



March 20, 2023

The Honorable Bernard Sanders
Chair
Committee on Health, Education, Labor, and
Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
Ranking Member
Committee on Health, Education, Labor, and
Pensions
United States Senate
Washington, DC 20510

Dear Senator Sanders and Senator Cassidy,

The National Rural Health Association (NRHA) is pleased to offer a response to the Senate HELP Committee Request for Information on the drivers of health care workforce shortages. Historic rural workforce shortages have been exacerbated by the COVID-19 pandemic. Communities across the United States are struggling to fill gaps in care, but none are so affected as rural communities whose struggles to maintain an adequate workforce predated the pandemic.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, rural health clinics, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

There are 60 million people who live in rural areas, accounting for 20% of the nation's population. And yet, provider to population ratios in rural areas are much lower than urban areas despite disproportionate needs for care. Research suggests rural communities often face challenges in maintaining an adequate health care workforce due to higher workloads, limited resources and difficulty recruiting clinical providers. These challenges are further compounded by the rural hospital closure crisis and the chronic underfunding of rural health safety-net programs. As Congress considers new policy solutions to address workforce shortages, it is important to continue level or increased funding for programs such as the National Service Corps, Nurse Service Corps, Graduate Medical Education Teaching Health Centers (GME THC) and rural Graduate Medical Education programs, as well as student loan repayment programs that incentivize providers to practice in rural and other underserved areas.

Physicians

Rural communities have been grappling with physician shortages for years. Although 20 percent of the United States population lives in rural areas, only 11 percent of physicians practice in rural areas. As of 2017, AAMC reported that an additional 14,100 to 17,600 physicians were needed in nonmetropolitan areas in order to give underserved populations the same access to care.¹ By 2030, AAMC predicts that the demand for physicians will outstrip the supply and that the United States will experience a shortage of 121,300 physicians; shortages that will be further exacerbated in rural areas. Geographic disparities can be attributed to challenges with

¹ "Rural Healthcare Workforce Overview", *Rural Health Information Hub*, <https://www.ruralhealthinfo.org/topics/health-care-workforce>.

recruitment and retention, capacity for new providers and the maldistribution of providers and resources among rural and urban facilities.

Recruitment and retention. Rural health care providers disproportionately serve older, sicker, and poorer populations. Rural health care facilities are more likely to provide a lower volume of services, have more Medicare and Medicaid dependent patients as payers, and are less likely to be privately owned. Therefore, rural entities do not have the financial resources necessary to compete with larger, urban facilities when recruiting and retaining providers. Large, urban hospitals are more likely to offer higher remuneration, bonuses, and competitive recruitment packages than rural hospitals with limited resources. Moreover, physicians trained and educated in urban areas are less likely to serve rural areas or remain in a rural area once hired. Community based clinical training in rural areas is an essential component of addressing healthcare workforce shortages.

Potential Solutions: Evidence suggests physicians from rural areas or physicians with exposure to rural areas are more likely to practice in rural communities long-term. For this reason, many rural communities are touting the success of grow-your-own programs. Grow-your-own programs encourage folks to join the health care workforce by increasing exposure to health careers early on. Career exploration opportunities, K-12 apprenticeships, nursing, and other health-allied education at community colleges keep rural students engaged in the health care system at a low cost for the community. Federal programs, like Area Health Education Centers, play a fundamental role in providing critical resources to rural communities to support grow-your-own programs.

Graduate Medical Education (GME). Opportunities to complete GME requirements through rural residency is another critical element to growing the rural healthcare physician workforce. A GME Rural Track program can be defined as, “as an accredited course of postgraduate training leading to certification in independent practice for any physician specialty, occurring in rural and urban places where greater than 50 percent of training occurs in a geographically rural location by federal definition”.² Research suggests that eighteen months of training in a rural location more than doubles placement of graduates in rural community practice and they are more likely to stay than residents trained in urban locations.

Potential Solutions: While most of GME policy is set through Medicare and Medicaid, the HELP Committee has significant influence over community-based GME training through the Teaching Health Center GME (THC GME) program, as well as rural capacity development for residency training through programs like the Rural Residency Planning and Development program.

