes students in their final year of medical school, dental school, or a school pursuing eligible primary care health professions

¹² The HRSA Health Workforce Connector is a searchable database of open job opportunities and information on NHSC-approved sites; see <https://connector.hrsa.gov/connector/>.

¹³ For more detailed information in the public domain regarding NHSC field strength data, see <https://data.hrsa.gov/topics/health-workforce/field-strength> and also <https://data.hrsa.gov/data/download>.

training leading to a degree or certification in nurse midwifery, nurse practitioner, or physician assistant education. In FY 2024, to support HRSA's efforts to distribute the maternal health workforce to high-need areas, the S2S LRP offered a supplemental award of up to \$40,000 to NHSC-awarded maternity care health professionals providing health services in maternal care health professional target areas (MCTA) with high scores.

NHSC LRP: The NHSC LRP offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service at an NHSC-approved site in a HPSA. In FY 2024, to address the persistent critical shortages of primary medical care providers, HRSA increased the NHSC LRP maximum new award amount available to physicians, nurse practitioners, certified nurse midwives, and physician assistants who provide primary care services in primary care HPSAs, up to \$75,000 for a full-time, 2-year service commitment, and up to \$37,500 for a half-time, 2-year service commitment. Clinicians in non-primary medical care disciplines providing behavioral health or oral health care services in mental health or dental HPSAs continue to be eligible for an initial NHSC LRP award of up to \$50,000 for a full-time, 2-year service commitment, and up to \$25,000 for a half-time, 2-year service commitment. The NHSC LRP also offers participants in all HPSA types the option of continuing their service for an additional award for each year until all eligible educational debt has been satisfied. The program recruits both clinicians as they complete training, and clinicians who are practicing professionals immediately available for service.

Beginning in FY 2018, and annually through FY 2024, appropriations acts have provided funding to the NHSC to expand and improve access to quality opioid use disorder (OUD) and SUD treatment in rural and underserved areas nationwide. HRSA continues to use these funds to support awards made through the NHSC SUD Workforce LRP and the NHSC RC LRP.

NHSC SUD Workforce LRP: The primary purpose of this funding is to expand the availability of SUD treatment providers providing outpatient services at specified sites, including OUD treatment programs, office-based OUD treatment facilities, and non-opioid outpatient SUD facilities. The funding supports the recruitment and retention of health professionals needed in underserved areas to provide evidence-based SUD treatment and prevent overdose deaths. Providers receive loan repayment to reduce their educational financial debt in exchange for a service commitment to work at SUD treatment facilities.

In FY 2024, SUD providers included:

- Physicians (allopathic and osteopathic physicians), nurse practitioners, and physician assistants with training on opioid or other SUDs registered to prescribe controlled medications, and/or board certification in addiction medicine or addiction psychiatry;¹⁴
- Licensed or certified health professionals providing SUD services; and
- Licensed primary care and behavioral health professionals.

¹⁴ Section 1262 of the Consolidated Appropriations Act of 2023, removed the federal requirement for practitioners to apply for a special waiver prior to prescribing buprenorphine for the treatment of OUD. Section 1263 of the Act, meanwhile, requires new or renewing Drug Enforcement Administration registrants to prescribe any Schedule II-V controlled medications, effective June 27, 2023, to have met certain OUD or other SUD training requirements; to be board certified in addiction medicine or addiction psychiatry; or to have graduated within 5 years and be in good standing from medical, advanced practice nursing, or physician assistant school that included completion of an opioid or other substance use disorder curriculum.

NHSC RC LRP: A portion of the annual appropriations noted above provided funding for the NHSC RC LRP, which is a program for providers working to combat the opioid epidemic in the nation’s rural communities. The NHSC RC LRP first made loan repayment awards in FY 2019, in coordination with HRSA’s Rural Communities Opioid Response Program initiative to provide evidence-based substance use treatment, assist in recovery, and prevent overdose deaths across the nation.

NHSC and IHS: Appropriations acts for 2019 through 2024 have included an annual set-aside between \$15 and \$16 million to support awards under NHSC LRPs to fully-trained medical, nursing, dental, mental health clinicians, and SUD treatment providers delivering health care services in ITUs.¹⁵ Federal IHS clinics, tribal health clinics, urban Indian organizations, and dually-funded tribal health clinics/community health centers are automatically HPSA-designated.

In FY 2024, the LRPs described above also offered a one-time award supplement of up to \$5,000 to providers who demonstrated medical Spanish language proficiency and were serving at sites that identified the recruitment need for providers capable of caring for limited English proficiency patients in HPSAs. HRSA piloted the Spanish language initiative in FY 2024 and continues to explore opportunities to expand the initiative to include other languages.

NHSC State LRP: The NHSC State LRP provides grant funding for states and territories to operate their own LRPs; each state and territory can design programs that address the most pressing health care needs of their residents. Primary medical, behavioral, and oral health clinicians who receive awards through NHSC State LRP-funded programs pay off student debt in exchange for working in HPSAs within their state. In FY 2022, HRSA made 3-year NHSC State LRP grant awards using the \$100 million in dedicated appropriations in the ARP Act.¹⁶ The Act provided greater flexibilities for State LRP grant recipients in that it did not require the typical dollar-for-dollar federal-state match, and it allowed up to 10 percent of the federal grant funds to be used to administer the program at the state level. In FY 2024, NHSC State LRP grantees made 2,057 new awards to providers in their respective states.

FY 2024 Awards Overview: Overall in FY 2024, the NHSC made 172 new and 61 continuation scholarship awards, as well as 4,375 new and 2,125 continuation loan repayment awards.¹⁷ Additionally, the NHSC made 235 new S2S LRP awards to eligible students in their last year of medical, nursing, or dental school.

¹⁵ Through IHS, the federal government funds all three of the ITU programmatic components. Tribal contract, or compact, health centers (also called a “638” contract or compact) are operated by tribes or tribal organizations, and urban Indian outpatient health care programs and facilities specialize in caring for American Indians and Alaska Natives. They are operated under the Indian Self-Determination and Education Assistance Act (P.L. 93-638). Urban Indian health centers are designated Federally Qualified Health Centers that provide comprehensive primary care and related services to American Indians and Alaska Natives. The facilities are owned or leased by urban Indian organizations and receive funding through Title V of the Indian Health Care Improvement Act.

¹⁶ Additional NHSC State LRP awards data for this ARP Act-funded cycle are available at <https://nhsc.hrsa.gov/loan-repayment/state-loan-repayment-program/awards>.

¹⁷ These FY 2024 NHSC award totals exclude State LRP awards made by grantees still in the 3-year ARP Act-funded project period.

IV. Report Requirements

Requirement #1: The number, identity, and priority of all HPSAs designated in such year and the number of HPSAs which the Secretary estimates will be designated in the subsequent year.

