Texas Department of Agriculture

Commissioner Sid Miller

Office of Rural Affairs
State Office of Rural Health
Grants Office

Texas Rural Health and Economic Development Advisory Council

Rural Policy Plan
December 2018

TDA Mission Statement

Partner with all Texans to make Texas the nation's leader in agriculture, fortify our economy, empower rural communities, promote healthy lifestyles, and cultivate winning strategies for rural, suburban and urban Texas through exceptional service and the common threads of agriculture in our daily lives.

Rural Policy Plan Purpose

The Rural Policy Plan is submitted according to Texas Government Code section Sec. 487.804 which requires the Texas Rural Health and Economic Development Council to, not later than December 1 of each even-numbered year, develop a rural policy plan that includes:

(1) Strategic initiatives for this state regarding economic development, community development, and rural health, including priorities for the use and allocation in this state of federal block grant money; and

(2) Recommendations for legislation and program development or revision.

Texas Rural Health and Economic Development Council

The Texas Rural Health and Economic Development Council is created by Texas Government Code section 487.802 in the Texas Department of Agriculture. Its membership is comprised of:

(1) one local offical in this state with health care expertise, appointed by the commissioner;

(2) one county county offical in this state with health care expertise, appointed by the commissioner;

(3) one senator serving a predominantly rural area, appointed by the lieutenant governor;

(4) one member of the house of representatives serving a predominantly rural area, appointed by the speaker of the house of representatives;

(5) a representative of an institution of higher education in this state that specializes in public health and community and economic development, appointed by the commissioner; and

(6) four public members with health care or economic development expertise, appointed by the commissioner.

The Texas Rural Health and Economic Development Advisory Council's objective is to address the needs of rural Texas and prepare a rural policy report for the Texas Legislature and others. Members of the Texas Rural Health and Economic Development Council as of December 1, 2018 are:

- The Honorable Donna Campbell, State Senator
- The Honorable Kyle Kacal, State Representative
- The Honorable Sydney Murphy, Polk County Judge
- Don McBeath, Texas Organization of Rural and Community Hospitals
- Mr. Kevin Carter, High Ground of Texas
- Dr. Sheila Page, D.O., Aledo, Texas
- Mr. George Bennack, University of Texas Rio Grande Valley
- Mr. Alejandro (Alex) Meade, III, Mission Economic Development Corporation

A Rural Health Task Force was created to assist in efforts to expand and improve access to health care in rural areas of the state. The Task Force advises on the development of strategic initiatives regarding rural health. The Rural Health Task Force is comprised of members of the Advisory Council along with the following additional, ad-hoc members:

- Mr. Troy Alexander
- Ms. Lillie Gilligan
- Dr. Katharina Hathaway
- Dr. Jeffrey Luna
- Dr. Ron McMurry
- Dr. Jonathan Wayne Williams

Executive Summary

As required by Texas Government Code section 487.804, the Texas Rural Health and Economic Development Advisory Council issues this rural policy plan on December 1, 2018 addressing strategic initiatives for this state regarding economic development, community development, and rural health, including priorities for the use and allocation in this state of federal block grant money; and recommendations for legislation and program development or revision. There are many challenges in health and economic development for rural Texas. Approaches and solutions to address them are varied and complex, as well as costly. This report focuses on a narrower strategic approach to bring about the most effective improvements in the areas of health and economic development where there is the greatest potential benefit gained with limited investment by the citizens of Texas.

Texas Rural Healthcare

The Texas Rural Health and Economic Development Advisory Council believes that a focus by the Texas Legislature in a number of specific areas would bring about an improved and enhanced rural health care system in Texas. The Council would call on the Legislature to focus on six target areas:

1) The rural hospital closure crisis

Recommendation: The Texas Legislature should address the rural hospital Medicaid payments and mandate the longstanding policy of paying rural hospitals at cost to treat Medicaid patients. This will curtail the rate of rural hospital closures and help stop the decline in access to labor and delivery services in rural Texas.

2) Challenges for the rural EMS system

Recommendation: Assess workforce data to assist rural communities in EMS workforce planning; continue to pilot and expand innovative models for reducing transportation time to care; explore funding models that would encourage recruitment and retention in rural EMS agencies

3) The continuing shortage of a rural healthcare workforce

Recommendation: Increase Family Medicine residency slots with focus on Academic Health Sciences Centers that historically encourage rural practice, including mandating promotion of rural practices and rural health tracks. Increase appropriations for student loan repayment programs for all levels of rural healthcare providers

4) Telemedicine and telehealth in rural Texas

Recommendation: A state agency should be tasked with (or created) coordinating and cataloging telemedicine projects across the state, and working toward the utilization of current

infrastructure including state agency and university network infrastructure to establish a statewide video conferencing backbone to which telemedicine projects may operate from and achieve interconnectivity with other telemedicine sites. Technology and security standards should be established for telemedicine utilization on the statewide platform.

5) Coordination and availability of information on rural health programs and funding

Recommendation: A "one-stop shopping" source for information about rural health related programs and funding within state, federal, and other organizations should be created to maximize the current efforts of those programs. The State Office of Rural Health within the Texas Department of Agriculture (TDA) is the logical placement for such a program and the Texas Legislature should allocate funds for staff and resources.

6) Restoration of the State Office of Rural Health to its previous capacity

Recommendation: The Texas Legislature should commit to a multi-session restoration of the State Office of Rural Health to prior levels with 20+ full time staff working on and coordinating efforts to enhance rural health care access across Texas.

Texas Rural Community and Economic Development

Community and economic development are keys to the growth and sustainability of a community's economy. TDA's community and economic development responsibilities include supporting rural communities with their community and economic development activities along with supporting broadband activities as well as small and local businesses through grant and loan programs. The following areas should continue to be addressed:

- Continue to develop innovative grant opportunities through the Texas Community Development Block Grant (TxCDBG) program to assist communities with grants geared toward rural health and economic development initiatives.

- The Texas Legislature should consider legislation to help incentivize rural broadband services to assist in funding broadband deployment into rural communities and areas where it is not yet economically viable for private sector providers to deliver service.

- Continue to explore and develop opportunities to support rural, small and agricultural businesses and communities. Should state general revenue be made available, continue to support innovative economic development strategies that fall outside the parameters of federally funded programs.

Texas Rural Healthcare

Access to timely and quality healthcare in rural Texas remains a challenge. While Texas is a growing and prosperous state, much of rural Texas is being left behind in the area of health care access. Population and political strongholds in the urban metropolitan areas seem to be overlooking the value of rural Texas and its impact on all of Texas. With much of the food, fuel, and fiber for Texas and the nation originating in rural Texas, it becomes good public policy for the State Legislature to take a priority interest in the health and well-being of its rural residents, who are its backbone and work force. The issues of rural health and healthcare access are complex and challenging, with many integral parts and components. The Legislature has attempted to address some of the challenges through many programs over the years, but, many challenges remain. This report does not offer a complete solution to rural health access in Texas; bringing about true and equal access to health care in rural Texas will remain a challenge, especially given budgeting limitations. Rather, this report focuses on a few specific areas where there is a greater likelihood of enhancing health care in rural Texas.

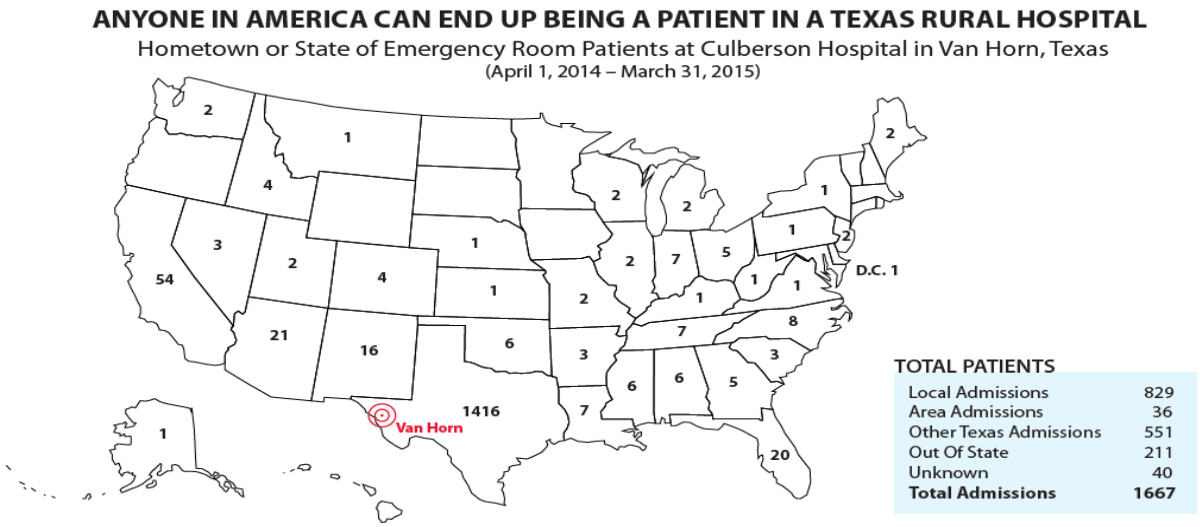
Geographic isolation, a critical lack of physicians and specialty providers, hospital solvency, and socioeconomic factors create considerable barriers for rural residents to receive adequate healthcare services. Eighty-four percent of Texas's landmass is rural and expansive distances have significant implications for access to care and the delivery of quality health services. Of the state's 254 counties, 177 counties are rural or non-metropolitan. An overwhelming majority of rural hospitals are located in one of the state's 139 federally designated Health Professional Shortage Areas (HPSAs) and 111 Medically Underserved Areas (MUAs), measures that signify both provider shortages and adverse health outcomes. Additionally, 63 Texas counties do not have any hospital and 35 counties do not have a primary care physician.[1]

Hospital closures across Texas have put an increased burden on emergency medical services from surrounding areas. Furthermore, ambulances may be required to take patients great distances, diminishing the possibility of receiving life-saving aid within the "Golden Hour."

