Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Austin, Texas
September 26th- 28th, 2012

Meeting Summary

The 72nd meeting of the National Advisory Committee on Rural Health and Human Services was held on September 26-28, 2012 in Austin, Texas.

Wednesday, September 26, 2012

The meeting was convened by Governor Musgrove, Chairman of the Committee. Governor Musgrove stated that the primary focus of the meeting is the examination of two issue areas as topics for recommendations and white papers to the Secretary: Rural Workforce Opportunities for Low-Income Populations (Human Services Committee) and FESC and F-CHIP: Future Models of Rural Health Care Infrastructure (Rural Health Infrastructure and Hospital Subcommittee).

The Committee members present at the meeting were: Governor Ronnie Musgrove (Chair); Eugenia D. Cowan, PhD; John Stewart Cullen, MD; Pamela deRosier; Barbara Fabre; Phyllis A. Fritsch; Larry Gamm, PhD; Roland J. Gardner, MS; David Hartley, PhD, MHA; Thomas E. Hoyer, Jr., MBA; Michele J. Juffer; Karen Madden, MA; Barbara Morrison, MS; Wayne Myers, MD; Karen R. Perdue; Shane H. Roberts; John Rockwood, Jr., MBA, CPA; Roger Wells, PA-C; Christy Green Whitney, RN, MS.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Steve Hirsch, Executive Secretary. Truman Fellows present: Nathan Nash and Emily Schlichting.

HHS UPDATE

Marjorie McColl Petty, J.D.
Regional Director
U.S. Department of Health and Human Services

Marjorie McColl Petty thanked the Committee for their dedication and service. She shared with the Committee that she grew up in the rural community of Jal, New Mexico. Her mother had three children under the age of five and had to take them to a veterinarian as a health care provider because there was no doctor in the area. There is now a community health center in Jal, New Mexico that serves a wide area including Hobbs which is sixty miles away.

Ms. McColl Petty spoke about Dr. Adrian Billings who practices in Alpine, Texas. She said that east and west Texas are like two different countries. She shared that the distance from Dallas, Texas to El Paso, Texas is almost the same as the distance from El Paso, Texas to San Diego, California. She shared that there is also a great amount of diversity in Texas. She stated that Adrian Billings is a sole practitioner in Alpine and there are no other physicians close by. He got involved with the National Health Service Corps because he wanted to go back to west Texas to serve. He is the sole physician in the clinic and is very grateful to have the assistance of a resident. Dr. Billings is collaborating with a Federally Qualified Health Center in Fort Stockton so he could get support in his service. Dr. Billings introduced Ms. McColl Petty to a staff member at the medical center named Gloria Rodriguez and she shared the challenge of engaging young people in that area of the country in health professions. Some of the barriers are cultural barriers. Ms. McColl Petty noted that Gloria Rodriguez is a great role model for what is possible for men and women in the health care profession.

Dr. Billings said that emergency response is a huge challenge in rural Texas. If there is an emergency in the Midland Odessa area and there is a need for an ambulance, it can take four or five hours or more for emergency response. Telemedicine is beneficial but some complications for telemedicine are that there are limited hours when specialists are available.

The Encouraging the College Bound into Health Occupations Grant (ECHO) in New Mexico that is run in collaboration with the University of New Mexico connects rural primary providers with a telemedicine system. This gives local provider's contact with key specialists on specific issues. The additional benefit is connecting the primary providers so that they feel like a community.

Ms. McColl Petty shared that her region which is Region VI includes five states: Arkansas, Louisiana, Oklahoma, Texas, New Mexico and sixty eight tribes are part of that geography. Western Oklahoma and western Texas and all of New Mexico are primarily qualified as frontier. Culturally they are a melting pot. New Mexico has over 46% Hispanic and Texas has 38% Hispanic and there are growing populations in Arkansas. There is a strong presence of African Americans in Arkansas, Louisiana and Texas.

Region VI is also part of the bi-national border. Texas had the largest link in the numbers of people along the border and the length of the mileage. There is 1,254 miles that are part of the Texas-Mexico border. There is a strong border health commission and it is very impressive because of the relationship of the members. The rapport expresses that there are no barriers between them as a team. If the border were the fifty first state, it would rank last in per capita income and first in poverty and unemployment and has some of the worst outcomes in health issues. The border population is also expanding rapidly. El Paso and Juarez is among the largest border metroplex is the world and together the two cities have a population of more than two million. El Paso is an international gateway and an example of how two nations can live together in concert. The mayor of El Paso and the mayor of Juarez are on a first name bases and speak often.

There are incredible challenges in that area but there is also an amazing infrastructure with the extension of Texas Technical Medical School in El Paso and the requirement of the physicians to be trained in bilingual health and medical health language. The area has evolved and addressed the challenges that exist because of the bilingual and bi-national issue. Region VI has more than 550 rural health clinics and 313 are in Texas. There are 177 Critical Access Hospitals and 135 Federally Qualified Health Centers.

There are challenges related to the tribal populations. There are four different Indian Health Service areas. Some of the challenges deal with Medicaid expansion because the states have the choice whether to expand medically or not but if a high number of Native American tribes are affected in the decisions it makes the negotiations a huge challenge.