As part of HRSA's cooperative agreement with state primary care offices (PCO), the state PCOs assess needs in their states, determine what areas are eligible for designations, and submit HPSA designation applications to HRSA. Communities or facilities that would like HRSA to designate them as a geographic, population, or facility HPSA may submit data to their state PCO. HRSA reviews the HPSA applications submitted by the state PCOs, and if they meet the designation eligibility criteria for the type of HPSA requested in the application, HRSA designates a HPSA. The designation process includes both the analysis of the data submitted with each new request and the review of previously designated HPSAs. Additionally, there is a permanent automatic designation in statute of certain facility HPSAs (e.g., Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, IHS, tribal, and urban Indian organizations, and those rural health clinics that provide services regardless of ability to pay).¹⁸ HRSA determines the priority of a HPSA by assigning a numerical score based on a calculation weighing a number of factors of need for persons in a given geographic area, including physician-to-population ratio, infant mortality, access to health services, health status, and the ability to pay for health services. While HRSA created the HPSA designation for the placement of NHSC clinicians, more than 30 federal and state agencies and programs currently use the HPSA designation for resource allocation. HRSA is required to publish updated lists of designated HPSAs annually in the *Federal Register*.¹⁹

All HPSAs proposed for withdrawal remain designated until HRSA publishes the annual *Federal Register* notice of designated HPSAs that excludes them. State PCOs may submit new, updated, or reinstatement designation applications based on up-to-date data to replace HPSA designations currently proposed for withdrawal at any time.

HRSA received 833 designation applications from state PCOs during FY 2024, many of which were to update or create new HPSAs in areas where old HPSAs no longer met the designation criteria. HRSA approved many of these applications and continues to work to review and approve the remaining designation applications that qualify.

As of September 30, 2024, there were 7,543 primary care HPSAs; 6,888 dental health HPSAs; and 6,246 mental health HPSAs. Overall, the number of HPSAs decreased by 7.5 percent from FY 2023. In consideration of the COVID-19 pandemic's impact on the health workforce, HRSA did not withdraw HPSAs placed in a "proposed for withdrawal" status during 2023, to provide state PCOs additional time to work with local communities and HRSA to submit designation

¹⁸ The Health Care Safety Net Amendments of 2002 established the automatic facility HPSA designation for these facilities for a period of 6 years; the Health Care Safety Net Act of 2008 made the automatic facility designation permanent.

¹⁹ HRSA maintains an online database of designated HPSAs and their HPSA scores that is updated daily; see <http://hpsafind.hrsa.gov>.

information and prepare for potential workforce changes. HRSA issued a final *Federal Register* notice in January 2024 that officially withdrew any HPSAs still in a “proposed for withdrawal” status. HRSA issued a second notice in July 2024 that alerted state PCOs of any HPSAs in a “proposed for withdrawal” status, but did not officially withdraw any HPSAs. In November 2024, HRSA published a *Federal Register* notice that withdrew HPSAs that were still in a “proposed for withdrawal” status, which accounts for the decrease in the total number of HPSAs in 2024.²⁰

Requirement #2: The number of site applications filed under section 333 of the PHS Act in such year for assignment of Corps members and the action taken on each such application.

Section 333 of the PHS Act establishes the framework by which the NHSC evaluates formal requests from facilities seeking eligibility for NHSC recruitment and retention assistance (see **Requirement 7** for a description of the evaluation process). The NHSC determines eligibility based on the following:

- Continued need for health professionals in the area;
- Appropriate and efficient use of NHSC members previously assigned to the entity;
- Support by the community for the assignment of an NHSC member to that entity;
- Unsuccessful efforts by the facility to recruit health professionals from other sources;
- Reasonable prospect of sound financial management by the entity; and
- Willingness of the entity to support or facilitate mentorship, professional development, and training opportunities for Corps members.

Specific requirements for participation as an NHSC-approved site include providing health services in or to a designated HPSA; providing comprehensive primary care services; providing services on a free or reduced fee schedule basis to individuals at or below 200 percent of the federal poverty level; and accepting patients covered by Medicare, Medicaid, and the Children’s Health Insurance Program. More information on site eligibility is available on the NHSC’s website (<http://www.nhsc.hrsa.gov/sites/index.html>).

New Site Application Cycles occur annually, determine the eligibility of new facilities to participate in the NHSC, and provide an opportunity for eligible health care organizations to recruit, hire, and retain qualified clinicians. Site Recertification Application Cycles ensure NHSC-approved sites with an approval expiration date maintain their status and continue to meet NHSC site eligibility criteria and program requirements. The NHSC opened a New Site Application Cycle on May 14, 2024, and opened a Site Recertification Application Cycle on August 19, 2024. In addition, the NHSC accepted streamlined applications from facilities classified as NHSC auto-approved sites (e.g., FQHCs and IHS sites) throughout FY 2024. The cumulative number of NHSC site applications, including NHSC auto-approved sites, submitted during FY 2024 was 5,029, with 4,174 approved, and 855 disapproved. As of September 30, 2024, 1,749 new site and 2,397 recertification applications were approved and included in a total of 22,650 NHSC-approved sites across all programs.

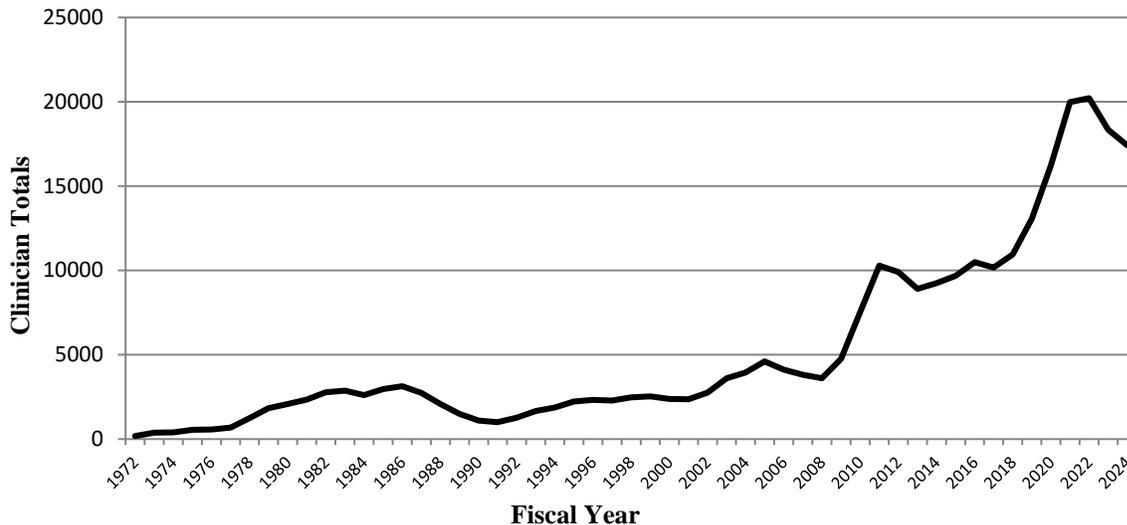
²⁰ See [89 Fed. Reg. 82](#) (Jan. 2, 2024); [89 Fed. Reg. 54471](#) (July 1, 2024); and [89 Fed. Reg. 87882](#) (Nov. 5, 2024).

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

In FY 2024, the NHSC field strength consisted of 17,419 clinicians fulfilling their service commitments at approved health care sites (see **Appendix A** for the distribution of NHSC clinicians by discipline and program for FY 2024). The NHSC recruits clinicians through the NHSC SP and LRP, the S2S LRP, the SUD Workforce LRP, and the RC LRP. Though NHSC clinicians who have chosen the Private Practice Option provided under section 338D of the PHS Act (42 U.S.C. § 254n) and participants in the NHSC State LRP are not considered to be “Corps members,”²¹ the yearly NHSC field strength calculation includes them, respectively, as Private Practice Option clinicians and State LRP participants who have been supported by NHSC funds. The field strength in FY 2024 included participants who began service in that year, as well as those whose service began in previous years and who were still fulfilling a service commitment to the NHSC, either through an initial contract or a continuation contract.