Public policy and funders often prioritize serving the largest number of people, which limits the focus on rural Texas. With 84% of the population living in urban areas and a concentration of representatives in the Texas Legislature and the U.S. Congress serving from urban areas, rural is rarely a funding and policy priority, despite the fact that urban and rural residents alike rely heavily on the resources of rural America, and indeed rural Texas. As a very mobile society, Americans travel long distances on a whim. MMGY Global reported that in 2016, 39% of leisure travel in the US included a road trip, up from 22% the previous year.[2] Such a trend indicates that urban residents may be increasingly likely to end up in a rural hospital emergency room. A study conducted by the Texas Organization of Rural & Community Hospitals from April 2014 to March 2015 tracked emergency room visits in Van Horn located in far

[1] *Program Planning and Rural Health Needs Analysis,* Texas State Office of Rural Health, 2018
[2] https://www.mmgyglobal.com/news/news-2017%E2%80%932018-portrait-of-american-travelers

West Texas. Of the patients who visited the emergency room in Van Horn during that time, 48 percent did not live in the local area, and many lived outside of Texas altogether.[3]



The Texas Rural Health and Economic Development Advisory Council believes that a focus by the Legislature on the following six target areas would bring about an improved and enhanced rural health care system in Texas: 1) the rural hospital closure crisis, 2) challenges for the rural EMS system, 3) the continuing shortage of a rural healthcare workforce, 4) telemedicine and telehealth in rural Texas, 5) coordination and availability of information on rural health programs and funding, and, 6) restoration of the State Office of Rural Health to its previous capacity.

Rural Hospital Closures

The number of rural hospitals in Texas has declined from more than 300 in the mid-1960s to 161 (as of December 1, 2018). A more recent spike in closures started in 2013 following several years of stability among Texas rural hospitals when there were few closures. Nineteen (19) Texas rural hospitals have closed permanently or temporarily since 2013. Of the 19 closures, 2 are the same hospital closing twice, 3 have reopened but with more limited services, 3 offer only emergency and outpatient services with no inpatient care, and 1 is a clinic with no emergency care. In total, the 19 closures occurred in 18 communities, 10 of which no longer have any emergency or hospital care. Several more Texas rural hospitals are highly vulnerable and on the brink of closure due to financial distress and bankruptcy.

[3] *Rural Hospital Environmental Impact Study,* Texas Organization of Rural & Community Hospitals, 2017

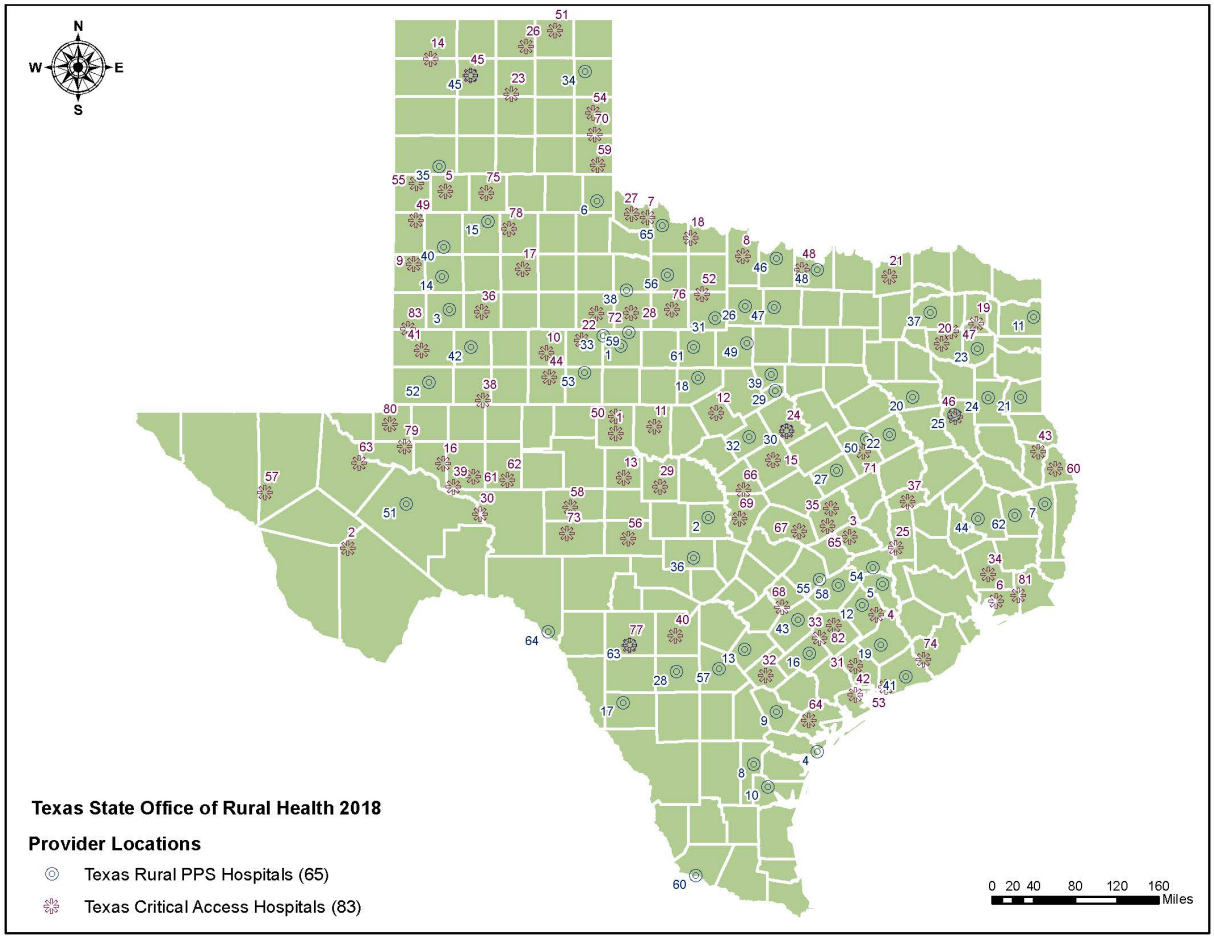
There are many reasons a rural hospital may close: reduced payments; inadequate patient base as a result of overall declining populations; poor management; lack of physicians to treat and admit patients; increasingly high levels of uninsured patients; diversion of care to a nearby community; escalating cost for supplies, equipment, and workforce; and the shift from inpatient to outpatient care resulting in lower payments. Although extremely rare, a hospital can even be closed by a regulatory agency because it has attempted to save money by failing to maintain required safety and care standards. The reasons are many, but every rural hospital closure is the result of operating expenses exceeding the revenue.

The Texas Organization of Rural & Community Hospitals (TORCH) attributes the closures primarily to reduced payments from Medicare and Texas Medicaid in recent years. Medicare payment reductions and the elimination of payment add-on programs amount to a $50 million decrease per year for Texas's 161 rural hospitals in the last five years. Additionally, Medicaid is no longer paying rural hospitals the full cost to treat Medicaid patients, thus creating a loss for rural hospitals estimated as high as $65 million per year. Starting in 1993, the Texas Legislature directed the Texas Health and Human Services Commission to provide rural hospitals with a Medicaid payment level that covers a substantial portion of their cost. According to TORCH, the transformation to a Managed Care system where the state purchases private insurance for Medicaid beneficiaries failed to carry over the special rural hospital payment provisions. As a result, the managed care companies almost consistently pay rural hospitals below cost levels, creating a loss for the hospitals. Rural hospitals contend that if they receive a full cost payment, it will create a more financially stable operating platform and would curtail the increasing closure rate.

The Medicaid underpayment may be contributing to another alarming development. According to the Texas Department of State Health Services and TORCH, only 66 of the state's 161 rural hospitals continue to provide labor and delivery services and three hospitals have stopped the service since January 1, 2018. Hospitals cite the losses they incur from providing the services as a primary reason for halting labor and delivery in order to help keep the hospital open. According to the affected hospitals, the losses incurred from labor and delivery services are a result of the fact that 50-70% of babies born in rural Texas are covered by Medicaid, which pays at a rate below the cost to provide the service.

Map 1: Texas Rural Hospitals

Critical Access Hospitals (CAH) and Prospective Payment System Hospitals (PPS), 2018



Recommendation: The Texas Legislature should address the rural hospital Medicaid payments and mandate the longstanding policy of paying rural hospitals at cost to treat Medicaid patients. This will curtail the rate of rural hospital closures and help stop the decline in access to labor and delivery services in rural Texas.