The THC GME program has been identified as a way to support primary care medical and dental residency programs in an outpatient, community setting for rural and underserved communities. NRHA encourages the Committee to explore how the THC GME program can be enhanced in a way to increase the number of training sites in a rural in order to be a more significant lever for rural physician training. According to researchers at RuralGME.org, approximately 14% (48 of 349) of THC GME training sites were in a rural area in 2022, with 7 of the 61 THC GME programs analyzed (or 11%) training residents for 50% or greater training time in a FORHP rural area

² Longenecker, Randall, and Lori Rodefelf, (2023). “Rural Track Program Funding: An Erosion in Definitions of Rural Places Requires New Action”, *NRHA*.

(meeting the formal definition of a Rural Training Program (RTP)).³ For example, the Committee could expand eligible lead THC GME applicants to include outpatient Critical Access Hospital (CAH) and Rural Emergency Hospitals (REH) in rural areas given their significant focus on ambulatory care. CAHs currently are not eligible to receive traditional GME payments as they are paid outside the Medicare prospective payment system. Therefore, broadening the range of outpatient providers in rural areas, like CAHs, will engage additional rural facilities as potential training sites under the THC GME program.

Additionally, the Committee may look to the Rural Residency Planning and Development (RRPD) program at HRSA as a model for developing residency training programs in rural areas. Currently, only two percent of residency training occurs in rural areas. The RRPD program supports start-up costs to establish new rural residency programs, including accreditation costs, faculty development, and resident recruitment. The program has seen great success to date. Since funding the first cohort in FY 2019, award recipients have created 32 new accredited rural residency programs in family medicine, internal medicine, psychiatry, and general surgery; filling 188 residency slots of the approximately 415 new residency positions in rural areas.⁴ NRHA urges the committee to continue to expand the RRPD program and look to it as a capacity building model for other health professionals in rural areas.

Related to broader Medicare GME policy, NRHA believes Congress should pass S. 230, the Rural Physician Workforce Production Act, introduced by Senator Tester (D-MT) and Senator Barrasso (R-WY). This bill addresses existing problems within GME to address the geographic maldistribution of physicians across the United States. Specifically, certain rural hospitals may receive additional payment under Medicare for full-time equivalent residents who receive training in rural areas.

Student loan repayments and other incentive programs. Student loan repayment programs and other programs that incentivize providers to serve in rural and other underserved areas are essential to closing the workforce shortage gap between rural and urban areas.

Potential Solutions: NRHA urges continuous support for these critical programs:

- The National Health Service Corps (NHSC) Loan Repayment Program. NHSC supports more than 20,000 health care providers through scholarships and loan repayment programs. In exchange for money to reduce educational debt, health care providers agree to practice in rural or other underserved areas for an allotted time. Further investments should be made to continue mandatory funding of the NHSC program in order to maximize the program reach in rural areas across the country.
- State Loan Repayment Program (SLRP). Funded through the Health Resources and Services Administration (HRSA), SLRP allocates funds to states and territories to create their own programs that address the health needs of their residents. NRHA believes this program could better serve underserved populations if it included a rural set aside.

³ Health Resources and Services Administration. (2022). Teaching Health Center Graduate Medical Education. <https://bhwh.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education>

⁴ Health Resources and Services Administration. (2022). Rural Residency Planning and Development Program. <https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd>

- Conrad 30 J-1 Visa. The Conrad 30 Program admits 30 foreign-born graduate medical students to train and serve in Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA). NRHA urges Congress to pass the Conrad State 30 and Physician Access Reauthorization Act, introduced by Sen. Klobuchar (D-MN), which reauthorizes the program for three years and lifts the cap for states if certain requirements are met.
- Primary Care Offices (PCO). PCOs provide healthcare workforce and shortage designation analysis, technical assistance, and liaison with federal, state, and local partners. One of the core functions of the PCO is federal shortage designation, which is used to support workforce programs in many rural areas throughout the country. The workload on PCOs has continued to grow in terms of frequency, complexity, and number of tasks facing PCOs, however funding has not increased to account for the heightened workload. NRHA requests the Committee explore options for bringing additional resources to the PCO program in order to ensure rural areas have access to data and resources needed for rural workforce recruitment and placement.