NHSC clinicians who have fulfilled their service commitment and remain in service to underserved communities (see **Requirement 6**) are not included in the field strength calculation. **Figure 1** illustrates the history of NHSC field strength from FY 1972 through FY 2024.

Figure 1: NHSC Field Strength, FY 1972 – FY 2024



²¹ The term “Corps members” is defined in 42 U.S.C. § 254d(a)(3)(B) and has certain guarantees under the law (e.g., members may work half-time to fulfill their service requirement, while non-members (i.e., Private Practice Option) cannot). Awardees through the NHSC State LRP have contracts with states, not the Secretary, and they are not members of the Corps. Both members and non-members are included in the field strength, as noted above, because they are federally funded.

As in FY 2023, the FY 2024 decreases in NHSC clinicians serving, when compared to the NHSC's FY 2022 field strength, reflects the completion of service commitments by clinicians who had NHSC contracts funded through the ARP Act. Clinicians are awarded loan repayment contracts in a given year and complete their service commitments over a multiyear period determined by the program. NHSC participants remain in the field strength beyond the year of their initial award; therefore, the impact of reductions in funding may result in a field strength decline in a later FY.

To preserve continuity of services in underserved communities, the NHSC uses its resources to award current participants' continuation contracts prior to awarding contracts to new participants. The significant increase in demand for continuation contracts to support providers who received ARP-funded awards reduced the amount of funding available to make new awards and contributed to a decrease in the NHSC field strength in FY 2023 and FY 2024. Historically, resources for the NHSC are provided through a combination of multi-year mandatory appropriations and annual discretionary funding. In recent FYs, the timing of both mandatory funding extensions and the enactment of annual appropriations has varied significantly, creating uncertainty about NHSC funding levels and the availability of NHSC program resources, which impacts programs' ability to plan for and make scholarship and loan repayment awards. The NHSC will continue to seek a return to a multi-year reauthorization of mandatory appropriations, as stability in the NHSC's funding encourages health site and applicant confidence in NHSC programs.

Requirement #4: The recruitment efforts engaged in for the Corps in such year and the number of qualified individuals who applied for service in the Corps in such year.

HRSA's efforts to market and promote all NHSC programs included increased outreach to broad audiences. Using campaign metrics from social media, web traffic, digital channels, and email data, NHSC communications methods continue to adapt and improve while using best practices and focusing on data-driven results to inform effective outreach and recruitment activities.

NHSC Communications Strategy: The NHSC continues to expand its outreach strategy by partnering and collaborating with NHSC alumni; other federal agencies; medical, dental, nursing, and other health professional associations and organizations; academic institutions; and external state and regional partners.

The NHSC uses earned media, both organic and paid social media, print media, and digital media to amplify messages regarding the recruitment and retention of qualified providers. Through targeted, interactive messaging, focused calls to action, and engaging imagery, the NHSC has effectively used its available resources to reach a broader audience of potential applicants, promote the program to health professions students, and gain additional stakeholder and partner support to extend the NHSC's message. The result is sustained interest among potential applicants in NHSC programs and an increase in NHSC-approved health care sites and treatment facilities.

NHSC Stakeholder Engagement and Conferences/Exhibits: In FY 2024, the NHSC engaged stakeholders and promoted its scholarship and loan repayment programs through webinars, conference calls, social media, mass distribution emails, presentations, exhibits at 12 conferences, and an advertisement in a conference program. HRSA participated in 70 outreach activities to promote NHSC programs with academic institutions in FY 2024, engaging with medical, dental, nursing, and behavioral health students. By fostering relationships with national health organizations, professional associations, academic institutions, and state PCOs, the NHSC expanded its reach to broader audiences including health professions students, clinicians, faculty, school administrators, and sites.

In addition to professional and student associations, HRSA promoted NHSC program opportunities to students and faculty through regional outreach. Through its regional offices, HRSA participated in 82 outreach activities to promote NHSC programs with academic institutions in FY 2024, engaging with medical, dental, nursing, and behavioral health students. Throughout the year, HRSA sent emails to more than 19,000 professional and academic institutions promoting the NHSC's various opportunities.

HRSA and IHS worked together to promote NHSC programs as recruitment tools to fill health professional vacancies at sites serving tribal communities. ITUs that exclusively serve tribal members can qualify as NHSC sites and extend their ability to recruit and retain primary care providers by using NHSC scholarship and loan repayment incentives. HRSA's 10 regional offices worked with ITUs and offered assistance in completing site profiles and posting vacancies on the Health Workforce Connector (HWC). HRSA worked with ITUs to verify current HPSA scores, enabling those sites to be competitive in recruiting NHSC scholars and loan repayment program participants.

As of September 30, 2024, 1,068 ITUs were NHSC-approved, and 819 clinicians from those sites were in an NHSC commitment. Maintaining those clinicians serving at ITUs is due in part to the \$16 million annual congressional set-aside in the NHSC's FY 2024 discretionary appropriation to support awards for applicants serving at NHSC-approved ITU sites. HRSA continues to strengthen relationships with tribal organizations and increase overall awareness of NHSC opportunities with one-on-one collaboration and tribal-specific webinars. From FY 2023 to FY 2024, HRSA's targeted outreach to tribal communities helped realize a 36 percent increase in NHSC LRP applicants and a 38 percent increase in NHSC SP applicants who identify as American Indian.

NHSC Recruitment Resources: HRSA's virtual job fairs and the HWC offer platforms to link large numbers of career-seeking clinicians with job opportunities at NHSC-approved sites. While HRSA intends these recruitment tools for the NHSC and other HRSA-supported health care provider recruitment and retention programs, prospective program participants and career-seeking health professionals alike can access these free, public-facing resources.

HRSA held four virtual job fairs in 2024 to promote opportunities at NHSC sites. These events hosted 200 health care facilities in communities across 38 states and Guam. Collectively, these sites highlighted 925 available job and training opportunities to interested clinicians. The virtual job fairs hosted more than 2,800 total attendees and had an average attendance rate of over 80

percent (more than 3,500 registrants), which is above industry attendance standards; one of the 2024 job fairs hosted the highest number of attendees to date.

The job fair events and promotions contributed to almost 7,600 newly created user profiles on the HWC. Overall in 2024, with more than 8,700 new job opportunities posted, the HWC saw more than double the number of new job opportunities posted in FY 2023.

NHSC Recruitment Activities: To inform its recruitment strategy and ensure successful outcomes, the NHSC obtains data via application submissions and receives program feedback through digital content engagement metrics and analysis of inquiries. HRSA then uses this data to develop comprehensive communications plans and to direct promotional resources to where they are most effective. This ongoing, data-driven process has resulted in an increased and expanded qualified applicant pool for all NHSC programs, more applicants who are eligible for awards, and greater awareness of NHSC programs among new providers and health professional students. HRSA's marketing and outreach strategy ensures that eligible applicants, participants, and stakeholders can engage with and participate in NHSC programs throughout the year through the website and NHSC social media platforms.

As part of a larger outreach strategy, HRSA frequently updates NHSC web content to ensure relevance and accuracy for visitors to the NHSC's website. New content includes application resource documents, including checklists and comparison charts, to assist applicants in better understanding the requirements for NHSC programs before application cycles are open. Using real-time metrics and analyzing customer data to inform content revisions and updates, the site provides information in a way that visitors can easily access and use, as evidenced by an engagement rate of nearly 69 percent overall, considered excellent by industry standards. The engagement rate rose by more than 6 percent in FY 2024, a result of ongoing improvement efforts.