Ms. McColl Petty stated that collaboration is vital between agencies in order to have services available. She was able to connect the Apaches to the United States Department of Agriculture to receive a 3.2 million dollar grant for a waste water treatment program. She said that those are the types of connections that the Committee can help initiate through their recommendations.

Four Region VI states have the highest numbers of uninsured in the country. Texas has 29.6% uninsured, New Mexico has 25%, Louisiana 22% and Oklahoma has 22% uninsured. Critical Access Hospitals and Federally Qualified Health Centers play a critical role in insuring health care delivery for the rural residents. Rural Americans are less likely to have preventive care, routine blood testing and eye exams.

The benefits of the Affordable Care Act are particularly important for rural areas. It provides health insurance for millions of rural Americans. The new estimates from RAND suggest that 5.5 million rural Americans will gain insurance coverage by 2016 through the expansion of the Medicaid eligibility. The creation of state-based health insurance will provide rural Americans with more insurance opportunities. The challenge in Region VI is whether insurance exchanges will be state delivered or delivered through the federal exchange. There is dialogue happening in New Mexico about what is appropriate and it looks like Texas will be a national exchange, Arkansas has a combination and it is not decided in Louisiana. Oklahoma may be initiated through the state in 2014. The new law also includes tax credits for small businesses to make employee coverage more affordable.

The Affordable Care Act also expands access to preventive services and bands insurance companies from imposing lifetime dollar limits on health benefits or denying the preexisting condition exclusion. Rural areas will benefit from the workforce provisions in the law. The National Health Service Corps has been expanded and about 50% of the clinicians practice in rural areas. The White House Rural Council has expanded the National Health Service Corps to Critical Access Hospitals. Primary care residency training programs have been expanded and 15 of the 22 new teaching health centers serve rural communities. These are busy times for the Department of Health and Human Services and the Committee is the expert. This dialogue is very important. She said it has been a privilege to work for this administration and there is great responsiveness to what

works and what does not. Financial assistance has been available when a rural area could not meet the threshold.

In conclusion, Ms. McColl Petty thanked the Committee for offering Health and Human Services counsel on implementation of issues.

Q&A

David Hartley said that he was pleased to hear more about west Texas with its unique geography and asked Marjorie McColl Petty to talk more about the distances involved in the area. He said that there are frontier demonstrations the Committee will be discussing and that Texas has not been part of those demonstrations. There is a vast area towards Big Bend and living there must be a real challenge. The Committee will be considering frontier extended stay clinics and he is curious whether it will work in that area.

Marjorie McColl Petty said that Adrian Billings would be a key person to discuss what will work in those areas. He is a physician and he partnered with a Federally Qualified Health Center in Fort Stockton.

John Cullen wondered why there is a low infant mortality rate along the border since there is a large poverty and unemployment rate.

Marjorie McColl Petty said that her suspicion is that the Hispanic families are very close knit and single mothers have support and are not trying to manage on their own. It is an important cultural characteristic.

Governor Musgrove said that Texas has the highest number of uninsured at 29.6%. The bi-national line has a high number of uninsured. If the percentage along the border of uninsured was removed, what would the percentage be for the other areas?

Marjorie McColl Petty said she does not have the percentage but the border has a definition in terms of mileage. The level of some diseases and uninsured is around three times the level of the rest of the state in that area. There has been discussion about creating a public health entity just for that area.

Linda Jones, M.S.P.H.,
Director
State Office of Rural Health
Texas Department of Agriculture - Office of Rural Affairs

Linda Jones thanked the Committee for visiting Texas and for the opportunity to speak. Ms. Jones spoke about the challenges and opportunities in Texas. She shared with the Committee that 177 of 254 counties in Texas are rural counties. 89 of the counties have a population of less than 10,000. 15% of the state's total population is rural but they cover a

vast geographical area. The largest numbers of frontier counties are in the western part of the state.

Ms. Jones said that Texas is kind of like two states, the eastern part that is very populated and the western part that is sparsely populated. The change in population from 2000 to 2010 shows a loss of population in the west Texas area. Population change is a long, slow process and presents challenges. There is a small town in west Texas named Coleman that is experiencing population decline. The number of deaths is exceeding the number of births. The community of Coleman used to have 350 people in the high school but now has 218 people. Many of the towns in west Texas are struggling with vitality and there are businesses closing in downtown areas. Rural America is aging, poorer and has more chronic disease. The 65 to 74 year olds are growing in large proportions and this will be a struggle for health care delivery systems. Trauma related death rates are higher in rural areas than urban areas.

Health Care professional workforce shortage is another huge issue in rural Texas. There is a physician shortage but there are several programs in the state that support education of the health care workforce. The funds were eliminated during the last legislative session so they are trying to get supporters in order to get the funds restored. It takes a long time to train doctors. There is a rural scholar recognition program and a person in the community can partner with a hospital or civic group and the community will pay one half of the person's tuition and living expenses and the agency will pay the other half. It is a successful program and there are physicians who benefit from it who grew up in the community and want to return and serve the community. Large numbers of people lacking health insurance in Texas are in the border area, outside of the metropolitan areas in the southern part of the state and in west Texas.