Rural Hospital Capacity. Despite a demonstrated need for more physicians in rural areas, rural hospitals may choose to maintain smaller staff sizes due to issues with capacity. Rural hospital administrators are often tasked with choosing between bringing on new staff or keeping the lights on. In the last decade, 147 rural hospitals have shuttered their doors, and more are operating on thin or negative margins. Even if a rural hospital has the resources to bring on a new hire, the community may not be equipped to accommodate new residents. Rural communities are facing massive housing shortages, due to the pandemic which spurred an influx of remote workers to relocate to smaller towns. Now, many rural communities are reporting challenges in finding housing for their local workforce.⁵ NRHA urges Congress to expand funding opportunities for hospital capital and rural development to increase capacity.

Nurses

Nurses are the backbone of the health care workforce but due to burnout, insufficient wages, and crippled pipeline programs the United States is witnessing a mass exodus from the nursing profession. Throughout the pandemic, Chief Nursing Officers consistently reported staffing as their most significant problem; stressors from the pandemic only accelerated what has been coming down the pipe for years.⁶ In rural communities, advanced practice registered nurses (APRNs) have stepped up amidst the physician shortage and in many communities, they are often the only providers offering primary care. However, nursing shortages continue to plague rural areas at a disproportionate rate to their urban counterparts. Many blame the rise of travel nurses; the lucrative pay associated with these more transient roles has driven many nurses from traditional

⁵ Pettypiece, Shannon, (2023). "The Remote Workers Have Left, but the Housing Havoc They Created Remains". *NBC*, <https://www.nbcnews.com/politics/economics/remote-workers-left-housing-havoc-created-remains-rcna68874>.

⁶ Zhavoronkova, M., et al. (2022). "How to Ease the Nursing Shortage in America." Center for American Progress, <https://www.americanprogress.org/article/how-to-ease-the-nursing-shortage-in-america/>.

employment opportunities. Rural hospitals and clinics are simply unable to offer comparable wages due to scarce resources.⁷

Preceptor Capacity. An aging workforce taking care of an aging population has also created unforeseen challenges for nurses. Research suggests the one third of the current nursing faculty workforce is set to retire by 2025.⁸ Nursing schools do not have the capacity to train and educate nurses at the rate at which the country needs largely due to a lack of nurses seeking higher education and an aging nurse faculty workforce set to retire. Among Nurse Practitioner primary care education programs with a rural, 43% are not consistently able to offer rural clinical sites to students due to preceptor shortages.⁹

Potential Solutions: NRHA urges the Committee to explore opportunities to support preceptor capacity for nursing training, particularly in rural areas. HRSA's Nurse Faculty Loan, Faculty Loan Repayment Program, and Nurse Education, Practice, Quality and Retention-Clinical Faculty and Preceptor Academies Programs should consider priorities for programs that have preceptor training sites located in rural areas. The Committee may also look to the aforementioned RRPD program as a model to expand the number of rural sites able to precept nursing students.

Education and loan repayment programs. Nurses are essential providers in rural communities but without greater investment in nursing education and loan repayment programs, young people will choose to practice in more lucrative areas or professions.

Potential Solutions: NRHA urges continued congressional support and increased funding for the Nurse Corps Repayment Program, and the Nursing Expansion Grant Program. NRHA would also like to echo comments made by the American Association of Nurse Practitioners (AANP) in support of increased funding for Title VIII Nursing Workforce Development. Like AANP, NRHA supports an increase in funding for these programs to \$530 million for FY24 to meet the growing need of nursing education programs.

Scope of practice. Rural areas have greater rates of non-physician practitioners providing primary care. Barriers such as inconsistencies in the scope of practice regulations at the state level can limit the ability of certain advance practice registered nurses, physician assistants, and other providers to work at the top of their education and training in rural areas.¹⁰

Potential Solutions: NRHA urges Congress to reintroduce and pass the Improving Access to Nurses and Care Act. This bill allows APRNs to practice at the top of their licenses to provide certain services under Medicare and Medicaid without physician supervision. Expanding the scope of

⁷ Wright, A. (2021). Rural Hospitals Can't Find the Nurses They Need to Fight COVID. *The Pew Charitable Trusts*, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/09/01/rural-hospitals-cant-find-the-nurses-they-need-to-fight-covid>.