In FY 2024, the website underwent a comprehensive review to revise navigation and content to meet plain language and user experience best practice goals and to adhere to federal standards for web assets. As a result, the website's readability score improved by more than 10 points across its top 20 most-visited pages. The website also had more than 1 million visitors over this timeframe, up nearly 9 percent over FY 2023 numbers, and more than 3.5 million page views, an increase of more than 3 percent.

In FY 2024, the NHSC LRP introduced a \$25,000 increase in the maximum new award amount for full-time participants serving in primary care HPSAs. HRSA supported a robust campaign to promote the increased award to eligible NHSC LRP applicants. The result was a nearly 22 percent increase in the number of page views of the website's most-visited page, the NHSC LRP page. Consequently, more than 1,400 providers received awards that exceeded the previous years' new award maximum of \$50,000, including 235 physicians serving in primary care HPSAs.

The NHSC also continued to target SUD treatment providers and behavioral health professionals who are at critical shortage levels in rural America, which is among the hardest hit areas by the ongoing opioid crisis. The NHSC aligned its recruitment activities with guidance from the

Department of Health and Human Services' Overdose Prevention Strategy. The NHSC's partnership with the Substance Abuse and Mental Health Services Administration's Providers Clinical Support System continued in FY 2024 to bolster efforts to connect eligible NHSC clinicians, potential applicants, and health professions students with free training on administering medications for OUD treatment. This strategy is also part of the NHSC's SUD clinician recruitment efforts, as completed training can provide application priority for eligible applicants to the NHSC SUD Workforce LRP and the NHSC RC LRP. During HRSA's promotion of the training opportunity and open application cycles, page views to the Medications for Opioid Use Disorders page increased by 35 percent compared to similar totals for FY 2023.

To meet the nation's behavioral health challenges, in FY 2024, the NHSC supported 7,911 behavioral health providers in service in communities in HPSAs. Of that number, about 24 percent (roughly 1,900) are SUD clinicians and health professionals and nearly 90 percent of these clinicians have SUD treatment credentials, including the Providers Clinical Support System-Medications for Opioid Use Disorders free training. About half provide evidence-based SUD treatment and care in rural communities.

Additionally, HRSA successfully promoted the NHSC S2S LRP's new \$40,000 award enhancement for eligible maternal care health providers who will serve higher-scoring MCTAs in primary care HPSAs.

HRSA continued to employ successful traditional recruitment strategies, including robust organic social media campaigns, and paid and earned media such as AdWords and keyword search campaigns. In FY 2024, marketing tactics included revising current video content to amplify the impact and benefits of NHSC participation and collaborating with NHSC alumni and approved sites to promote open application cycles and build program awareness year-round. Combined, these strategies increased metrics across NHSC social media platforms using both paid and organic activities. The number of engagements (e.g., link clicks, shares, reposts, and retweets) increased by more than 37 percent. Link clicks for low-cost, no-cost posts increased by more than 387 percent in FY 2024.

In addition to provider recruitment, the FY 2024 outreach campaign for the NHSC sought to recruit eligible health centers and rural health clinics. These efforts resulted in more than 1,752 new sites becoming NHSC-approved. In FY 2024, HRSA also implemented an evergreen site recruitment campaign for facilities classified as NHSC auto-approved (e.g., FQHCs and IHS sites). This resulted in 704 new NHSC auto-approved sites (40.1 percent of all new sites) recruited. New sites are vital to the NHSC's ability to widely distribute a skilled health workforce and to increase access to quality health care across the nation.

The NHSC conducted direct email outreach via GovDelivery to announce the opening of the FY 2024 NHSC application cycles. The current GovDelivery opt-in email lists for NHSC programs include nearly 1.5 million recipients; GovDelivery emails were the second most popular referrer of traffic to the NHSC website, with organic searches as the most popular. HRSA sent emails to targeted distribution lists that included prospective applicants, academic institutions, and NHSC partners including NHSC alumni, the National Advisory Council on the NHSC, professional associations, NHSC sites, program participants, and state PCOs.

As summarized in the table below, these efforts resulted in more than 2,900 applications to the NHSC SP and more than 7,100 new applications to NHSC LRPs, including the NHSC SUD Workforce LRP and the NHSC RC LRP.

Table 1: Eligible²² Applications and New Awards, FY 2024

<i>Program</i>	<i>Applications</i>	<i>New Awards</i>
<i>NHSC SP</i>	3,181	172
<i>NHSC LRPs</i>	8,031	4,375
<i>S2S LRP</i>	356	235

Requirement #5: The number of patients seen and the number of patient visits recorded during such year with respect to each HPSA to which a Corps member was assigned during such year.

In aggregate, NHSC clinicians serving in FY 2024 saw approximately 18.3 million patients and conducted an estimated 73.2 million patient visits. The NHSC estimates that primary medical care clinicians in the field saw 8.0 million patients and conducted 32.2 million patient visits. The NHSC’s oral health clinicians saw an estimated 1.9 million patients and conducted 7.8 million patient visits, and behavioral health clinicians saw approximately 8.3 million patients and conducted 33.2 million patient visits.²³

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

The NHSC continues to monitor the retention rates of NHSC scholars and LRP participants who are providing services to the underserved beyond the fulfillment of their service commitment. Retained clinicians are those who provide care in a designated HPSA after their service obligation ends, even if the community where they served no longer qualifies as a HPSA.

²² Eligible NHSC SP and LRP applicants are determined via automated screening to have met basic NHSC program participation requirements. A second round of individualized screening determines whether eligible applicants are qualified; qualified applicants meet statutory requirements to participate in the NHSC program to which they have applied.

²³ The NHSC uses aggregate variables based on historical patient data from community health centers to factor the total count of unique patients estimated to have been seen, and the total count of patient visits estimated to have been conducted, by NHSC clinicians within the reporting period. This patient data is documented and reported through the Uniform Data System, a standardized data collection system used primarily by community health centers to track patient demographics and service utilization.

Short-Term Retention

HRSA uses the Clinician Dashboard (<https://data.hrsa.gov/topics/health-workforce/clinician-dashboards>) to calculate the retention rate for NHSC providers. The Clinician Dashboard uses National Provider Identifier numbers from the Centers for Medicare & Medicaid Services in conjunction with other data sources to assist in determining the current practice locations of providers who previously served in the NHSC. HRSA estimates the 2-year short-term retention rate among respondents who completed their NHSC service commitment in FY 2022 to be 81 percent (of 3,571 clinicians tracked).

The data sources that contribute to the retention calculations do not include a narrative describing the experiences that NHSC providers have at their sites while completing their service obligations. Historically, the most common reasons given by participants for not remaining at their NHSC-approved site following their service commitment were financial considerations and site operations.²⁴

Long-Term Retention

The Clinician Dashboard also collects data that enables the NHSC to measure the long-term retention of NHSC clinicians. While the number of clinicians tracked for the NHSC's short-term retention metric is a subset of the total number of clinicians who completed service within the prior two FYs, the NHSC clinician long-term retention metric measures retention across the full dataset of all NHSC alumni tracked for 10 service completion years. The data show that 82 percent of those who fulfilled their service commitments between 2012 and 2023 (of 31,029 clinicians tracked) currently work in a HPSA, while 87 percent of these NHSC alumni clinicians are either still in a HPSA or have remained in the same community where they served, even if it no longer qualifies as a HPSA, a metric referred to as Community Retention.