There are 80 Critical Access Hospitals in Texas. The state is second in the number of Critical Access Hospitals in the nation. Each hospital is having a different experience. Some are struggling to keep the doors open and others have established great working relationships with surrounding communities and are providing services on a regional basis. Cooperation amongst the communities depends on long term cultural situations. Each community is unique in their approach and attempts to solve these problems.

The destiny of communities is determined by the demographics. This includes whether there is population growth, urbanization, ethnic diversity and increasing longevity of the population. Two thirds of the people in the state are overweight or obese and that causes large numbers of chronic diseases. This is a huge issue that needs to be addressed. There are a large number of people with diabetes, more people with self-care limitations and more persons needing access and transportation to health care.

The organizational structure of the Texas Department of Agriculture includes: Commissioner of Agriculture, Deputy Commissioner, six division leaders, Trade and Business Development Chief Administrator and Administrator for the Office of Rural Affairs.

INFRASTRUCTURE PANEL

Jerry Massey
Senior Vice President
Affiliate Operations
East Texas Medical Center Regional Healthcare System

Jerry Massey shared that from 1977 to 1983 he worked on the Houston Galveston area health systems plan that was integrated into the state health plan. He noted that the 1115 waiver process is very similar to the state health system plan. A challenge for him is that it sometimes feels as if grants are month to month and as a rural hospital administrator this is a very challenging time. He feels there is a disconnect between health planners and health operators. Access to care and cost has been a problem in the past and it is a problem today. Health administrators and health planners need to work together on the same issues that are important to the population.

Mr. Massey said that northeast Texas is large enough that it could be considered one state. The border of Texas is 200 miles from Dallas. He is located in the area between Dallas and Texarkana in the piney woods of east Texas. The counties are not frontier but there are no population centers in the area. There are 1.5 million people in 40,000 square miles and the biggest city is Tyler, Texas with 90,000 people. The population is spread over a large area. Specialty care is about 1 to 3 hours away for most people. They have had to create a rural health system in the area because there are no large hospitals.

East Texas Medical Center is in Tyler, Texas and is a level one trauma center. There is an extensive network of primary care physicians. A 501A organization employs the physicians and contracts them with the health system. There are 20 rural health clinics outside of Tyler and they have over 50 providers. They use midlevel practitioners and all rural health clinics have access to pediatrics. Because of Medicaid reimbursement rates many providers will not take Medicaid so many of the Medicaid recipients go to rural health clinics. In the 20 clinics there are 150,000 annual visits. In some of the large locations there are some specialties but it is difficult to have specialties in an area without critical masses of patients.

Mr. Massey said that their philosophy in providing rural health is to try to do everything possible in the rural area in terms of health care. They do not want to move their patients to different areas but to do everything possible locally. The population is older and it is difficult for them to travel and there is a huge number of uninsured and poor. They provide the second largest not-for-profit EMS network in the United States. Pre-hospital care is a precursor in the success of keeping people alive. Most of the rural health clinics are located on campuses because it provides access to a broad range of diagnostics so there is improved quality of care.

Smith County is the major county in east Texas and there is a surplus of physicians in the county. In the west and southeast of the region there are healthcare shortages of physicians. It is extremely difficult to get physicians to locate in rural areas. In the past 10

years they have not been able to find a physician to go into rural areas and practice alone because it is not economically viable. If there is a rural health clinic, a physician can be integrated into a system of care.

Mr. Massey said that he would advocate rural hospitals working together in the future in order to survive. Individual hospitals in the state are going to have a difficult time surviving alone. One hospital that closed recently in the state of Texas and if the expected cuts and changes happen then hospitals will have to work together or more will close.

The supplemental federal and state reimbursement programs have been a great assistance. Rural health clinics enable Easter Texas Medical Center to provide primary care coverage in rural areas. There is an enormous infrastructure of primary care in rural health clinics around the country. Federally qualified health centers do not work as well in rural areas because they have to have a critical mass of patients in order to survive. Enhancing rural health clinics should be discussed more often. The upper payment limit program worked when it was available even though it only recovered the amount of money needed to take care of a Medicaid patient.

There are two Critical Access Hospitals that provide a needed mechanism to attract capital. Critical Access Hospitals are a wonderful way to provide care for the population. East Texas Medical Center developed one of the first free standing emergency rooms in Texas over 20 years ago. The problem is that it requires a critical mass of patients to be economically viable. East Texas Medical Center has designed the hospitals around the rural health clinics. This allows them to pay a competitive wage to providers and give them a place to work. Without the rural health clinics, it would be difficult to keep the hospitals open.

Mr. Massey stated that the change from an upper payment limit (UPL) program to a complex Texas 1115 Medicaid Waiver has been difficult but it may work when everyone learns more about it. The employed MD practices in rural health areas that are not rural health clinic based have been unsustainable and tertiary care at smaller affiliates has been difficult to maintain. Federally qualified health centers have not worked in the smaller towns because there is not enough critical mass for a Federally Qualified Health Center and a rural health clinic in the same area.