⁸ "Nursing Faculty Shortage." (2022). American Association of Colleges of Nursing, <https://www.aacnnursing.org/news-information/fact-sheets/nursing-faculty-shortage>.

⁹ Kaplan, Louise PhD, ARNP, FNP-BS, FAANP, FAAN; Pollack, Samantha W. MHS; Skillman, Susan M. MS; Patterson, Davis G. PhD. NP program efforts promoting transition to rural practice. *The Nurse Practitioner* 45(10):p 48-55, October 2020. | DOI: 10.1097/01.NPR.0000696920.66207.65

¹⁰ Dill, M. J., S. Pankow, C. Erikson, and S. Shipman. 2013. "Survey Shows Consumers Open to a Greater Role for Physician Assistants and Nurse Practitioners." *Health Aff (Millwood)* 32(6): 1135-1142.

<https://doi.org/10.1377/hlthaff.2012.1150>

practice for these providers is essential in wake of the physician shortage. NRHA also supports modernizing Medicare payment policies and repealing unnecessary barriers to care such as physician supervision requirements for Physician Assistants (PA). PAs are indispensable providers to rural areas; they are one of three health care professions providing primary care in rural areas along with physicians and APRNs.

EMS and other health allied professions

Emergency Medical Services. The pool of EMS volunteers is shrinking in rural areas. Rural emergency medical services (EMS) are more likely to be staffed by volunteers and less likely to be publicly funded. However, EMS professionals, including volunteers, must pay out of pocket for training. Additionally, first responders must complete 40 hours and EMTs must complete 120-150 hours. Even if rural residents were interested in volunteering, training is expensive and not everyone has the time to fulfill training requirements.

Potential Solutions: To reverse current trends and increase the number of EMS professionals in rural areas, Congress needs to create policy solutions that address access to training, reimbursement, recruitment and retention, and scope of practice. Moreover, Congress needs to streamline funding to rural EMS. **NRHA urges Congress to pass S. 265, the SIREN Reauthorization Act, introduced by Sen. Durbin (D-IL), and we support the reintroduction of S.2450, the Rural Health Innovation Act.** The SIREN Act reauthorizes rural emergency medical service training and equipment assistance program whereas the Rural Health Innovation Act, introduced by Sen. Blackburn (R-TN), creates two new grant programs to increase access to emergency care in rural areas.

Community Health Workers. Accounting for nearly 20 percent of the U.S. population, rural America is highly diverse with a specific set of needs for each community. Community health workers (CHW) play an important role in the rural health care system by connecting patients to health care services. Often raised within the communities they serve, CHWs share the same cultural and linguistic backgrounds as their clients.

Potential Solutions: To expand the CHW workforce in rural areas, NRHA recommends that Congress introduces legislation like S.2210, the Better Care Better Jobs Act. This bill funds state Medicaid programs to improve home- and community- based services (HCBS). Additionally, Congress needs to pass legislation to Support and advocate for the training and recruitment of more CHW in emergency preparedness, surveillance, and public health to better support rural communities in times of crisis.

Maternal Health Workforce

The United States is grappling with a rural maternal health crisis. Rural Black and brown women in rural areas are more likely to experience severe maternal mortality and morbidity due to structural barriers to care and racism. Expanding and diversifying the maternal health workforce is essential to improve rural maternal health outcomes. It is important that Congress considers policy interventions that address both racial and geographic disparities.

Labor and Delivery Unit Closures. Rural hospitals are increasingly forced to close their labor and delivery units due to financial vulnerability, workforce shortages, and low reimbursement rates. According to March of Dimes, maternity deserts are more likely to be in rural areas. Evidence

suggests the current trend of maternity ward closures disproportionately affect rural and Black and brown communities- our most vulnerable populations. One study from 2015-2019 found that 89 rural obstetric units closed across the country.¹¹ Hospital administrators attribute these closures to low Medicaid reimbursement rates. Currently, Medicaid is one of the largest (40%) payers for pregnancy and childbirth related services in the United States. This proportion is higher in more rural states.¹²