Rural EMS Services

Rural EMS has faced a number of ongoing and emerging challenges over the past several decades in Texas as well as across the United States. In many cases, rural EMS systems were created by volunteers who recognized the necessity of emergency response in their communities. Over time, these systems have struggled financially to continue to provide such services. Licensing and training requirements have become more stringent, creating additional challenges to provide volunteer EMS or paramedic services in environments facing challenges with limited time and resources. Due to such requirements and decreasing access to accredited training in rural areas of Texas, volunteer paramedic services in

particular are extremely rare. Many rural EMS departments have instead transitioned to a model with the high cost of paid staff borne by taxpayers. At the same time, regulatory and technological requirements for vehicles, equipment, and materials are regularly updated and are very costly. As departmental funds are directed toward staffing, the funding for capital improvements to vehicles and equipment has diminished. In the past, Local Project Grants (LPG) appropriated by the Texas Legislature were one way that rural EMS agencies were able to offset such costs and make the necessary updates to their fleet and equipment. However, funding for LPGs was discontinued, leaving rural EMS agencies with decreasing capacity to maintain vehicle fleets and equipment, or replace capital equipment as necessary. [4]

A 2008 study highlighted common workforce issues faced by rural EMS, namely that only 43% of rural EMS agencies reported full staffing compared to 50% of urban agencies. The study also concluded that rural agencies are more likely than their urban counterparts to lose staff due to burnout (42% to 34%) and burdensome continuing education requirements (41% to 33%).[5] In 2014, the National Association of State EMS Offices released a document titled "EMS Workforce Planning and Development Guidelines for State Adoption" in which it identified a critical lack of data as an enduring challenge to EMS workforce planning, particularly in rural America.[6] Such data would help to elucidate EMS workforce realities in rural areas, including information regarding wages and reliance on volunteers, and would allow for planning specific to rural needs.

A core challenge facing EMS in rural Texas is the reimbursement model by which it is paid for services. While Medicare policy is set at the federal level, the Texas Medicaid program is able to be modified at the state level. As Medicaid reimbursements continue to decline, rural EMS is put in a particularly arduous position. As it stands, Medicaid operates on a fee for service basis, which does not reimburse the full cost of transporting a Medicaid patient. At a national level, as well as in Texas, the concept of expanding the services for which EMS can be reimbursed is an ongoing area of discussion. A model by which EMS is reimbursed for an array of services, such as pre-hospital assessment and treatment, prevention, and screening could serve as a benefit to the overall health of patients, increase the financial viability of rural EMS agencies, and reduce emergency department admissions and readmissions, which are extremely costly to both hospitals and Medicaid.[7]

A study by the American College of Emergency Physicians in 2015 verifies that a rural EMS response may take almost twice as long as an urban response and a number of other studies document the delayed response in rural areas. The consequences of such delays are higher rates of trauma deaths in rural areas from causes such as traffic and farm equipment accidents, as well as injuries from firearms. A 2017 report from the CDC indicated that the death rate from unintentional injuries in rural areas is 50% higher

[4] http://txemsa.com/the-issues/
[5] "*Challenges for Rural Emergency Medical Services: Medical Oversight,"* Freeman V., Slifkin R., Patterson D., 2008
[6] https://nasemso.org/wp-content/uploads/EMS-Workforce-Guidelines-11Oct2013.pdf
[7] "Reimbursement: What Does the Future Look Like," Robbins, Vincent D., https://www.jems.com/articles/print/volume-43/issue-1/departments-columns/management-focus/revenue-realities.html

than in urban areas.[8] The vast geography of rural Texas and a reliance on a mostly volunteer EMS system will continue to hinder rural EMS response in the absence of increased resources for workforce, training, and equipment.

The Texas Department of Transportation Safety Division through the Texas A&M Engineering Extension Service (TEEX) provides funding for Texas Rural/Frontier EMS training with a goal of increasing access to training to facilitate EMS in communities around Texas. These funds can be applied to initial training, as well as refresher, continuing education, and instructor training.[9] However, these funds are typically very popular and do not exist at a level such that extensive use is possible. According to the Texas EMS Alliance, there have been several rural EMS agencies that have applied for such training funds and have never received them, due to fund depletion early in the grant year.

Recommendation: Assess workforce data to assist rural communities in EMS workforce planning; restore funding to Local Project Grants and expand funding for rural EMS trainings; explore funding models that would encourage recruitment and retention in rural EMS agencies

Rural Health Workforce

Recruiting and retaining a qualified healthcare workforce in rural and remote areas remains another major challenge facing rural hospitals and rural health practice in general. Workforce disparities in rural areas exist in part due to the aging of the population, lack of exposure to rural training as part of the current medical education system, and salary competition in nearby urban markets.[10] Rural communities have a smaller patient population and often struggle financially, which limits the ability to incentivize physicians to practice in the rural areas. Primary care physicians may also be reluctant to relocate to communities without a hospital or other institutional support.

A study of the physician workforce in Texas by the North Texas Regional Extension Service Center[11] of the Dallas – Fort Worth Hospital Council Foundation found:

- Texas ranks 47th in the nation in active primary care physicians (PCPs) per 100,000 population
- 35 Texas counties have no physicians of any kind
- 80 Texas counties have five or fewer physicians
- 147 Texas counties have no obstetrician/gynecologist
- 185 Texas counties have no general psychiatrist
- 158 Texas counties have no general surgeon

[8] "Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States," *Morbidity and Mortality Weekly Report,* Centers for Disease Control and Prevention, January 2017
[9] *https://teex.org/Pages/training/texas-rural-frontier-ems-funding.aspx*
[10] *Program Planning and Rural Health Needs Analysis,* Texas State Office of Rural Health, 2018
[11] Report accessed at https://dfwhcfoundation.org/wp-content/uploads/2015/04/mhaNTREC2015studyfinal.pdf

- The physician workforce in Texas is disproportionately located in the five most populous counties (Harris, Dallas, Tarrant, Bexar, Travis). 57% of the total workforce practice in these counties, though only 44% of the state's population resides in these counties.
- Smaller counties of 40,000 people or less are home to 8.6% of the state's population, but only 2.5% of the total workforce practice in these counties
- There is a ratio of only 52 physicians per 100,000 population in counties of 40,000 people or less in Texas, compared to 228 per 100,000 for the five most populous counties and 183 per 100,000 for the entire state
- Texas is one of the few states where growth in the physician workforce is matching or exceeding growth in the general population. Since the passage of tort reform in 2003, Texas has licensed an average of 3,200 new physicians a year.
- Texas physicians have little capacity to take on extra work or see more patients. Over 78% of Texas physicians indicate they now are at full capacity or are overworked and overextended.

It is clear that Texas needs to develop programs to direct even more students into careers as health care professionals, especially physicians. Two promising approaches have emerged to increase the number of physicians with a focus on rural health care. One is to shift resources to prioritize an expansion of medical school residency slots rather than a narrow focus on expanding graduate medical education. Data repeatedly shows that physicians are more likely to set down roots and open a practice in the areas where they train.[12] More residency slots in Texas, based on history and data, will lead to more physicians in Texas and, given the appropriate attention and resource allocation, more physicians in Texas will lead to more physicians in rural areas. A second option is to expedite the training of primary care physicians in Texas. The Texas Tech University Health Sciences Center Family Medicine Accelerated Track (FMAT) is an innovative 3-year accelerated medical school curriculum (rather than the traditional 4-year program) that culminates into a degree and leads to a standard 3-year family medicine residency.[13] Additionally, including rural health care tracks in medical school can provide students the opportunity during their education to gain sustained practical experience in a rural health care setting, thereby developing an understanding of the community while building relationships within it. One program that currently offers this track to medical students is the University of Texas Medical Branch.[14] Other medical schools in Texas should be encouraged and incentivized by the Legislature to pursue similar programs.

Nursing is also experiencing a shortage. In 2017, a Health Resources and Services (HRSA) study projected a shortage of 15,900 full-time registered nurses in Texas by 2030. While licensed practical and vocational nurses may fill gaps in care when RNs are not available, HRSA also projected a deficit of

[12] *https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/08/11/to-address-doctor-shortages-some-states-focus-on-residencies*
[13] https://www.ttuhsc.edu/medicine/admissions/fmat.aspx
[14] https://som.utmb.edu/som-educational-affairs/office-of-clinical-education-(oce)/rhctrack/rural-health-care-track-(rhct)

33,500 licensed practical/vocational nurses in Texas by 2030.[15] The shortage of nurse educators and graduates persist despite innovative programs funded in recent sessions by the Texas Higher Education Coordinating Board and the Legislature to support faculty salaries, fast-track programs, and student scholarships.

Mental Health Workforce

There is an immense gap between the behavioral health needs and behavioral health services in rural county jails. This crisis is prevalent throughout the United States, but is especially alarming in the state of Texas. The average Texas county sheriff attends to more behavioral health patients than the average licensed psychiatrist in the state. Other than sporadic crisis intervention with suicidal inmates by MHMR personnel, there is no organized counseling or, when indicated, comprehensive psychiatric medical treatment for individual inmates. Family or group counseling for the inmates is all but nonexistent and rural county budgets are unable to cover costs of psychiatric medicines.

Sheriff's budgets are strained by covering deputies' overtime for transporting inmates to inpatient behavioral health programs or psychiatric hospitals. It is common for officers to transport county jail inmates for hundreds of miles to secure an inpatient bed. Before the inmate can get a psychiatric/behavioral health bed, he or she must first be medically screened at a local hospital emergency room. Counties are billed for these services by the rural hospitals, but they are usually unable to pay those bills. This drives up the cost of care for the civil emergency department patient and puts a great strain on the rural hospital district or county hospital. Most rural county jails house from 16 to 40 percent of inmates with unmet behavioral health needs at any given time.