Requirement #7: The results of evaluations and determinations made under section 333(a)(1)(D) during such year.

Section 333 of the PHS Act establishes the framework by which the NHSC evaluates formal requests from facilities seeking eligibility for NHSC recruitment and retention assistance (see **Requirement #2** section above for eligibility requirements and the number of applications received and their disposition). HRSA determines an entity's compliance with section 333(a)(1)(D) of the PHS Act through a three-step process to become an NHSC site.

The first step verifies whether the geographic area, the population group served by the site, or the site itself is designated as a HPSA. As noted in the **Requirement #1** section above, designation of a HPSA involves the evaluation of several factors and data, including the continued need for health professionals in a geographic area. Generally, the need and demand for health professionals is documented by the ratio of the number of individuals in the area to the number of available health professionals (see 42 C.F.R. Part 5).

²⁴ HRSA last conducted the NHSC Participant Satisfaction Survey in 2019.

The second step reviews whether the area, population group, or facility is a HPSA of greatest need. HRSA analyzes and scores indicators to determine which HPSAs are in greatest need with measures of need for primary care, dental, and mental health services such as:

- Ratio of individuals to health providers in the area;
- Rate of poverty;
- Accessibility of primary health care services (travel time or distance);
- Rate of infant mortality or low birthweight births;
- Presence of fluoridated water;
- Ratios of population under 18 and over 65; and
- Prevalence of SUD, or alcohol abuse specifically.

HPSA scores range from 0 to 25 for primary care and mental health, and 0 to 26 for dental health; higher scores indicate greater need. Additionally, the NHSC recognized MCTA scores as a subset of designated primary care HPSAs to determine the greatest need for maternity health professionals in FY 2024. MCTA scores range from 0 to 25. Certain types of facilities, including FQHCs and rural health clinics providing access to care regardless of ability to pay, receive an automatic facility HPSA designation.

Third, for an application to be accepted, the submitting entity must meet all the following requirements:

- Be part of a system of care;
- Have a documented record of sound fiscal management;
- Verify appropriate and efficient use of current and former NHSC personnel;
- Be accessible to individuals regardless of their ability to pay;
- Accept Medicaid, Medicare, and Children's Health Insurance Program beneficiaries;
- Maintain a sliding discount fee schedule; and
- Have general community support for the assignment of an NHSC member to that entity.

The NHSC offers NHSC recruitment and retention assistance to all facilities that apply and meet the above requirements. Upon approval of their application, facilities post vacancies on the HWC as they occur. The NHSC lists vacancies on the HWC, which includes primary care, dental health, and behavioral health provider vacancies in designated HPSAs, as well as information related to the services provided and populations served by NHSC-approved sites. The HWC is located at <https://connector.hrsa.gov/connector>. Vacancies for NHSC-approved sites are also posted to NHSC social media channels throughout the year.

V. Conclusion

As of September 30, 2024, there were 17,419 primary medical care, oral health, and behavioral health practitioners serving at NHSC-approved sites in areas of greatest need across the country, and there were more than 22,000 NHSC-approved sites in the United States. Moreover, the clinicians included in the FY 2024 NHSC field strength provided care to more than 18 million patients. In FY 2024, the NHSC expanded promotion and outreach activities and engaged in greater collaboration with partners, including added outreach, coordination, and marketing to

ensure stakeholder awareness of expanded loan repayment award opportunities for primary medical care providers. Additionally, eligible maternity care clinicians who received new NHSC loan repayment awards in FY 2024 are serving in communities with identified MCTAs. FY 2024 marks the NHSC's second cycle for MCTA placements.

ARP Act-supported 3-year grants made to states in FY 2022 through the NHSC State LRP continued to contribute to the NHSC field strength in FY 2024. As NHSC clinicians initially supported with ARP Act funding in FY 2021 and FY 2022 completed their service commitments, the field strength decreased by approximately 5 percent, from 18,335 in FY 2023. The NHSC used its mandatory appropriation in FY 2024 to prioritize support for more than 2,100 commitments (continuations) to clinicians already serving high-need urban, rural, and tribal communities through its programs.

The decrease in the NHSC field strength in FY 2024 was due in part to the ongoing interest in 1-year continuation contracts from ARP Act-supported providers previously awarded multi-year initial contracts. The staggered entry into the field of NHSC S2S LRP and NHSC SP scholars with ARP Act-supported initial awards, meanwhile, will continue to impact the total number of NHSC clinicians serving through FY 2030.

The NHSC will continue to focus on ensuring that NHSC providers are serving in HPSAs with the greatest need, and on leveraging existing statutory authority to encourage health professions students and clinicians to pursue careers in primary care. Prioritizing these efforts, while fostering collaborative partnerships, will allow the NHSC to continue to address the nationwide shortage of health care providers in underserved communities.

Appendix A: National Health Service Corps FY 2024 Field Strength

National Health Service Corps – Overall Field Strength (as of 9/30/2024; full acronym key follows tables)

State	Total	NHSC LRP Total	NHSC SUD LRP Total	NHSC RC LRP Total	NHSC SP Total	S2S LRP Total	State LRP Total	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee
AK	244	42	9	34	4	2	153	64	180	8	236
AL	112	74	13	12	9	4	0	65	47	87	25
AR	158	125	14	18	0	1	0	63	95	85	73
AS	1	0	0	1	0	0	0	0	1	1	0
AZ	726	332	58	94	56	29	157	459	267	301	425
CA	1,369	862	83	52	170	110	92	1,182	187	1,002	367
CO	364	162	35	31	25	14	97	270	94	187	177
CT	451	278	136	12	12	13	0	410	41	255	196
DC	158	68	11	0	18	8	53	158	0	89	69
DE	63	17	14	8	6	3	15	46	17	17	46
FL	608	455	81	16	34	22	0	524	84	418	190
GA	313	198	28	22	28	13	24	214	99	181	132
GU	6	2	1	1	0	2	0	0	6	2	4
HI	121	46	5	6	18	5	41	56	65	68	53
IA	208	101	15	43	5	4	40	76	132	92	116
ID	246	139	39	25	19	8	16	119	127	131	115
IL	837	536	81	28	55	32	105	612	225	490	347
IN	341	191	51	36	13	8	42	237	104	219	122
KS	211	74	27	65	2	3	40	44	167	114	97
KY	520	247	53	126	9	9	76	99	421	247	273
LA	224	114	29	15	6	9	51	131	93	113	111
MA	303	109	70	3	28	23	70	281	22	200	103
MD	371	193	60	7	23	20	68	303	68	161	210
ME	108	24	17	37	9	5	16	19	89	64	44
MI	672	301	71	56	22	23	199	365	307	285	387
MN	364	188	43	77	14	7	35	170	194	66	298
MO	669	423	67	58	25	34	62	316	353	293	376
MP	21	3	0	1	2	0	15	0	21	1	20
MS	100	74	5	8	3	1	9	29	71	48	52
MT	193	94	19	41	9	9	21	53	140	72	121
NC	522	256	83	50	67	24	42	255	267	278	244
ND	109	9	16	19	0	3	62	44	65	18	91
NE	140	43	19	15	3	0	60	61	79	40	100
NH	47	10	11	21	5	0	0	16	31	36	11
NJ	73	32	16	0	9	2	14	68	5	53	20
NM	290	115	28	79	14	23	31	116	174	99	191
NV	146	49	17	11	3	5	61	94	52	47	99
NY	1,132	715	193	69	56	53	46	911	221	500	632
OH	599	314	110	85	18	11	61	350	249	414	185
OK	485	256	75	110	5	7	32	182	303	124	361
OR	412	172	73	64	41	16	46	208	204	223	189
PA	287	114	41	22	29	14	67	207	80	154	133
PR	83	31	45	7	0	0	0	73	10	70	13
RI	193	37	26	0	10	0	120	193	0	73	120
SC	187	109	17	21	14	9	17	95	92	142	45
SD	98	48	5	28	1	0	16	25	73	14	84
TN	256	108	26	12	9	2	99	158	98	103	153
TX	501	312	63	25	38	18	45	383	118	323	178
UT	189	59	35	25	9	2	59	96	93	45	144
VA	355	156	25	31	24	7	112	177	178	160	195
VI	7	4	1	2	0	0	0	3	4	4	3
VT	96	10	9	30	1	2	44	13	83	52	44
WA	560	284	55	48	74	38	61	405	155	347	213
WI	262	107	24	45	21	6	59	108	154	108	154
WV	242	129	27	30	8	1	47	78	164	146	96
WY	66	21	9	24	2	1	9	10	56	12	54
Total	17,419	8,972	2,184	1,806	1,085	665	2,707	10,694	6,725	8,882	8,537
Percentage of Total Field Strength		51.51%	12.54%	10.37%	6.23%	3.82%	15.54%	61.39%	38.61%	50.99%	49.01%