Potential Solutions: Without federal support, obstetric units will continue to close, forcing pregnant people to travel longer distances and putting their health at risk. Evidence suggests long travel distances are more likely to result in maternal and infant mortality. NRHA recognizes that low Medicaid reimbursement are partly responsible for current workforce shortages and strongly disavows any additional cuts to the Medicaid program. For hospitals without obstetric services, we recommend Congress creates a grant program through HRSA to train providers in obstetric readiness. We also urge Congress to increase its funding for the RMOMs program housed within the Health Resources and Services Administration (HRSA). We support the following funding levels rural maternal health programs:

- \$8.8 million to continue established RMOMs grantee cohorts.
- \$10 million for the Rural Obstetric Network Grants Program.
- \$6 million, \$5 million for grants and \$1 million for evaluation, for the Rural Maternal and Obstetric Care Training Demonstration. We also recommend that this program live within the Federal Office of Rural Health Policy at HRSA.

Obstetrician-gynecologists (OB-GYNs) and family physicians. Presently, only 6% of OB-GYNs serve rural areas. Due to low reimbursement rates, overwhelming workloads, and scarce resources, OB-GYNs are more likely to take higher paying jobs at larger, urban hospitals. Family physicians play a significant role in providing maternity services in rural areas, but the number of family physicians trained in obstetrics is in decline.

Potential Solutions: To increase the number of family physicians trained in rural obstetrics, NRHA supports the creation of a one-year rural obstetric fellowship program for family practice residents at the federal level. Funding could be provided through traditional Medicaid GME mechanisms for the actual fellowship, with grant funding made available to build capacity to create new rural obstetric fellowship programs.

Certified Nurse Midwives. Certified nurse midwives and certified midwives are an essential and yet often overlooked part of the perinatal workforce. Certified nurse midwives attend over 30% of all births in rural hospitals. That number is staggering compared to national statistics in which CNMs only attend 9.8% of all births.¹³

¹¹ Rabin, R. (2023). "Rural Hospitals Are Shuttering Their Maternity Units." *The New York Times*, <https://www.nytimes.com/2023/02/26/health/rural-hospitals-pregnancy-childbirth.html>.

¹² "Births Financed by Medicaid." (2020). KFF, <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22collid%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D>.

¹³ Birth Settings in America: Improving Outcomes, Quality, Access, and Choice. (2020). National Academies of Sciences, Engineering, and Medicine. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25636>.

Potential Solutions: CNMs could play a more elevated role in the rural perinatal workforce if Congress removed unnecessary barriers to care such as physician supervision requirements and increased Medicaid reimbursement rates for their services. NRHA also supports the reintroduction of the Midwives for Moms Act to expand midwifery education programs to increase the number of midwife professionals from underrepresented groups. Priority should be given to promote practice in rural areas with limited access to professional health care.

Community-based midwives and doulas. Certified, community-based midwives may choose to work outside of hospitals, meeting their patients at home or birth centers located in the community. Like CHWs, community-based midwives and doulas are more likely to be part of the community they serve and therefore, they may share the same linguistic or cultural background as their patients. Moreover, midwives and doulas lead to better maternal health outcomes. For example, Black women are 3-4 times more likely to die in childbirth, but Black women who enlist midwifery or doula services report fewer complications during pregnancy and childbirth.¹⁴ However, restrictions on at-home births and lack of Medicaid reimbursement for services put midwifery and doula care out of reach for those who need their services the most.¹⁵ Sufficient Medicaid reimbursement is essential to make sure our most vulnerable populations have access to the services they need most.

Potential Solutions: Amidst the rural maternal health crisis, it is important that we have robust and diverse perinatal workforce. NRHA means diverse racial, ethnic and cultural background as well as diverse provider types and even distribution among rural and urban areas. NRHA urges Congress to reintroduce and pass the Black Maternal Health Momnibus Package to expand the maternal health workforce and improve maternal health outcomes in the United States, with modification to promote geographic disparity, in addition to race and ethnicity.