Between 1982 and 2010, across the United States, the decrease in mental health patients receiving inpatient care or services in another type of 24-hour residential treatment was approximately 34%, with a 69% decrease in the state and county psychiatric hospital category and a 14% increase in the other 24-hour treatment organizations. In this analysis, Texas fell within the 23% to 39% decrease state group.[16] With 9 state psychiatric hospitals, Texas has less than 2,500 acute care psychiatric beds and a total population of approximately 28 million. Applying the average ratio for industrialized countries of 71 beds per 100,000 (Organization for Economic Cooperation and Development), Texas should have over 19,000 acute care psychiatric beds. The root of the problem is largely based in two areas: a shortage of Texas licensed psychiatrists and a lack of acute care behavioral health beds. After medical clearances, inmates accused or convicted of crimes who have unmet behavioral health issues are confined to a cell that is, in reality, a secure bed. Often their sentences exceed several months, sometimes extending to over a year. They are held in a secure environment not unlike the psychiatric hospital inmate who is a danger to himself or others. The difference between a jail cell bed and a state hospital bed is that the jail has no medical support or laboratory services, no regularly scheduled individual, group and family

[15] *Supply and Demand Projections of the Nursing Workforce 2014-2030,* U.S. Department of Health and Human Services Health Resources and Services Administration, 2017

[16] *Trend in Psychiatric inpatient Capacity, United States and Each State, 1970 to 2014,* National Association of State Mental Health Program Directors, 2017

counseling, and little or no access to behavioral health medications, when indicated. In addition, there are many other types of health professionals required within a well-functioning health system and rural areas are consistently challenged to find those workers.

	2017 Healthcare Professional Total			Ratio of 2017 Population to Healthcare Professional			Ratio of Healthcare Professionals to 100,000 Population		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Primary Care Physician	1,592	19,550	21,142	2,052	1,306	1,362	49	77	73
Direct Patient Care Physician	2,728	49,822	52,550	1,198	512	548	84	195	183
Registered Nurse	16,321	217,706	234,027	200	117	123	500	853	813
Pharmacist	1,779	24,026	25,805	1,836	1,063	1,116	55	94	90
Psychiatrist	89	2,083	2,172	36,706	12,257	13,258	3	8	8
Psychologist	366	7,421	7,787	8,926	3,440	3,698	11	29	27
Advanced Practice RN	1,382	20,131	21,513	2,364	1,268	1,339	42	79	75
Licensed Vocational Nurse	14,642	68,259	82,901	223	374	347	448	267	288
EMS	8,638	54,893	63,531	378	465	453	264	215	221
Dentist	772	12,788	13,560	4,232	1,996	2,124	24	50	47

Healthcare Professional Data for the State of Texas in 2017
Texas Population (2017): Total – 28,797,290; **Rural –** 3,266,821; **Urban –** 25,530,469
Source: Health Professions Resource Center, Center for Health Statistics, Department of State Health Services

While the pipeline of health professionals into rural Texas remains insufficient, there are a number of efforts underway that are keeping the situation from growing worse. A few of the notable efforts to place more healthcare professionals in rural Texas include:

Rural Communities Health Care Investment Program (RCHIP) is administered by TDA and assists rural communities in recruiting licensed health care providers who are not physicians to practice in their community by providing partial student loan reimbursement or stipend payments. In the previous two fiscal years the RCHIP program has been awarded to 52 individuals in the amount of $225,172. The grant is a one-time award to those who commit to working at least 12 months in qualifying rural communities.

Texas Physician Education Loan Repayment Program (PELRP) is administered by the Higher Education Coordinating Board and provides loan repayment funds for up to $160,000 over a period of four years to qualifying physicians. Priority is given to primary care physicians who agree to practice in a Health Professional Shortage Area (HPSA), of which most rural areas qualify, for at least four years. There is also a mental health loan repayment program for professions that practice in a Mental HPSA.

New Texas Medical School - Sam Houston State University (SHSU) has partnered with Germane Solutions in order to open a new college of osteopathic medicine in southeast Texas. The land and the first three years of operating expenses have been donated and SHSU anticipates 150 residency positions for the first program year. These initial residency positions will not require any state funding and will bring $68 to $93 million in new federal funds to Texas.[17] The Texas Higher Education Coordinating Board recently gave its approval for this venture. Without state funding, student tuition may be higher than that of other public universities, which may present challenges for enrolling students. The promise of a new college of osteopathic medicine, which will be the second in Texas, is a welcome development for rural Texas as the current osteopathic school, the University of North Texas, has historically helped to direct a disproportionate number of graduates toward rural Texas through training and support.

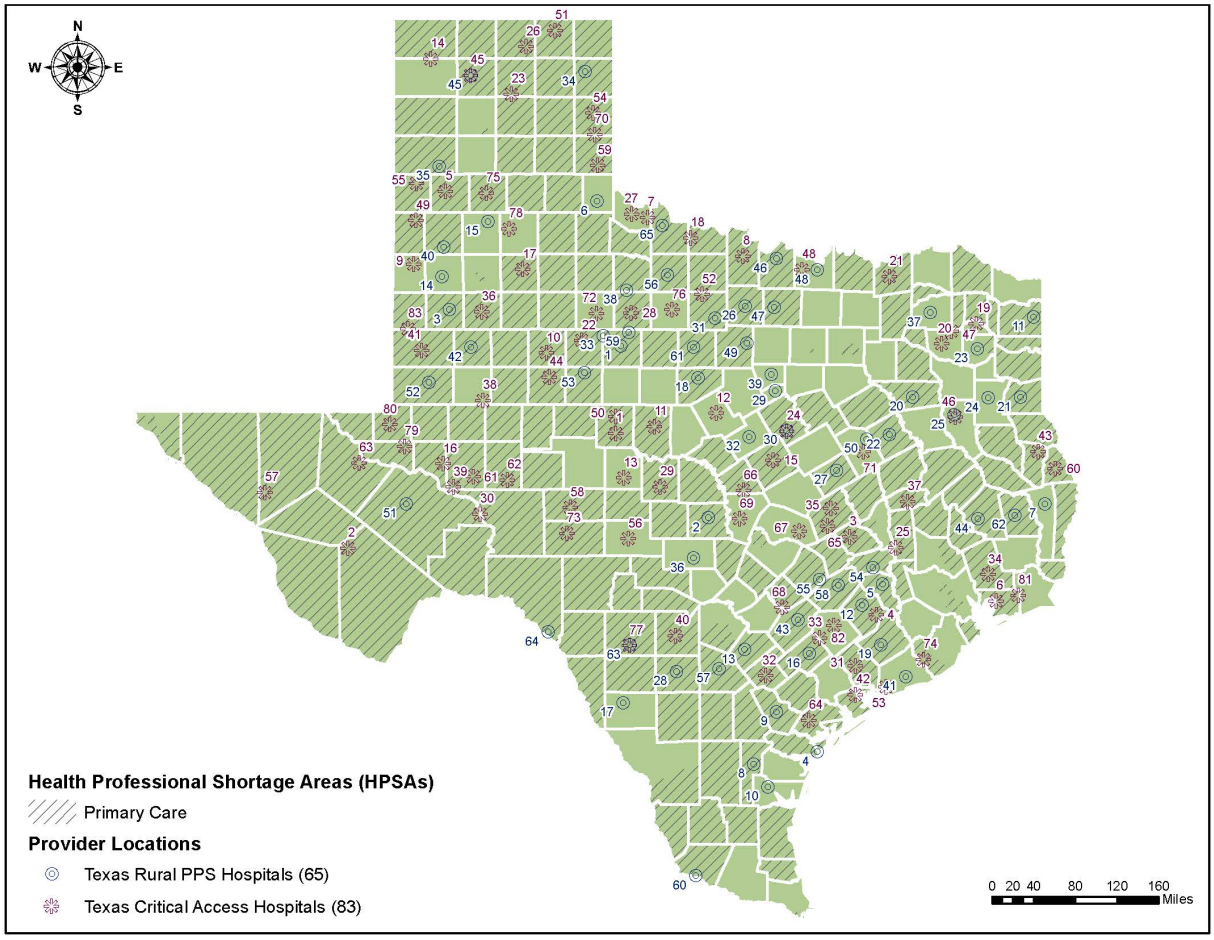
Please see the maps (Map 2, Map 3, and Map 4) below for an overlay of health professional shortages related to primary care, dental health and mental health for rural hospitals in Texas as of January 1, 2018.

Recommendation: Increase Family Medicine residency slots with focus on Academic Health Sciences Centers that historically encourage rural practice, including mandating promotion of rural practices and rural health tracks. Increase appropriations for student loan repayment programs for all levels of rural healthcare providers.