National Health Service Corps – Primary Medical Care Field Strength (as of 9/30/2024; full acronym key follows tables)

State	Total	NHSC LRP Total	NHSC SP Total	S2S LRP Total	State LRP Total	PHY	NP	PA	CNM	RN (State LRP)	PHARM (State LRP)	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee
AK	134	21	2	2	109	39	25	19	4	27	20	36	98	2	132
AL	65	54	8	3	0	23	35	7	0	0	0	43	22	53	12
AR	55	55	0	0	0	4	47	4	0	0	0	22	33	44	11
AS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AZ	384	199	47	25	113	103	171	76	13	0	21	253	131	199	185
CA	756	469	119	92	76	182	276	273	17	0	8	686	70	590	166
CO	181	82	16	12	71	56	50	55	11	0	9	142	39	98	83
CT	69	54	8	7	0	7	39	18	5	0	0	66	3	62	7
DC	86	34	17	6	29	39	30	13	4	0	0	86	0	50	36
DE	27	11	3	2	11	9	10	6	2	0	0	25	2	9	18
FL	291	251	24	16	0	67	156	55	13	0	0	248	43	232	59
GA	188	137	20	9	22	52	95	25	11	5	0	135	53	138	50
GU	3	1	0	2	0	1	0	1	1	0	0	0	3	2	1
HI	74	24	14	5	31	29	32	9	1	2	1	33	41	36	38
IA	74	42	3	3	26	12	37	11	6	2	6	32	42	38	36
ID	76	43	14	8	11	15	23	36	0	1	1	25	51	48	28
IL	507	329	53	31	94	139	220	124	24	0	0	379	128	341	166
IN	148	109	12	5	22	29	95	16	8	0	0	117	31	109	39
KS	81	42	2	2	35	5	44	13	2	17	0	21	60	37	44
KY	226	158	4	5	59	30	143	31	3	11	8	41	185	96	130
LA	90	50	3	5	32	16	64	9	1	0	0	38	52	36	54
MA	145	59	17	19	50	38	66	29	2	0	10	132	13	95	50
MD	147	66	17	16	48	45	72	20	6	4	0	112	35	85	62
ME	18	6	4	5	3	5	6	7	0	0	0	4	14	9	9
MI	339	152	10	11	166	103	139	86	11	0	0	158	181	114	225
MN	59	39	4	5	11	5	25	18	2	9	0	34	25	28	31
MO	269	216	10	13	30	84	153	29	3	0	0	91	178	95	174
MP	17	2	2	0	13	2	0	6	2	4	3	0	17	0	17
MS	72	63	2	0	7	15	51	4	0	2	0	26	46	39	33
MT	62	33	6	7	16	12	18	23	1	4	4	15	47	19	43
NC	213	143	53	17	0	43	86	79	5	0	0	103	110	151	62
ND	56	7	0	2	47	5	28	7	0	9	7	15	41	6	50
NE	54	18	2	0	34	11	13	9	1	15	5	27	27	14	40
NH	10	6	4	0	0	3	4	3	0	0	0	6	4	10	0
NJ	30	13	6	1	10	6	13	10	1	0	0	29	1	19	11
NM	104	62	10	17	15	34	53	13	4	0	0	41	63	46	58
NV	88	32	2	5	49	15	30	25	2	5	11	55	33	33	55
NY	492	371	48	47	26	133	193	124	42	0	0	411	81	286	206
OH	204	150	12	9	33	36	129	18	4	0	17	135	69	147	57
OK	129	119	3	3	4	24	72	26	5	2	0	51	78	73	56
OR	140	57	32	11	40	32	37	54	2	2	13	65	75	86	54
PA	128	66	19	10	33	32	63	27	6	0	0	106	22	82	46
PR	6	6	0	0	0	6	0	0	0	0	0	6	0	6	0
RI	94	20	4	0	70	18	29	15	0	31	1	94	0	24	70
SC	90	71	10	8	1	22	41	24	3	0	0	45	45	79	11
SD	17	13	0	0	4	2	12	2	1	0	0	8	9	5	12
TN	148	56	6	2	84	15	100	16	6	5	6	87	61	53	95
TX	245	178	27	16	24	45	138	44	7	8	3	184	61	198	47
UT	65	24	5	1	35	11	11	27	0	15	1	33	32	15	50
VA	168	84	11	6	67	30	93	28	1	11	5	89	79	95	73
VI	3	3	0	0	0	1	0	1	1	0	0	3	0	3	0
VT	38	1	0	0	37	7	19	12	0	0	0	7	31	1	37
WA	256	131	54	33	38	83	72	81	7	6	7	196	60	188	68
WI	84	29	3	5	47	20	43	18	3	0	0	30	54	26	58
WV	131	80	6	1	44	14	68	33	3	4	9	29	102	72	59
WY	20	9	2	1	8	7	6	4	0	0	3	5	15	6	14
Total	7,656	4,550	760	511	1,835	1,821	3,475	1,723	257	201	179	4,860	2,796	4,428	3,228
Percentage of Primary Care Field Strength		59.43%	9.93%	6.67%	23.97%	23.79%	45.39%	22.51%	3.36%	2.63%	2.34%	63.48%	36.52%	57.84%	42.16%
Percentage of Total Field Strength		26.12%	4.36%	2.93%	10.53%	10.45%	19.95%	9.89%	1.48%	1.15%	1.03%	27.90%	16.05%	25.42%	18.53%

National Health Service Corps – Oral Health Field Strength (as of 9/30/2024; full acronym key follows tables)