He noted that issues for consideration by the Committee include the challenge of access in regional settings. Rural areas do not have the critical mass of urban areas and any economic enterprise has to be able to have enough money to survive. Integrating the best attributes of rural health centers and Federally Qualified Health Centers would be beneficial. Programs that promote infrastructure development are important. There need to be sustainable models of health care and a focus on access and how to get the people in the community a primary care physician.

Dr. James Rohack, M.D.
Director, Scott & White Center for Healthcare Policy

Professor of Medicine and Humanities, Texas A&M Health Science Center

Dr. James Rohack said that he would speak about a model to consider as rural communities move forward and faces challenges. Scott & White believes that the characteristics of an integrated system are: physician led and managed, managing a continuum of care, a common electronic medical record, a common mission and to allow professionals to focus on appropriate patient care. A health care team with a multiplicity of expertise is important to be able to focus on patient needs.

Scott & White Clinic was founded in 1897 in Temple, Texas. Temple, Texas is named after the Bernard Moore Temple, the Santa Fe chief engineer. The railroad system went from the Gulf of Mexico to the Indian Territory. The railroad system realized it was more efficient to pay for their employee's health care in order to have healthy employees. Railroad workers would get injured and surgeons were needed and Dr. Scott was the chief surgeon. A railroad hospital was built in Temple, Texas and as it evolved physicians were added based on its needs. There were 2 surgeons, an internist, and a female physician who did pathology and anesthesia. Dr. Rohack stated that Scott & White have been dealing with meeting the needs of a diverse population and have known the importance of multi-tasking since they were founded.

Scott & White is also involved with graduate medical education. Their mission is to provide personalized, comprehensive, high quality health care enhanced by medical education and research. Physicians who are going to practice in rural areas need to be taught the particular skillset for those areas. There needs to be a curriculum in medical schools for students to get the skillsets needed to practice in rural communities. Working together to get medical students to go back into rural areas is important.

Scott & White Healthcare service area includes 32 counties, covering 29,448 miles. Their model is rural clinics and within the clinic there are family doctors, OBGYN, internists and there is a rotation of specialists into the communities. They have 3 Critical Access Hospitals, a 60 bed hospital in Brenham, Texas and a 30 bed hospital in Llano, Texas.

Dr. Rohack spoke about insurance for the Medicaid population. Scott & White have their own insurance product. In the 1970's there were Medicare cost contracts and they have the only one in Texas with about 1 million beneficiaries covered under the contracts in rural areas. The Medicare cost contract provides additional benefits to the beneficiary by covering their 20% copay and enhancing other benefits. It gives the infrastructure for wellness and outreach by identifying those at high risk and helping them with support systems to manage their chronic illness.

Dr. Rohack said that in the geographic area they cover there is less spending than other areas in Texas. Integrated care assists in lowering the costs and being part of a bigger system gives financial security. There are also challenges of being part a big system such as giving up autonomy. A small, rural hospital with 25 beds can make change happen quickly. Being a part of a big system makes change more challenging because of the infrastructure of the different agencies and the political aspect.

Dr. Rohack stated that understanding the evolution of how care is delivered to those who need it the most, should not be bound by rigid rules and also should recognize there has to be a cost.

Q&A

Karen Perdue said she appreciated the amount of information that the speakers shared. She said that in Alaska they struggle with the issue of cost also. Texas and Alaska are similar by having dramatic differences in across parts of their states. She asked how they deal with the diversity of the cost with policy makers in the state.

Dr. Rohack said they recognize that there is a cost shift because of uninsured. In a geographic area with a high uninsured rate the doctors are going to try and negotiate higher rates because of that reason.

Jerry Massey responded that much of the health spending is due to an older and poorer population in certain areas. There is a higher degree of poverty and there is an enormous epidemic of obesity and smoking. In order to control the spending there will have to be earlier intervention in assisting people in living healthy lifestyles.

John Cullen asked if they have competing health care systems within their areas and how does it impact the ability to bring down costs.

Jerry Massey said that there is one health system in his area that is a competitor but they are much larger and cover a larger area. Mr. Massey said that he does not think it makes much of an impact and they really do not compete much outside of the Tyler, Texas market. They are in the process of having electronic medical records and it is amazing to have shared information. None of the electronic medical record systems are good at integrating clinics and hospitals. It would be great to see health systems communicating through the health information networks.

Dr. Rohack said that there are a few other systems in their area and there is a veteran's administration.

John Rockwood asked about the emergency medical services. He stated that it is so important in keeping people alive and it is very much a local entity in his state. If it takes four hours to get a ground vehicle to someone with a problem then it is going to be very difficult to get older people to live in rural areas. Is there anything innovative being done in emergency medical services to get the right people to the patient?

Jerry Massey said that they pay about 7 million dollars a year to have an emergency medical system. Every unit is tracked with a GPS unit and there is a predictive capability of saying where the next call will come from. They preposition their units and are good at predicting the logistics. The equipment is expensive and is going to be difficult to sustain much longer. If there is good pre-hospital care there will be a better outcome for patients

so that is an important issue.