[17] Germane Solutions, 2018

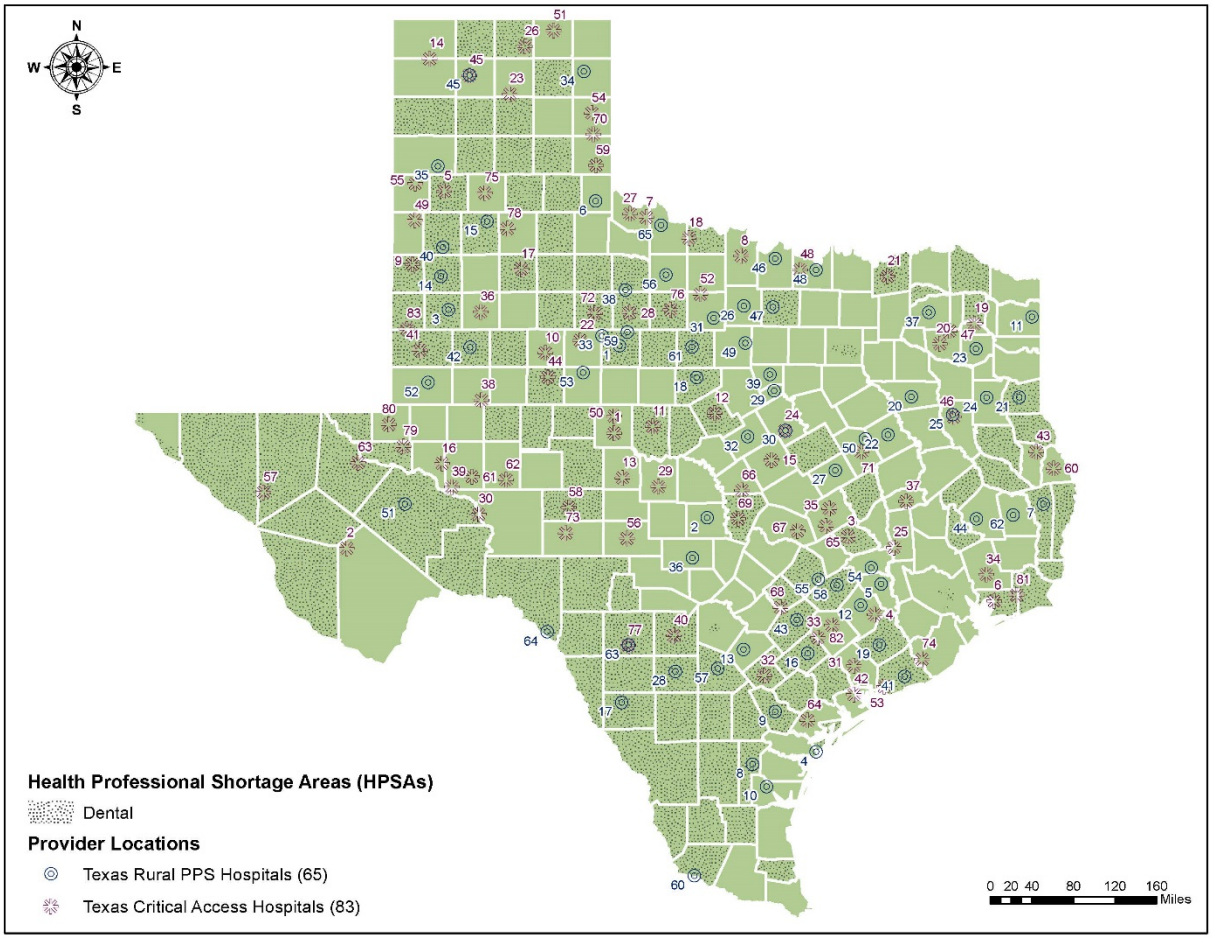
Map 2: Texas Rural Hospitals and Primary Care Health Professional Shortage Areas

Critical Access Hospitals (CAH) and Prospective Payment System Hospitals (PPS), 2018



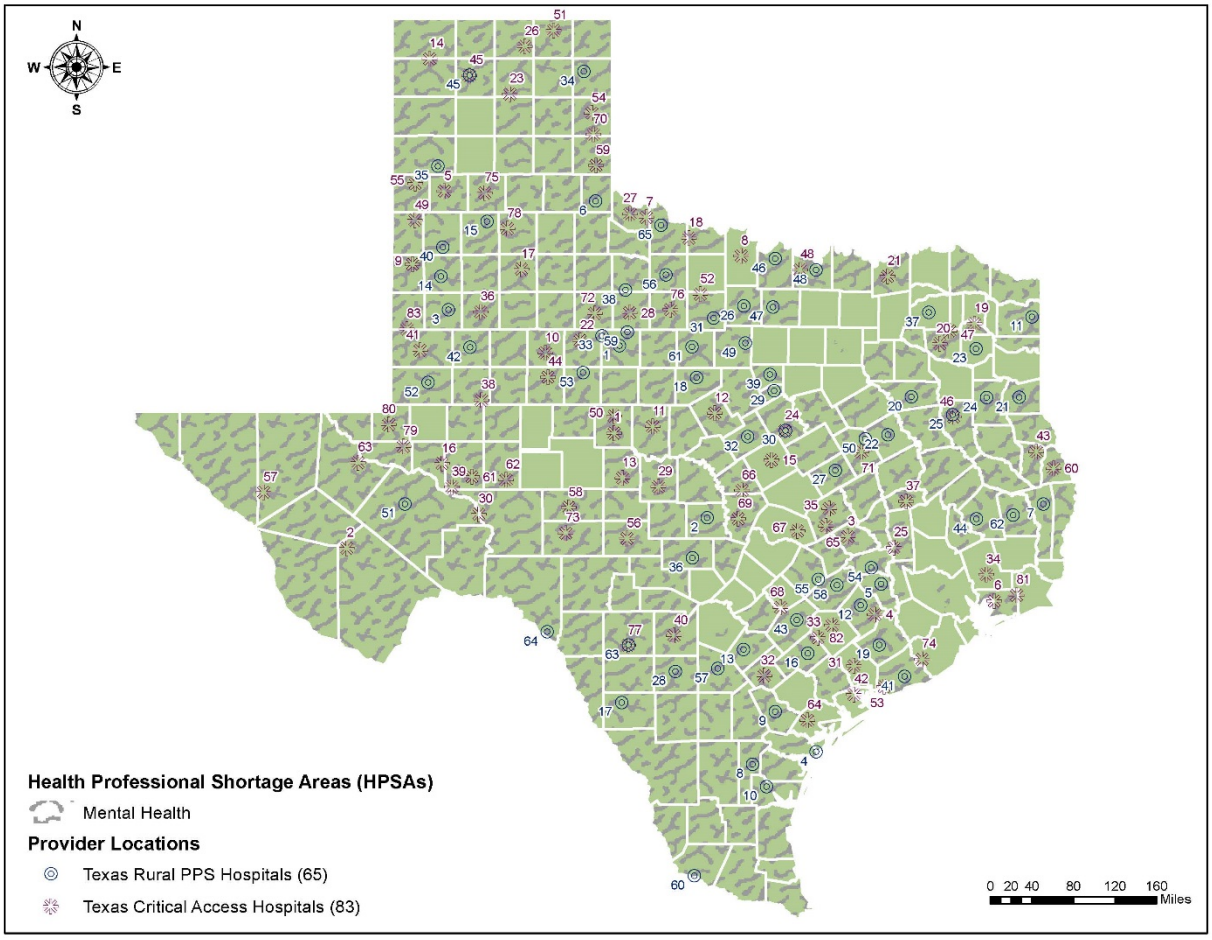
Map 3: Texas Rural Hospitals and Dental Health Professional Shortage Areas

Critical Access Hospitals (CAH) and Prospective Payment System Hospitals (PPS), 2018



Map 4: Texas Rural Hospitals and Mental Health Professional Shortage Areas

Critical Access Hospitals (CAH) and Prospective Payment System Hospitals (PPS), 2018



Telemedicine and Telehealth

The ability to utilize technology in order to bridge the physical distance gap between provider and patient is a critical part of providing rural Texas with the best services available. Across the nation, telemedicine and telehealth are being utilized to improve healthcare, specifically in rural communities where the nearest hospital or clinic could be a considerable distance away, and to address access to care for chronic conditions, remote patient monitoring, emergency care, and prenatal care. Telemedicine can address gaps rural hospitals face in specialty care. For behavioral health in particular, telemedicine can be used to help alleviate some patient concerns associated by allowing a more discrete way to receive treatment. [18]

The terms "telemedicine" and "telehealth" are sometimes used interchangeably, but Texas has worked to ensure that the two terms, and the practices associated with them, remain distinct. Whereas telemedicine

[18] *Rural Hospital Environmental Impact Study,* Texas Organization of Rural & Community Hospitals, 2017

is the practice of providing a health care service by a physician or under the supervision of a physician to a patient in a different location through telecommunications or information technology, telehealth is any health service, also provided through telecommunications or information technology, that falls outside of this narrow telemedicine definition that is performed by a health professional, acting in accordance with their license or certification within the state of Texas.[19]

There are several areas where telemedicine has shown promise, including specialist referral services, patient consultations involving remote examination of medical data, continuing medical education, and consumer/patient medical and health education. These services may not only improve access to care, but can increase workforce capacity within rural settings. An example of this is Project ECHO, an innovative solution pioneered in New Mexico, which uses a telehealth linkage to connect university-based faculty specialists to primary care providers in rural and underserved areas in order to extend specialty care to patients with chronic, costly and complex medical illnesses. The ECHO model™ is notable for its hub-and-spoke knowledge-sharing networks, in which expert teams (the hub) use videoconferencing technology to conduct virtual clinics with multiple community providers (the spokes).[20] Texas has not yet utilized Project ECHO in a comprehensive and coordinated manner and there remain extensive opportunities to benefit from this model as a cost-effective way to help build more broad medical expertise in rural areas of the state.