State	Total	NHSC LRP Total	NHSC SP Total	S2S LRP Total	State LRP Total	DD	RDH	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee
AK	29	7	1	0	21	24	5	7	22	0	29
AL	5	5	0	0	0	4	1	1	4	5	0
AR	14	14	0	0	0	11	3	10	4	12	2
AS	0	0	0	0	0	0	0	0	0	0	0
AZ	67	34	7	1	25	55	12	47	20	26	41
CA	234	168	38	13	15	216	18	206	28	194	40
CO	44	26	6	0	12	30	14	33	11	30	14
CT	19	17	2	0	0	11	8	18	1	18	1
DC	21	11	1	0	9	18	3	21	0	12	9
DE	5	1	3	1	0	5	0	5	0	5	0
FL	77	63	10	4	0	64	13	71	6	75	2
GA	19	11	6	2	0	16	3	17	2	13	6
GU	1	1	0	0	0	1	0	0	1	0	1
HI	18	12	4	0	2	17	1	8	10	16	2
IA	33	25	2	0	6	21	12	20	13	26	7
ID	24	20	4	0	0	13	11	11	13	24	0
IL	39	31	1	0	7	35	4	30	9	29	10
IN	28	23	0	3	2	18	10	26	2	26	2
KS	26	22	0	0	4	11	15	12	14	20	6
KY	29	16	5	3	5	24	5	6	23	20	9
LA	24	14	3	2	5	16	8	12	12	15	9
MA	22	12	6	1	3	18	4	22	0	19	3
MD	16	10	6	0	0	15	1	12	4	16	0
ME	14	10	4	0	0	7	7	4	10	12	2
MI	84	55	11	10	8	64	20	63	21	63	21
MN	34	25	6	0	3	24	10	29	5	18	16
MO	127	65	15	20	27	96	31	73	54	96	31
MP	0	0	0	0	0	0	0	0	0	0	0
MS	5	2	1	1	1	4	1	0	5	4	1
MT	23	18	2	1	2	16	7	6	17	14	9
NC	42	24	14	4	0	38	4	25	17	28	14
ND	2	0	0	0	2	2	0	1	1	0	2
NE	13	11	1	0	1	8	5	9	4	11	2
NH	1	0	1	0	0	1	0	1	0	1	0
NJ	12	5	2	1	4	12	0	11	1	7	5
NM	39	26	4	3	6	31	8	24	15	26	13
NV	4	2	1	0	1	2	2	3	1	3	1
NY	112	96	4	4	8	97	15	98	14	85	27
OH	57	30	5	2	20	42	15	36	21	34	23
OK	26	23	2	1	0	21	5	13	13	16	10
OR	53	41	6	3	3	27	26	33	20	42	11
PA	64	29	10	4	21	43	21	50	14	35	29
PR	8	8	0	0	0	8	0	8	0	8	0
RI	26	5	6	0	15	18	8	26	0	11	15
SC	8	7	1	0	0	5	3	6	2	8	0
SD	6	5	1	0	0	3	3	1	5	2	4
TN	11	8	3	0	0	10	1	10	1	11	0
TX	56	43	11	0	2	47	9	39	17	52	4
UT	19	12	4	0	3	14	5	12	7	8	11
VA	37	19	12	1	5	35	2	15	22	31	6
VI	0	0	0	0	0	0	0	0	0	0	0
VT	9	1	1	0	7	8	1	0	9	2	7
WA	90	68	14	1	7	74	16	69	21	76	14
WI	52	29	15	1	7	39	13	25	27	41	11
WV	24	20	1	0	3	16	8	8	16	18	6
WY	0	0	0	0	0	0	0	0	0	0	0
Total	1,852	1,230	263	87	272	1,455	397	1,293	559	1,364	488
Percentage of Oral Health Field Strength		66.41%	14.20%	4.70%	14.69%	78.56%	21.44%	69.82%	30.18%	73.65%	26.35%
Percentage of Total Field Strength		7.06%	1.51%	0.50%	1.56%	8.35%	2.28%	7.42%	3.21%	7.83%	2.80%

National Health Service Corps – Behavioral Health Field Strength (as of 9/30/2024; full acronym key follows tables)