Roland Gardner asked about the competition between Federally Qualified Health Centers and rural health centers and said he feels that they can successfully coexist.

Jerry Massey said that he believes that they can coexist but it has to be in partnership. It has to be recognized that they do many of the same things and have the same problems. They can coexist when they work together and communicate with each other about the things they do best.

Barbara Morrison asked about home and community based services for the aging population and if they are collaborating with the Area Agencies on Aging.

Dr. Rohack said that they have a discharge planning process that engages the Area Agencies on Aging and have applied for a grant to get a lower level individual with a laptop to be able to be the interface rather than sending a trained nurse back to that community. The information technology infrastructure allows better care at the site with someone who can take information but is not necessarily a medical expert.

Jerry Massey said that they operate home health in about 40 counties but the problem in rural areas is the payment systems. In a rural area a nurse may only be able to see 4 patients in a day because of distance.

WORKFORCE PANEL

Larry Temple
Executive Director
Texas Workforce Commission

Larry Temple told the Committee that he is very familiar with the challenges of rural America and the variations from one area to another. He said that east Texas verses the Pan Handle and west Texas are very different. Mr. Temple noted that the Texas Workforce Commission has 28 local workforce development boards that oversee and administer services. He shared that 70% of the population lives in the metropolitan areas. There are 254 counties in Texas and about 175 of them are considered rural. About 80 or 90 counties are considered frontier. The Texas Workforce Commission combines all programs into a one stop shop are and it is a convenient way of delivering services. It is a locally controlled system and the boards are business and employee driven. The local workforce boards provide plans on how they are going to support the local strategy. The local board decides what their targeted demand occupations are and where they will spend their money.

Business representatives, community college representatives, state agencies, local economic development representatives and secondary school representatives get a chance to understand what is happening in their economy and what the emerging jobs will be

through the local boards. This information is shared with businesses and to students so they can make informed decisions about what they will study and where they will go to school.

Larry Temple said that Texas Workforce Commission delivers the childcare service, Temporary Assistance for Needy Families (TANF) work program and the Supplemental Nutritional Assistance Program (SNAP). Texas is a workforce state and work with the employer community to identify trends and match their case load with qualified individuals. They work with training programs that support the TANF eligible population. The first line of defense for the welfare program is moving people into employment. In Texas there has been a considerable decrease in the TANF population. The data shows that about 65% of the people who have completed the Choices workforce program are eligible for unemployment insurance benefits now. The safety net for the TANF population is unemployment insurance and that is a positive change. This means the person has to be monetarily eligible for unemployment so they had sustainability in the workplace. That has not been visible in the welfare population in the past.

Supporting individuals in a post-employment period has made a huge difference. These people go to the Workforce Solutions office because they have a problem and they want employment. If an employer visits the Workforce Solutions office they are looking for workers. Approximately 2 million people have visited the Workforce Solutions office in the past year. Last year there were 268 thousand jobs created in the state of Texas and many of those jobs were in the service industry.

There are barriers for people who are looking for employment but the most important is the lack of a good job reference. Mr. Temple asked a business owner what the criteria is for a person to be hired as an assistant manager. The business owner said that he hires from within and the prerequisite is that the person was at work and on time for six months. The job of the assistant manager is to open the store and it is very important that the assistant manager is dependable.

Texas Workforce Commission provides post-employment services for TANF clients such as: transitional Medicaid, earned income disregard for 4 months and childcare. The program emphasizes the value of working. Many of the people who have completed the program have employment and would be eligible for unemployment insurance if they became unemployed which is an amazing transformation for the program.

On average an individual who completes the Workforce Solutions Program gets a job within 42 days. If an individual does not get a job within 42 days they are placed in supervised employment through a governmental entity or non-profit. That individual is monitored to determine why they are not able to get a job or stay employed and offered support.

The Texas Workforce Commission is seeing better workforce placement in rural areas than in urban areas. The community needs to be prepared when there is a lay-off or when there is a new company moving into the area and the workforce boards are a vital source

for that information. The local board is able to direct where the resources will be spent. Businesses and people looking for work want a solution to their workforce needs. Having one location to assist in solving those needs is important. Client information is input one time and populates all of the programs available for an individual.

Serving veterans is an important issue to be discussed. There is a Texas Veteran's Leadership Program that connects combat veterans with local veterans who are able to assist them and know the issues they are facing. They are locating the veterans in shelters, on the street, living with parents or back home with their family. Some veterans are not sharing their struggles with their families and need assistance. The State of Texas is having job fairs for veterans to assist them in finding employment.

The unemployment insurance programs in the State of Texas are moving towards a call center environment which is much more convenient. There were 274 offices this time last year and the federal funding has been cut dramatically. The states are the labs of innovation, not Washington DC, and there are states discovering innovative ways to provide services. The call center environment works well for unemployment service and so does internet filing. Katrina and Ike were two examples of how important it is for people to be able to apply for benefits via the internet.