While Texas was an early pioneer in the use of telemedicine through Texas Tech University Health Sciences Center in Lubbock and the University of Texas Medical Branch in Galveston, its full potential in rural areas to expand access to care has not been realized. Historical barriers have been the availability of broadband in rural areas, the cost of video equipment and examination peripheral equipment, reimbursement, and even a resistance from providers to accept the technology into medical practice. However, many of those barriers are rapidly decreasing and it is the sense of the Rural Health and Economic Development Advisory Council that telemedicine use in rural Texas is on the cusp of rapid expansion.

Payments from Medicare, Medicaid, and private insurance for telemedicine services have broadened in recent years and many services that would be paid by those insurers for an in-person visit are now also paid for visits that occurred electronically. The availability of broadband and advances in technology have lessened that barrier, which is particularly important as some services require excellent video connection and resolution that cannot be at risk of disruption. Although some areas of Texas are without sufficient broadband to facilitate telemedicine, most rural hospitals do appear to have sufficient access.

Recent telemedicine advances brought about by the Texas Legislature include Senate Bill 1107, passed in 2017, which allowed virtual visits to be considered equivalent to in-person visits, removing some barriers in place by the Texas Medical Board. House Bill 1697, also passed by the Legislature in 2017 directed the Texas Health and Human Services Commission (HHSC) to establish a pediatric tele-connectivity resource program for rural Texas. Under this program, grants are to be awarded to

[19] "Texas Laws and Regulations Relating to Telemedicine," Texas Medical Association, April, 2018
[20] https://echo.unm.edu/

nonurban health care facilities to connect with pediatric specialists and pediatric subspecialists who provide telemedicine medical services. The bill did not come with funding, ultimately making it a challenge to implement, however, HHSC is moving forward with it utilizing alternate funding for a few rural hospital pilot sites.

The roll out of House Bill 1697 has demonstrated a new challenge for telemedicine in Texas. In working through the identification of potential pilot sites, HHSC has realized that it is difficult to determine who is already using telemedicine in Texas (hospitals, providers, universities) and what equipment may already be in use. It has also come to light that much of the equipment in use is proprietary in nature and does not interface with other networks and equipment. Some rural hospitals use multiple telemedicine platforms that have two or three different telemedicine units, which connect to two or three different remote locations. In many cases, the connections are also on different dedicated broadband circuits. The lack of interconnectivity and operability and the redundancy in connectivity will inevitably add to the cost of telemedicine and could limit its growth.

The Texas Statewide Health Coordinating Board identified the potential of this problem as far back as 2002 when it recommended that "an agency or body should be designated that can serve as the authority and recognized expert on TMTH (telemedicine/telehealth) information for current and future TMTH providers, grantees and policymakers," and that "…this entity should produce a Texas unified TMTH state plan, which would serve as a point of coordination for all TMTH projects within the state."[21] The Texas Rural Health and Economic Development Advisory Council emphasizes the relevance of this recommendation at this current time for telemedicine/telehealth in Texas.

Recommendation: A state agency should be tasked with (or created) coordinating and cataloging telemedicine projects across the state, and working toward the utilization of current infrastructure including state agency and university network infrastructure to establish a statewide video conferencing backbone to which telemedicine projects may operate from and achieve interconnectivity with other telemedicine sites. Technology and security standards should be established for telemedicine utilization on the statewide platform.

Enhanced coordination of information and rural health resources

Many state and federal agencies have information and implement programs related to rural health. This widespread distribution of rural health programs and funding is a challenge to lawmakers, health providers, community leaders and the public. Such agencies include the Department of State Health Services, the Higher Education Coordinating Board, the Department of Agriculture, and most of the Texas health sciences centers, including their Area Health Education Center programs. The far-flung approach historic to these program locations diminishes their effectiveness at enhancing health care

[21] Report accessed at www.dshs.texas.gov/chs/shcc/reports/tmreport.pdf

access in rural Texas. A "one-stop shopping" source for information about rural health related programs and state and federal funding that may be available to Texas would serve to provide comprehensive information aimed at making the programs more effective. Rural citizens, lawmakers, health providers, and community leaders would be likely to find such a resource helpful in their efforts. A cataloging of all such programs and funding would need to take place followed by development of a method for interested parties to regularly and easily access the information through a central point of inquiry. Programs would remain within the institutions where they are presently located, but awareness of their existence would be through the central rural health clearinghouse. Logical placement of the program would be with the State Office of Rural Health within the Texas Department of Agriculture.

Recommendation: A "one-stop shopping" source for information about rural health related programs and funding within state, federal, and other organizations should be created to maximize the current efforts of those program. The State Office of Rural Health is the logical placement for such a program and the Texas Legislature should allocate funds for staff and resources.

State Office of Rural Health

Each state has an office or agency that focuses on rural health and rural hospital issues in that state. These offices serve as a focal point for rural health within each state. They are recognized by the Federal Office of Rural Health Policy (FORHP) and most receive limited grant funding from the FORHP. In Texas, the recognized State Office of Rural Health (SORH) is a department within the Texas Department of Agriculture.

The Texas SORH was originally established by the Texas Legislature in 1991 when federal support funds first became available. It was originally named the Center for Rural Health Initiatives and was housed within the Texas Department of Health. In 2004, the Legislature created a stand-alone agency named the Office of Rural Community Affairs, which began administering the SORH program along with several rural Community Development Block Grant programs. In 2010, it was renamed the Texas Department of Rural Community Affairs to emphasize that it was a Texas state agency. In the 2011 session of the Legislature, at the insistence of then Governor Rick Perry, the office was abolished and most of the functions, including rural health, were moved into the Texas Department of Agriculture.

The office serves as the primary contact on many rural health issues and is the state conduit for a number of federally funded programs for rural hospitals. The **Medicare Rural Hospital Flexibility (FLEX)** Program has provided an average of approximately $760,000 each year over the past 4 fiscal years to fund technical assistance in the domains of financial and operational improvement and quality improvement for the benefit of Texas Critical Access Hospitals (CAH). Funding has increased in the most recent fiscal year to approximately $900,000 due to the high number of Texas CAHs. Through FLEX, Texas SORH is the initial reviewer of applications from Texas rural hospitals seeking CAH designation by the Centers for Medicare and Medicaid Services.

The **Small Rural Hospital Improvement Grant Program (SHIP)** has directed over $2 million into Texas rural hospitals of 49 beds or less through 214 funding requests in FY18 and FY19 combined. SHIP funding helps to purchase equipment and/or training to help hospitals attain value-based purchasing; join/become accountable care organizations, or create shared savings programs; and purchase health information technology, equipment and/or training.

Recently, population shifts and federal definitions that determine rural communities have impacted the eligibility of certain counties for federal assistance. For instance, growth in the Dallas – Fort Worth metro area expanded into area previously considered rural and resulted in loss of funding for the hospital in Glen Rose. This creates a disadvantage to those facilities whose rural circumstances remain the same but are now considered to be within a metro area designation.

The Texas SORH also manages two state level grant programs that benefit rural hospitals. The **Rural Health Facility Capital Improvement Program (CIP)** provides grants for hospitals and other rural health facilities totaling $2,000,000 a year with each individual grant capped at $75,000. This program is unique in its ability to use state funds for capital improvements, construction, and facility upgrades, which are critical to aging rural hospitals. Recipient hospitals must provide a 25 percent match of the CIP funds requested and the funds can also be used for equipment, contracts for non-medical services, or patient transportation. In 2018, program resources were sufficient to fund fewer than half of the proposed projects. Project requests not able to be funded represented over $3.3 million.

As discussed in the workforce section, the **Rural Communities Health Care Investment Program (RCHIP)** provides up to $10,000 incentive payments to non-physician health providers that will work in a rural community with an annual cap for all grants in the program of approximately $160,000. Funding for both RCHIP and CIP come from the Tobacco Endowment Fund which has decreased in recent years, limiting the programs' abilities to meet applicant demand. Annual grant award amounts from both funds vary from year to year based on investment returns and authorization by the Texas Legislature.

Funding for the State Office of Rural Health has declined almost every year since 2008 when internal emphasis in the Office of Rural Community Affairs appears to have shifted more to rural community development. The number of full-time employees working exclusively on rural health issues has fallen from an estimated 20+ in the late 1990s to only 4 when the program was moved to the Texas Department of Agriculture.

For a listing of programs available from the State Office of Rural Health please see **Appendix A**.

Recommendation: The Texas Legislature should commit to a multi-session restoration of the State Office of Rural Health to prior levels with 20+ full time staff working on and coordinating efforts to enhance rural health care access across Texas.

Rural Community and Economic Development

Community and economic development are keys to the growth and sustainability of a community's economy which include its rural health facilities. The health system is one of the major employers in many rural communities. TDA's community and economic development responsibilities include supporting rural communities with their community and economic development activities along with supporting broadband activities as well as small and local businesses through grant and loan programs. Also, economic development activities include supporting TDA's marketing programs such as International Trade, GO TEXAN, the Texas Wine Program, the Texas Shrimp Program, and the Texas Specialty Crop Program.

Community Development

Texas Community Development Block Grant (TxCDBG) Program - TDA administers the TxCDBG Program, which addresses community needs with funds provided by the U.S. Department of Housing and Urban Development (HUD). The goal of the TxCDBG program is to develop viable communities by providing decent housing, suitable living environments, and expanding economic opportunities, principally for persons of low and moderate income.