Behavioral Health Workforce

NRHA urges Congress to continue its efforts to expand the behavioral health workforce and better integrate behavioral health services into primary care. Research indicates that approximately 37% of Americans live in mental health shortage areas, however, this number is much higher in rural areas.¹⁶ As of 2023, over 70% of rural counties do not have access to a psychiatrist.¹⁷ Rural America is not a monolith and therefore, the distribution of providers between rural areas is not equal either. Presently, rural residents living in the south are less likely to have access to psychiatrists, psychologists and social workers.¹⁸ The maldistribution of providers across geographic regions can largely be attributed to limited capacity for education programs in rural areas, lack of physicians to supervise training and lack of reimbursement for newer roles.

14 Ellmann, N. (2023). "Community-Based Doulas and Midwives." Center for American Progress, <https://www.americanprogress.org/article/community-based-doulas-midwives/>.

15 Guarnizo, T. (2022). "Doula Services in Medicaid: State Progress in 2022." Center For Children and Families, <https://ccf.georgetown.edu/2022/06/02/doula-services-in-medicaid-state-progress-in-2022/>.

16 "Filling the Gaps in the Behavioral Health Workforce." (2023). Bipartisan Policy Center, <https://bipartisanpolicy.org/event/behavioral-health-workforce/>.

17 Andrilla, H. & Patterson, D. (2023). "Behavioral Health Workforce Issues," WWAMI.

18 (Andrilla & Patterson, 2023)

NRHA applauds Congress for passing provisions in the CAA 2023 to expand coverage for Marriage and Family Therapists (MFT) and mental health counselors (MHC) under Medicare, and were encourage to see that 200 new residency slots were created for psychiatry or psychiatry subspecialties.

Potential Solutions: More can be done to expand the behavioral health workforce. NRHA urges Congress to consider the following recommendations:

- Pass S.198 Rural Health Clinic Burden Reduction Act legislation to update the statute for rural health clinics to include behavioral health in the definition of primary care. The existing RHC statute dictates that 50% of RHC services must be primary care, making it difficult to expand access to behavioral health and SUD services.
- Create supports for “Rural-Serving” regional workforce training centers and primary care and behavioral health pathway programs at Rural Public Universities which target training opportunities for rural and other underserved communities.
- Provide guidance to state and local governments on how to use SUD settlement funds to reinvest rural behavioral health and SUD community resources given the high rates of use and mortality in rural communities.
- Build a more inclusive behavioral health workforce by expanding payment options for behavioral health support specialists (BHSSs), peer specialists, community health workers and paraprofessionals.

President’s Budget

The president’s budget includes several key items to bolster the health care workforce. In addition to the grant programs mentioned above, NRHA supports the President’s workforce initiatives and urges Congress to incorporate these programs into the FY 2024 appropriations package, including:

Federal Office of Rural Health Policy FORHP: \$13 million for the Rural Residency Development Program.

Two new rural hospital stabilization programs housed within the Federal Office of Rural Health Policy (FORHP) include:

- \$30 million to help sustain rural hospitals. \$20 million is for Rural Hospital Stabilization Pilot Program to support at-risk hospitals and the remaining \$10 million is for the new Financial and Community Sustainability for At-Risk Rural Hospitals Program, which will target rural hospitals at-risk for imminent closure to provide immediate technical assistance to avoid closure.
- \$10 million to support the Rural Health Clinic Behavioral Health Initiative, allows clinics in rural areas where there are no existing behavioral health providers to fund the salary of a behavioral health provider.

The Health Resources and Services Administration (HRSA):

- \$157 million for Teaching Health Centers Graduate Medical Education.
- \$1.9 billion for Community Health Centers, including \$700 million in new mandatory funds to behavioral health service expansion.



- \$47 million for Area Health Education Centers.
- \$176 million for the National Health Service Corps.
- \$387 million for Behavioral Health Workforce Development Programs.

It is important that Congress either maintains or increases the funding for these critical programs to ensure that our pipeline programs have sufficient resources to remain operational and effective. These programs are critical in developing a health care workforce for rural and underserved communities. Cuts to funding will only accelerate workforce shortages and broaden gaps in care for rural and other underserved communities.

We thank the Senate HELP committee for the opportunity to submit comments on this issue and we look forward to working together to address the many drivers of health care workforce shortages. If you have any questions or would like more information, please contact Kristen Batstone at Kbatstone@ruralhealth.us.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", written in a cursive style.

Alan Morgan
Chief Executive Officer