Q&A

Barbara Fabre said that she works with child care in Minnesota. Successful economic development is jobs, housing, transportation and childcare. Childcare is the 3rd largest service industry and they need support. Many childcare centers are open 52 weeks out of the year and get no vacation. There are limited dollars and they do not have health insurance in many cases. Ms. Fabre said that she would encourage workforce development to give support to the childcare providers because they are small businesses.

Larry Temple said that they have money set aside for quality initiatives that local workforce boards use to support child care. One of the big problems in the child care program is that there are many providers that are located in areas where most of their children are coming from low income homes and depended on subsidized childcare. The business model does not support being 100% subsidized child care. There has to be support from other sources.

Eugenia Cowan said that she is with tribal TANF and noticed that there is no tribal TANF in Texas. She asked if the service population includes a substantial proportion of Native Americans.

Larry Temple said that El Paso has the biggest concentration of Native Americans and have elected not to have a program.

David Hartley said that part of the infrastructure for getting people back to work is transportation and wondered if their areas are doing anything creative to solve the problem.

Larry Temple said that one thing his agency learned is that they are not transportation experts so they supply money to people who are transportation experts. They supply gas cards and those types of services to individuals in need. Providing supplemental funds with what is already available is important.

Phyllis Fritsch asked about the integration with the community colleges related to workforce training.

Larry Temple responded that community colleges are represented on the local boards so they can know what businesses need and business can know what services are available. A change is that the colleges are moving to a more flexible training model instead of just the semester platform. Colleges are becoming much more employer friendly. Training for the underemployed who are eligible for workforce investment training and TANF funding training may be working part time and need night classes or online classes. There is dual enrollment. Rather than set up a separate employment service for TANF, everyone who comes into the work centers are seen by the employment services. Many of the referrals back to the colleges are coming from the employment counselors who identify if the person is eligible. The definition of work ready is if a person has the skills for a job available, they are work ready. They do not spend training dollars on people who are work ready. The funds are limited so the money goes to people who do not possess the skills for the jobs that are available.

INFRASTRUCTURE PANEL

Shannon Calhoun
Executive Director
Southeast Texas Health Systems

Shannon Calhoun thanked the Committee for the opportunity to speak. The topic of her discussion is three accountable care organization applications. The applications were based on history of rural collaboration. The focus was on virtual integration that allows autonomy and financial independence of the participants but gains in economy of scale and scope.

Ms. Calhoun worked with a for-profit network to do applications for the accountable care organization. She stated that the law says that an accountable care organization certified by Medicare will be willing to become accountable for quality, cost and overall care of Medicare fee-for-service beneficiaries assigned to it. There needs to be a formal legal structure that can receive the disbursements and then distribute them. It has to serve 5,000 assigned Medicare beneficiaries. There has to be an appropriate number of primary care physicians that support the 5,000 beneficiaries. There has to be a leadership and management structure and it has to be demonstrated in the application that there are processes to promote evidence based medicine and patient engagement. There also needs to be a demonstration of coordination of care. If there is cost savings then the accountable

care organization receives 50% of the savings. The savings has to be applied to an infrastructure and process to improve care and the other is used for incentives.

Accountable care organization advanced pay application requirements run concurrently and they could not consider doing an accountable care organization if they were not capable of having funds to sustain the infrastructure. There is not an infrastructure in rural markets to do information technology and data sharing. The advanced pay eligibility did not get much response from the rural market place because of the eligibility requirements.

The New Light Rural Health Network applications were based on collaboration and would have to find an economy of scale and scope to get the high level experts. A resource center that was shared by all three applications was created. In the resource center there was information technology, the medical director, administration, care coordination and chronic disease management. The providers were grouped based on business issues and not on shared patients. Geography or proximity to other providers was not a requirement. Southeast Texas Health Systems did a calculation of whether they would have 5,000 beneficiaries and they thought they would come close in three applications based on the groupings.

The result of the applications was that they did not meet the required number of assigned beneficiaries and were allowed to merge the applications. They merged two applications and abandoned one but this still did not reach the number of beneficiaries after merging.

Some of the barriers to success of rural providers in Centers for Medicare and Medicaid Services Accountable Care Organizations are:

- Accountable Care Organization rules do not allow the acknowledgment of primary care delivered by nurse practitioners or physician assistants
- Claims data from rural health centers does not include MD visits
- Advanced Pay Program caps are too low
- Step 2 “Plurality of Primary Care” is not favorable to rural providers, and could be harmful
- Providers do not have the Centers for Medicare and Medicaid Services patient centric data

Recommendations to assist the success of rural providers in Accountable Care Organizations include:

- Assign all Medicare and Medicaid beneficiaries by zip code to rural communities that provide a plurality of primary care for their service area zip code to a Community Care Organization
- Provide advanced payments to all coordinated care organizations to support infrastructure development
- Shared savings equality between Centers for Medicare and Medicaid Services, beneficiaries, physicians and hospitals

Monica L. Wendel, Dr. P.H., M.A.

Assistant Dean for Community Health Systems Innovation
Director, Center for Community Health Development
Texas A&M Health Science Center

Monica Wendel talked about the Texas 1115 Medicaid Transformation Waiver and the ways that rural communities in Texas are finding a way to benefit from it even though it was not designed for rural communities. Many programs are not designed for rural communities so they are accustomed to dealing with this issue. Availability, Transportation and costs of care are issues in rural communities.