Rural Texas communities often prioritize water and sewer infrastructure, knowing that they must ensure the basic services are available in order to attract businesses and workers.

The Community Enhancement Fund category set aside $5 million in 2018 to construct facilities and purchase equipment to assist primarily low- to moderate-income communities – most of the selected projects proposed new or expanded health care services. In 2019, a new category called the Fire, Ambulance, and Service Truck (FAST) Fund will provide rural communities the opportunity to purchase vehicles and equipment to address EMS and other emergency response needs. In addition, the Texas Capital Fund category has provided construction funding in the past for several medical facilities that create or retain jobs in rural Texas, including skilled nursing and specialized medical facilities.

$63,053,134 in TxCDBG funds was awarded to 215 projects in FY 2017-18, but many applications were not funded and critical needs left unmet. For a listing of programs available from the Texas Community Development Block Grant Program please see **Appendix B**.

Recommendation: Continue to develop innovative grant opportunities through the TxCDBG program to help assist communities with grants geared toward rural health and economic development initiatives.

Economic Development

Broadband Access

Broadband access is critical to the support of rural health, economic development, and community development. Rural communities are already hindered by closing hospitals, a shortage of emergency medical services (EMS), and a lack of health professionals serving the areas. Broadband could help alleviate the stress put on the communities and workforce.

Broadband offers exciting possibilities for telemedicine. Rural hospitals struggling to retain staff with adequate experience can partner with larger facilities to consult on cases if the infrastructure to share data and medical records is available. First responders equipped for telemedicine can communicate and begin treatment in coordination with the nearest hospital, saving critical time when the distance to the appropriate facility is great.

Broadband access is an opportunity for rural communities to support local entrepreneurs in the modern economy. Connectivity for entrepreneurs is more necessity than luxury, and allows those that would otherwise open a business in an urban area to locate in rural Texas. Extending broadband coverage requires extensive coordination between local communities, state agencies for funding and oversight, and private-sector providers.

Texas prohibits municipalities and municipal electric utilities from offering telecommunications services to the public either directly or indirectly through a private telecommunications provider (Texas Utilities Code, § 54.201 et seq.). Due to current legislation, the state of Texas has unique challenges that must be overcome in order to ensure rural Texas broadband services are provided across the State of Texas. Having access to online education and job opportunities is critical in generating new cash flows into the community and improving quality of life.

Even though the United States Department of Agriculture manages the Community Connect Grants Program, which is designed to help fund broadband deployment into rural communities where it is not yet economically viable for private sector providers to deliver service, it is not advantageous to the State of Texas due to its current Texas Utilities Code requirements. The grant may be funded up to $1.5 million. Current TDA programs have not been conducive to funding broadband infrastructure, but staff continues to explore the potential for such a project.

The non-profit organizations, Connected Nation and Glasshouse Policy, performed listening tours and town hall meetings across Texas in 2018 to gather information on rural broadband concerns and issues. As a result of its listening tour, Connected Nation helped identify key concerns and needs in rural communities to include the following:

- School Connectivity and the Homework Gap
- Telemedicine
- Fiber Infrastructure and Broadband Access

- Availability of Grant Funding Information
- Emergency Services
- Broadband Mapping
- Broadband Planning and Community Technology Action Plans

The Connected Nation report entitled *Rural Broadband: A Texas Tour* can be found at https://www.edtx.org/get-involved/texas-rural-funders-collaborative. Glasshouse Policy is working with the Texas State Library and Archives Commission, the Innovation and Technology Caucus of the Texas House, and other public and private stakeholders to help develop policies and best practices to increase broadband Internet access across rural Texas. Glasshouse Policy's Town Hall meetings are expected to result in possible legislative recommendations. Glasshouse Policy's broadband research and work can be viewed at https://glasshousepolicy.org/our-work/#research.

Recommendation: The Texas Legislature should consider legislation to help incentivize rural broadband services to help fund broadband deployment into rural communities and areas where it is not yet economically viable for private sector providers to deliver service.

Support of Small and Local Businesses

The Texas Produce and Safety Office, funded by the U.S. Food and Drug Administration (FDA), will receive $6.5 million in funding over a five year span to create the necessary infrastructure and conduct grower outreach, education and inspections of fresh fruits and vegetables based on FDA Food Safety Modernization Act (FSMA).

TDA has continued to work with the U.S. Small Business Administration to implement a State Trade Expansion Promotion (STEP) program. TDA intends to increase the number of Texas small businessES exporting to foreign markets to boost the value of exported goods and services through export training, technical assistance, and state led trade shows, as well as financial support to conduct individual export activities.

The Young Farmer Grant provides matching funds to agriculture producers who are between the ages of 18-46 that are beginning or expanding operations. The program encourages a new generation of farmers and ranchers to see the industry as a vital economic resource.

Texas Capital Fund: In rural Texas, it is vital to create jobs and bring new monies into the community. The Texas Capital Fund infrastructure development and real estate programs are economic development tools designed to provide financial resources to non-entitlement communities funded through the TxCDBG Program. Funds from the infrastructure program can be utilized for public (and in some cases private) infrastructure needed to assist a business that commits to create and/or retain permanent jobs, primarily for low and moderate income persons. Funds from the real estate program must be used for real estate development to assist a business that commits to create and/or retain permanent jobs, primarily for low and moderate-income persons. The real estate and/or improvements must be owned by

the community and leased to the business. These programs encourage new business development and expansions. In FY17-18, this program supported commitments for 321 jobs in rural Texas communities.

Although job creation is not measured, the sidewalks, lighting, and other improvements funded through TDA's Downtown Revitalization and Main Street Programs (DRMSP) encourage both local residents and tourists to utilize local business districts. TDA recently increased the funding made available to these programs in an effort to expand the impact in rural communities. In FY 17-18, the DRMSP funded awards totaling $3,390,499 to 13 rural communities.

The Small and Microenterprise Revolving Loan Fund (SMRF): SMRF provides capital for rural communities to invest in new and/or existing small businesses and Microenterprises. In cooperation with a qualified, nonprofit development organization (NDO) and under a special provision of CDBG regulations, SMRF monies are loaned to local small businesses and microenterprises to support job creation/retention activity for predominately low and moderate income persons. Once the contractual job creation/retention requirements are satisfied, the contract is monitored for compliance and closed out by TDA. In 2016, this program awarded the following cities: Brownfield, Floydada, Levelland, Littlefield, Mathis, Slaton, and the county of Falls. The city of Mathis has capitalized on the program lending out monies to establish two startups; All Across Texas and Gigi's Pizza. They have also funded three expansions with the money creating 6 jobs for the local community.

Capital for Texas: TDA is working with Community Development Financial Institutions (CDFI), which were selected through a competitive bid process, to lend and manage funds allocated to TDA for its Capital for Texas Program (C4T). C4T was created as a result of an amendment to an allocation agreement to TDA by the United States Department of the Treasury (Treasury) through Treasury's State Small Business Credit Initiative (SSBCI), as authorized by Public Law 111-240 (Act). C4T is designed to increase rural communities small businesses' access to capital and enable private entrepreneurs to make market-driven decisions to grow jobs, assist their growth potential and employment capabilities through partnering community development financial institutions.

Other TDA Grant Programs

The Grants Office is responsible for administering numerous state and federal grants, loans and cooperative agreements available to farmers, ranchers, universities, schools, non-profits and private entities across the Lone Star State. For FY18-19, these awards totaled nearly $44 million.

TYPE OF GRANT	TOTAL VALUE OF AWARDS
Ag Research & Development Grants	$890,929.60
Boll Weevil Eradication Grant	$9,835,628.00
Capital for Texas Loan Participation Program	$1,600,000
Home Delivered Meal Grants	$16,898,279.85
Nutrition Education (including E3E and X3E grants)	$794,654.79
Organic Cost Share Assistance	$157,478
Specialty Crop Block Grant	$3,749,373.08
Specialty License Plate	$56,488.92
STAR Fund	$390,474.25
Surplus Agricultural Products Grant Program	$8,800,000.00
Urban School Agricultural Grants	$38,192.97
Young Farmer Grants	$614,205.93
Total	**$43,825,705.39**

Surplus Agricultural Products Grant Program: Since 2002, TDA's Surplus Agriculture Program has provided funding to offset some of the costs for collecting and distributing surplus agricultural products to food banks and other organizations that serve needy or low-income individuals. The 2018-2019 funds have been awarded to Feeding Texas for the term October 1, 2017 – September 30, 2019 in the amount of $8.8 million from General Revenue. With these funds, Feeding Texans will be able to source an estimated 61 million pounds of product.

Texans Feeding Texans Home-Delivered Meal Grant Program: This program was established to provide assistance to home-delivered meal providers by supplementing and/or extending their current program.

- 61 percent of Texas residents lived alone
- 66 percent said that the home-delivered meal programs provided half or more of their daily food intake
- A staggering 8.9 percent of all seniors in Texas were classified as food insecure and at risk of hunger

In 2018, TDA awarded 135 organizations serving 163 counties $8.44 million in funding. These organizations provided more than 13.5 million meals to homebound elderly and disabled residents in the state during the previous state fiscal year.

Recommendation: Continue to explore and develop opportunities to support rural, small and agricultural businesses and communities. Should state general revenue be made available, continue to support innovative economic development strategies that fall outside the parameters of federally funded programs.