State	Total	NHSC LRP Total	NHSC SUD LRP Total	NHSC RC LRP Total	NHSC SP Total	S2S LRP Total	State LRP Total	PHY MH	NP M H	PA M H	CNM MH	LCSW	LPC	HSP	MFT	PNS CRNA	SUD Counselor	R N M H	PHARM MH	Non-Rural	Rural	Health Center Grantee	Non-Health Center Grantee	
AK	81	14	9	34	1	0	23	5	11	6	2	17	23	3	2	0	0	1	2	9	21	60	6	75
AL	42	15	13	12	1	1	0	7	12	1	0	6	2	2	1	0	0	6	0	5	21	21	29	13
AR	89	56	14	18	0	1	0	2	17	1	0	37	30	0	0	0	0	0	0	2	31	58	29	60
AS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0
AZ	275	99	58	94	2	3	19	17	108	6	1	30	45	4	2	1	2	7	5	47	159	116	76	199
CA	379	225	83	52	13	5	1	35	70	21	1	100	4	48	68	3	0	10	10	9	290	89	218	161
CO	139	54	35	31	3	2	14	6	14	8	0	40	36	11	4	1	0	15	2	2	95	44	59	80
CT	363	207	136	12	2	6	0	12	58	2	0	134	92	16	22	0	0	18	7	2	326	37	175	188
DC	51	23	11	0	0	2	15	2	9	0	0	17	14	5	0	0	0	0	1	3	51	0	27	24
DE	31	5	14	8	0	0	4	1	8	2	0	7	4	1	0	0	0	7	1	0	16	15	3	28
FL	240	141	81	16	0	2	0	14	64	4	0	50	52	22	2	1	0	4	5	22	205	35	111	129
GA	106	50	28	22	2	2	2	5	27	3	0	15	26	10	3	0	0	7	3	7	62	44	30	76
GU	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	0	2
HI	29	10	5	6	0	0	8	1	1	1	0	2	2	16	0	1	0	1	2	2	15	14	16	13
IA	101	34	15	43	0	1	8	2	37	1	0	15	21	5	1	1	2	12	0	4	24	77	28	73
ID	146	76	39	25	1	0	5	8	18	7	0	46	31	12	1	0	0	13	1	9	83	63	59	87
IL	291	176	81	28	1	1	4	8	64	8	0	96	54	9	3	6	0	26	13	4	203	88	120	171
IN	165	59	51	36	1	0	18	7	64	0	0	38	19	12	1	2	0	8	8	6	94	71	84	81
KS	104	10	27	65	0	1	1	6	39	5	1	11	5	2	4	0	0	16	1	14	11	93	57	47
KY	265	73	53	126	0	1	12	14	76	4	0	53	60	6	1	2	0	13	8	28	52	213	131	134
LA	110	50	29	15	0	2	14	3	27	1	0	26	37	4	0	1	0	4	2	5	81	29	62	48
MA	136	38	70	3	5	3	17	6	49	7	2	29	20	2	1	1	0	4	13	2	127	9	86	50
MD	208	117	60	7	0	4	20	15	58	1	0	55	32	24	0	2	0	15	5	1	179	29	60	148
ME	76	8	17	37	1	0	13	10	28	8	0	17	3	0	0	2	0	3	3	2	11	65	43	33
MI	249	94	71	56	1	2	25	16	38	8	0	102	31	9	1	1	0	14	15	14	144	105	108	141
MN	271	124	43	77	4	2	21	13	46	12	2	68	48	23	15	4	0	28	6	6	107	164	20	251
MO	273	142	67	58	0	1	5	9	66	4	0	57	88	15	4	0	0	8	19	3	152	121	102	171
MP	4	1	0	1	0	0	2	0	0	0	0	0	1	1	0	0	0	2	0	0	0	4	1	3
MS	23	9	5	8	0	0	1	1	6	0	0	4	8	2	0	0	0	1	0	1	3	20	5	18
MT	108	43	19	41	1	1	3	11	17	7	0	16	27	3	0	2	0	15	0	10	32	76	39	69
NC	267	89	83	50	0	3	42	14	45	6	1	76	57	6	3	1	0	26	18	14	127	140	99	168
ND	51	2	16	19	0	1	13	2	5	2	0	10	12	0	0	2	0	10	6	2	28	23	12	39
NE	73	14	19	15	0	0	25	5	15	5	0	5	26	5	0	0	0	7	0	5	25	48	15	58
NH	36	4	11	21	0	0	0	3	11	1	0	7	6	2	1	0	0	2	3	0	9	27	25	11
NJ	31	14	16	0	1	0	0	3	3	4	0	13	1	0	0	0	0	3	1	3	28	3	27	4
NM	147	27	28	79	0	3	10	5	37	3	2	20	19	3	3	0	1	7	4	43	51	96	27	120
NV	54	15	17	11	0	0	11	5	5	3	0	16	7	1	7	0	0	8	1	1	36	18	11	43
NY	528	248	193	69	4	2	12	27	90	19	1	124	109	25	10	2	1	81	28	11	402	126	129	399
OH	338	134	110	85	1	0	8	4	88	6	0	82	66	6	0	0	0	32	26	28	179	159	233	105
OK	330	114	75	110	0	3	28	6	23	12	1	50	163	2	11	0	0	18	10	34	118	212	35	295
OR	219	74	73	64	3	2	3	10	55	17	1	40	38	8	6	4	1	22	9	8	110	109	95	124
PA	95	19	41	22	0	0	13	7	28	3	0	12	19	8	0	0	0	7	4	7	51	44	37	58
PR	69	17	45	7	0	0	0	5	0	0	0	13	0	21	0	0	0	4	8	18	59	10	56	13
RI	73	12	26	0	0	0	35	3	19	1	0	37	8	0	2	0	0	0	2	1	73	0	38	35
SC	89	31	17	21	3	1	16	6	20	4	0	14	30	1	1	1	0	5	1	6	44	45	55	34
SD	75	30	5	28	0	0	12	1	13	1	0	19	22	2	0	1	1	2	3	10	16	59	7	68
TN	97	44	26	12	0	0	15	4	33	1	0	14	19	4	4	2	0	1	4	11	61	36	39	58
TX	200	91	63	25	0	2	19	9	42	4	0	32	63	9	5	1	0	18	5	12	160	40	73	127
UT	105	23	35	25	0	1	21	5	12	20	0	38	17	4	2	0	0	2	1	4	51	54	22	83
VA	150	53	25	31	1	0	40	0	29	0	0	29	59	8	1	0	0	10	8	6	73	77	34	116
VI	4	1	1	2	0	0	0	0	0	0	0	3	0	1	0	0	0	0	0	0	0	4	1	3
VT	49	8	9	30	0	2	0	2	11	5	0	14	4	0	0	0	0	0	10	3	6	43	49	0
WA	214	85	55	48	6	4	16	13	35	16	0	27	51	18	9	1	0	28	2	14	140	74	83	131
WI	126	49	24	45	3	0	5	11	23	0	0	23	33	10	4	3	0	11	1	7	53	73	41	85
WV	87	29	27	30	1	0	0	4	26	3	0	8	8	19	0	0	0	2	2	15	41	46	56	31
WY	46	12	9	24	0	0	1	6	8	1	0	7	15	0	1	0	0	2	0	6	5	41	6	40
Total	7,911	3,192	2,184	1,806	62	67	600	396	1,708	265	15	1,821	1,667	430	206	49	8	568	289	489	4,541	3,370	3,090	4,821
Percentage of Mental Health		40.35%	27.61%	22.83%	0.78%	0.85%	7.58%	5.01%	21.59%	3.35%	0.2%	23.02%	21.07%	5.44%	2.60%	0.6%	0.1%	7.18%	3.65%	6.18%	57.40%	42.60%	39.06%	60.94%
Percentage of Total Field Strength		18.32%	12.54%	10.37%	0.36%	0.38%	3.44%	2.27%	9.81%	1.52%	0.1%	10.45%	9.57%	2.47%	1.18%	0.3%	<0.1%	3.26%	1.66%	2.81%	26.07%	19.35%	17.74%	27.68%

Acronyms and Abbreviations Used in Appendix A

(In order of appearance)

Program

NHSC SP	Scholars fulfilling NHSC obligation
NHSC LRP	Traditional loan repayors fulfilling NHSC obligation
NHSC SUD Workforce LRP	Substance use disorder workforce loan repayors fulfilling NHSC obligation
NHSC RC LRP	Rural community loan repayors fulfilling NHSC obligation
NHSC S2S LRP	Students to Service loan repayors fulfilling NHSC obligation
NHSC State LRP	State grant recipients use funding to operate their own loan repayment programs and contract directly with participants who fulfill service obligations in HPSAs within the state in exchange for loan repayment awards

Rural Status

Rural	Rural = clinicians serving in a rural setting
Non-Rural	Non-Rural = clinicians serving in any non-rural setting

Grantee Status

Health Center Grantee	Clinicians serving at a site that receives Section 330 grant funding from the Health Center Program; does not include the State LRP
Non-Health Center Grantee	Clinicians serving at any site type other than a health center funded with Section 330 grants; does not include the State LRP

Discipline

PHY	Allopathic/osteopathic physicians serving in the traditional NHSC LRP, excluding psychiatrists
NP	Nurse practitioners serving in the traditional NHSC LRP, excluding those with psychiatric specialty
PA	Physician assistants serving in the traditional NHSC LRP, excluding those with psychiatric specialty
CNM	Certified nurse midwives serving in the traditional NHSC LRP
RN	Registered nurses (State LRP only)
PHARM	Pharmacists (State LRP only)
DD	Dentists
RDH	Registered dental hygienists
PHY MH	Allopathic/osteopathic psychiatrists serving in the traditional NHSC LRP, the S2S LRP, and the State LRP, and all physicians serving in the SUD Workforce LRP and the RC LRP
NP MH	Nurse practitioners with psychiatric specialty serving in the traditional NHSC LRP, the S2S LRP, and the State LRP, and all nurse practitioners serving in the SUD Workforce LRP and the RC LRP
PA MH	Physician assistants with psychiatric specialty serving in the traditional NHSC LRP, the S2S LRP, and the State LRP, and all physician assistants serving in the SUD Workforce LRP and the RC LRP
CNM MH	Certified nurse midwives serving in the SUD Workforce LRP and the RC LRP
LCSW	Licensed clinical social workers

LPC	Licensed professional counselors
HSP	Health service psychologists
MFT	Marriage and family therapists
PNS	Psychiatric nurse specialists
CRNA	Certified registered nurse anesthetists
SUD Counselor	Substance use disorder counselors serving in the SUD Workforce LRP, the RC LRP, and the State LRP
RN MH	Registered nurses with a psychiatric specialty serving in the State LRP, and all registered nurses serving in the SUD Workforce LRP and the RC LRP
PHARM MH	Pharmacists serving in the SUD Workforce LRP and the RC LRP