Rural community infrastructure for health and human services is dependent on regional services. Some local services are provided by a specific type of provider that provides services beyond their normal scope. An example is a school nurse who provides mental health care to families and not just the student. Rural communities are dependent on services on the regional level and that means there is travel involved and there are barriers to access. Dr. Wendel said that Texas ranks 51st in mental health care spending behind Puerto Rico in the United States. Transportation is a barrier for people accessing care. Many of the rural communities do not have sources of public transportation. Cost of care and getting care is an issue in rural communities. People who work for small businesses or are self-employed in a small community may have to travel half a day to get care. This adds expenses of time and cost. The fragmentation of services in rural communities and continuity of care is an issue.

The focus of the 1115 Medicaid Waiver is transformation and it is meant to increase access to care, quality of care, and the efficiency of care and health improvement. Texas was unable to generate enough local public funds to draw down the cap of federal funding. The 1115 Medicaid Waiver was split into two parts: uncompensated care and the delivery system reform incentive pool.

The transformation happens through the delivery system reform incentive pool. The transformation is how the health service delivery looks in Texas. The State of Texas was split into twenty regions. Each region has to turn in a regional health care plan. Providers are allowed to propose projects and local sources of public funds provide incentive payments for the projects. This allows partnerships where there have not been partnerships in the past.

The 1115 Medicaid Waiver was based on 4 of the major hospitals in Texas. The small rural hospital was not a part of this and they were not knowledgeable of the programs they could participate in and they are doing a disproportionate share of uncompensated care. When the waiver was implemented, rural hospitals were included and were told to choose a region. The rural communities were apprehensive about being told what to do with funding. When the rural health care organizations realized that the 1115 Medicaid Waiver would allow them to work with providers and tell them what they have to achieve to be paid, they were willing to participate. The rural counties began to realize this could be beneficial because they will be able to leverage their resources. The hospital and counties are benefiting and there are new opportunities available. The rural communities

are able to determine their priorities and everything is based on a local needs assessment. The communities will know what the providers plan to do and the providers have to report back to the communities to get the incentive payments. The communities know where the funds are going and can see the benefit.

One rural community in Texas is reviewing their emergency medical system services and found that they have 100 patients in a county of 35,000 people that account for much of the budget. People who are lonely and people who need someone to check on them are accessing the emergency medical system. Calling the emergency medical system is the only way these people know to get medical attention. The community is addressing this issue and created an advanced practice provider program through the 1115 Medicaid Waiver. They are contacting the individuals who used the system consistently and doing home visits to them to decrease the amount of calls.

Competition in some communities drives up the costs because they are duplicating services to compete with each other for specialty services. In one community in Texas there are 3 cancer centers because the hospital systems are competing with each other. The waiver is forcing hospitals to collaborate because they cannot receive incentive payments for duplicate services being offered to the same population. There needs to be a collaborative post hospital discharge care coordination plan.

The State of Texas certifies its community health workers. Certified community health workers are working on discharge planning with the hospitals to assist people who meet the criteria of high risk of readmission. Once the patient is discharged, the community health worker is responsible for making contact with the patient to assure the patient has gotten their prescriptions filled and scheduled their follow-up appointment with their primary care provider. This promotes continuity between the hospital and their regular source of care. If the patient needs a home visit from a more advanced practitioner, the community health workers can make that contact for them which supports reductions of readmissions.

Mental health assistance is an issue in rural Texas and there is a need for health information technology services to be provided. Two counties are expanding a telehealth based counseling model that was pilot funded through a rural health network development grant. Doctorial students are seeing patients as part of their training so there is an ongoing supply of counselors. The students are supervised by licensed counselors who are also professors. The cost to the community is covered through incentive money that assists with expenses for technology and equipment.

Rural communities are more nimble than urban communities, which is a huge benefit with the 1115 Medicaid Waiver. The waiver allows rural communities to use their own resources in ways that they have not been able to in the past.

Keith Mueller, Ph. D
Gerhard Hartman Professor and Head

Department of Health Management and Policy
College of Public Health
University of Iowa

Keith Mueller started by explaining how the Rural Policy Research Institute views essential services and how they assure the delivery of essential services in rural areas with a focus on frontier areas. He said he would speak specifically about the Frontier Extended Stay Clinic model that was recently completed.

Dr. Mueller said that there are a series of questions that have to be answered when redesigning local delivery systems. What services have to be local, how local services integrate with care across the continuum and whether the delivery in frontier communities is unique from general trends, are all questions that need to be answered when redesigning local delivery systems.

Public policy is designed to try and develop policies to support appropriate, local services. In the policy arena, there is a focus on payment policies that are operationalized by measures of place and definitions of provider types. Hopefully there can be transition from incremental policies to something that is more rational, focusing on local services that are integrated across the continuum of services.

What is being done is developing criteria that recognize local circumstances that challenge sustainability of essential services. Those criteria are being used to drive policies that create and sustain revenue streams. Also, payment polices are being included as part of mix of revenues.