Texas State Office of Rural Health
Programs Overview

The State Office of Rural Health (SORH) provides services, programs and grants for rural health in the amount of approximately $4.5 million per year. The Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services and the State of Texas provide funding for SORH (generally split evenly between HRSA and the State of Texas). SORH serves as a coordinating, facilitation, and grant issuing agency for federal and state programs related to healthcare in rural areas.

The State Office of Rural Health (SORH) Grant Program funds the creation of the State Office of Rural Health requiring a 3-to-1 match from the State of Texas. While the program's federal dollars cover administration costs associated with creating and operating SORH, the State of Texas matching dollars are utilized to identify and address issues that affect rural hospitals and healthcare providers. These activities can include identifying and providing technical assistance addressing specific issues to funding program planning and needs analysis work. This work informs state and rural health stakeholders of current obstacles and barriers to access to care.

Funding Source: Health Resources & Services Administration (HRSA) and State General Revenue (GR)

Funding:

2018 – 2019: $179,270 (HRSA) / ≃$301,222 (GR match) / ≃$236,589 (CIP match)*

2017 – 2018: $179,871 (HRSA) / ≃$326,571 (GR match) / ≃$213,042 (CIP match)*

2016 – 2017: $172,000 (HRSA) / ≃$265,601 (GR match) / ≃$253,399 (CIP match)*

2015 – 2016: $171,598 (HRSA) / $540,000 (GR match)

Note: Above funding and matching amounts are approximate values

Activities:

All federal dollars are utilized to cover a portion of SORH administration costs (salary, fringe, indirect).

Matching State of Texas general revenue dollars are utilized to cover a small portion of SORH administration costs (salary, fringe, indirect), travel, etc., with the remaining primarily funding activities that aide rural hospitals and providers.

In Fiscal Year 2018, SORH is funding the work of a Program Planning and Needs Analysis project that will help guide SORH work and help identify issues facing rural hospitals.

Due to the reductions in match funding beginning in Fiscal Year 2016, SORH was unable to fund certain activities to assist rural hospitals and providers as it has in the past. Specifically, SORH cut the Health.edu program that provided unlimited online continuing education credits to 127 hospitals'.

*In order to meet the 3-to-1 match requirement and allow TDA to pull 100% of the HRSA grant, HRSA allows TDA to use activities funded through the Rural Health Facility Capital Improvement Program (CIP) as match for the SORH grant program.

The Rural Communities Healthcare Investment Program (RCHIP) is designed to attract and retain healthcare professionals in rural communities by providing incentives such as stipends or loan repayment assistance to non-physician healthcare professionals.

Funding Source: State General Revenue (dedicated – tobacco endowment)

Funding:			
	2018 – 2019:	$113,469	(in process)
	2017 – 2018:	$111,703	(19 awarded)
	2016 – 2017:	$144,138	(20 awarded)
	2015 – 2016:	$142,763	(29 awarded)

Activities: All RCHIP dollars are utilized for grant awards. The program provides up to $10,000 to any eligible non-physician healthcare professional agreeing to practice in rural medically underserved areas for one (1) year. ***This program is oversubscribed annually***.

The Rural Health Facility Capital Improvement Program (CIP) provides competitive grants to hospitals in rural counties to make capital improvements to existing health facilities, construct new health facilities, or purchase capital equipment. Eligible hospitals that can apply for these funds are rural public and nonprofit facilities.

Funding Source: State General Revenue (dedicated – tobacco endowment)

Funding:			
	2018 – 2019:	$1,598,453	(24 awarded)
	2017 – 2018:	$1,598,453	(33 awarded)
	2016 – 2017:	$1,877,439	(34 awarded)
	2015 – 2016:	$1,970,435	(27 awarded)

Activities: All CIP dollars are utilized for grant awards. The program provides up to $75,000 per award with a 25% applicant matching requirement. Examples of awarded projects include: medical equipment, backup generators, fire alarm systems, patient beds, building renovation and remodeling, a nurse call system, telehealth equipment, and an air conditioning system. ***This program is oversubscribed annually.***

The Small Rural Hospital Improvement Program (SHIP) Grant provides funding to all small rural hospitals to help them do any or all of the following: costs related to the implementation of prospective payment systems (such as updating chargemasters or providing training in billing and coding); pay for the costs related to delivery system changes as outlined in the Patient Protection and Affordable Care Act (PPACA) such as value-based purchasing (VBP), accountable care organizations (ACO) and payment bundling.

Funding Source: Health Resources & Services Administration (HRSA)

Funding:			
	2018 – 2019:	$1,118,700	(110 hospital grants)
	2017 – 2018:	$945,000	(105 hospital grants)
	2016 – 2017:	$822,444	(92 hospital grants)
	2015 – 2016:	$945,360	(93 hospital grants)

Activities: Less some administration costs, all SHIP funds are utilized for grant awards, providing approximately $8,000-$10,000 a year to each hospital applying for eligible activities. ***This program is non-competitive.***

The Medicare Rural Hospital Flexibility Program (Flex Program) encourages the development of cooperative systems of care in rural areas; joining together of Critical Access Hospitals (CAHs), EMS providers, clinics, and health practitioners to increase efficiencies and quality of care.

The Flex Program requires states to develop rural health plans, and funds their efforts to implement community-level outreach and technical assistance to advance the following goals:

- Improve quality of care and performance management
- Improve and integrate EMS
- Support Health system development and community engagement
- Develop and implement rural health networks
- Support existing CAHs and eligible hospitals
- Designate CAHs

To ensure alignment with current federal application requirements, legislative changes, and the local challenges of CAHs, the Texas Flex Program is working with federal agencies and stakeholders to update programs and activities.

Funding Source: Health Resources & Services Administration (HRSA)

Funding: 2018 – 2019: $901,523

2017 – 2018: $723,664

2016 – 2017: $723,664

2015 – 2016: $700,663

Activities: All Flex Program dollars are utilized to fund two projects exclusively for Critical Access Hospitals less dollars for administration costs and travel. The two projects are:

Quality Improvement Project: Partnering with the Texas Hospital Association Foundation (THAF), this project provides training and technical assistance to all Texas CAHs in regards to quality improvement and reporting.

While CAHs are not required to report quality as a requirement to be reimbursed by Medicaid/Medicare, the intention of the program is to have the hospital utilize the data to improve their quality of care and to also be prepared for the day when they will be required to report their quality measures.

This program could be made useful to ALL rural hospitals in the state if state funding were to be made available.

Financial and Operational Improvement Project: SORH partners with the Texas Organization of Rural & Community Hospitals (TORCH) to identify ten low-performing CAHs in the state annually. Once identified, site visits are performed with each one to assess their financial condition and operations. A cohort of the ten is then formed where they work on projects to address similar issues identified by the cohort.

This program could be made useful to ALL rural hospitals in the state if state funding were to be made available.

Community Development Block Grant (CDBG) Program for Program Year 2019

The primary objective of the Community Development Block Grant program is to develop viable communities by providing decent housing and suitable living environments, and expanding economic opportunities principally for persons of low- to moderate-income.

Eligible Applicants: Non-entitlement cities and counties whose populations are less than 50,000 and 200,000 respectively, and that are not designated as eligible for the entitlement portion of the federal Community Development Block Grant Program (CDBG).

Community Development Fund

The Community Development Fund is the largest fund category in the TxCDBG Program. This fund is available through a competition in each of the 24 state planning regions. Although most funds are used for Public Facilities (water/wastewater infrastructure, street and drainage improvements and housing activities), there are numerous other activities for which these funds may be used.
Max Award: $275,000 - $800,000 (varies by region).

Texas Capital Fund

Supports rural business development, retention, and expansion.

Infrastructure / Real Estate Development Programs

Provides grants or zero-interest loans for infrastructure and building improvements to create or retain permanent jobs. ***Max Award: $1,000,000***.

Main Street/Downtown Revitalization Program and Small & Microenterprise Revolving Fund

Provides grant funds for public infrastructure to eliminate deteriorated conditions and foster economic development in historic main street areas and rural downtown areas. An additional loan of up to $100,000 is available for downtown small businesses. ***Max Award: $250,000***.

Fire, Ambulance, and Service Truck (FAST) Fund

Provides funds for eligible vehicles to provide emergency response and special services to low- and moderate-income rural communities. ***Max Award: $500,000***.

Planning and Capacity Building Fund

An annual competitive grant program for local public facility and housing planning activities. Localities apply for financial assistance to prepare a “comprehensive plan” or any of its components.
Max Award: $55,000.

Disaster Relief Fund

The Disaster Relief Fund (DR) addresses emergency situations that have received an official state or federal disaster declaration. Funds can be used to restore infrastructure damaged by natural disasters to pre-disaster condition in design, function, and capacity. In a drought situation, the DR fund may also be used to install new facilities that resolve a primary drinking water supply shortage. ***Max Award: $350,000***.

Colonia Funds

Funds available to eligible county applicants for projects in severely distressed unincorporated areas. The term "colonia" generally means an identifiable unincorporated community that is within 150 miles of the border between the United States and Mexico.

Colonia Planning Fund

Assistance for the completion of planning activities to prepare colonia areas for water, sewer and housing improvements. ***Max Award: $100,000***.

Colonia Construction Fund

Assistance to fund water and wastewater improvements, housing rehabilitation, and other improvements in colonia areas. ***Max Award: $500,000***.

Colonia Economically Distressed Areas Program

Assistance to colonia areas to connect to a water and sewer system project funded by other state and federal funds. ***Max Award: $1,000,000***.