A lesson learned from the Frontier Extended Stay Clinic model is that local circumstances can prohibit and prevent transfer of patients for extended periods of time. Local capacity is needed to provide treatment and that helps avoid some transfers because some patients can be treated long enough that they can be discharged. This generates cost savings but the savings does not support the model as currently structured. There were improvements in clinical quality and patient experience at the Frontier Extended Stay Clinic model as a result of building their capacity to handle the treatment needed when patients were unable to be transferred.

Recommendations from the Frontier Extended Stay Clinic evaluation include:

- Recognizing FESC as a Medicare provider type
- Revisit the criteria for designation and consider broadening criteria
- Provide start-up funding for transitions
- Reduce minimum time for billing from 4 hours to 2 hours

Dr. Mueller stated that everyone has to participate in order for the FESC model to be successful. Payers have to participate and providers have to trim all costs possible. There have to be multiple sources of revenue to sustain the community service. Quality metrics and quality improvement have to be included as part of the model. There needs to be a focus on service by appropriate means including telemedicine. Providers need to

participate in patient care according to the top level of the skills in which they have been trained.

Paul Moore,
Ph.D.
Senior Health Policy Advisor
Office of Rural Health Policy, U.S. D.H.H.S.

Paul Moore spoke about focusing on appropriate local services rather than going back to the geography and provider based approach. He said that function and form follow finance.

Dr. Moore said that went to upstate New York and visited a round table discussion and listened to the issues that a Prospective Payment System (PPS) hospital was facing. The hospital was a progressive hospital and had infrastructure in place. They have a robust telemedicine set-up and a surgery department with some robotic surgery. The hospital was on the verge of closing. Dr. Moore said that they could be successful if they could move away from fee-for-service. There needs to be a move towards thinking of budget neutrality as looking at a beneficiary cost level and a more global budget neutrality rather than which providers and geographic areas are being paid.

Even if there is the ability to show the larger numbers and amount saved by keeping a patient at a local level and being about to address federal budget neutrality, it will still not get the job done. There will be a need for a local community to have a local subsidy with all partners at the table and all payers recognizing that it could be budget neutral but also a savings with better outcomes, quality care and a more appropriate level of services in local communities.

Q&A

Tom Hoyer said that health care researchers have proven that if there is a managed package of care that it is more efficient but it also costs more because people receive all of the services. Giving available funds to the local government and let them figure out their own solution to health care may be an option. The foundation of many affective providers began with the desire of an employer to keep the staff functioning. Taking a public health approach to the provision of services and getting traditional program payments to traditional providers off the table in small communities would create flexibility.

John Rockwood said it is surprising that they are considering another way of paying rural providers. It seems that all of the different payment mechanisms are exacerbating the problem. What are the services that need to be measured in each community and what services are important in maintaining health, need to be the focus instead of creating another payment mechanism and silo.

Keith Mueller stated that he agrees that the preference is a model that takes the resources that are currently used through separate payment systems and find a way to create revenue streams for local delivery of services and get the revenue streams to the localities to spend in an appropriate way, meeting certain objectives. A way to be confident that the funds are spent effectively but the measure of effectiveness are focusing on better care for individual patient encounters, better health in the community and reasonable total cost. This is the direction that needs to be taken but they will not get there in the near future so they have to make the most of what they have now to work with.

John Cullen said that when looking at the cost savings by avoiding transportation, he is concerned that the estimates are low. Also, when looking at the Frontier Extended Stay Clinic it is not taking into account the emergency level services. Before 4 hours, they can only charge the clinical level visit charge which is much lower than what can be charged in the emergency room but the services provided are emergency level services. When looking at the overall cost, is it possible that the methodology is adversely affecting the FESC concept?

Keith Mueller replied that it is possible but a caution is that they estimated the saving and transfers based on the total amount of transfers avoided regardless of the payment source of the patient. The savings are not real unless somebody makes the resources available for another use. If money is saved for a payer that is not investing in the FESC model, the savings is not for the community but for the payer.

David Hartley said that he would like to endorse the notion of merging revenue streams into a global budget even though it is not possible in the immediate future it is worth exploring, especially for a set of very small communities. The Frontier Extended Stay Clinic is important when there are long distances to travel and there is not a medical doctor on site and it is harder to make connections.

Wayne Myers commented that the fundamental notion of driving the economics off of fee-for-service for individual care is flawed. Many of the rural communities do not have enough people to do enough units of service to calculate the savings.

WORKFORCE PANEL

Reagan Miller
Director
Workforce Development Division
Texas Workforce Commission

Reagan Miller spoke to the Committee about the structure of the Workforce Development Division of The Texas Workforce Commission. The Health and Human Services Commission does the eligibility process for TANF and they do the employment piece of TANF at the Texas Workforce Commission.

The Texas Workforce Commission has 28 local workforce development boards who administer services locally. Subsidized childcare is the biggest grant that the boards administer and is roughly $500 million dollars a year.

The employment training program is called Choices Employment Program. Between 1997 and 2003, Texas Workforce Commission and the boards expanded the availability of Choices services. During the 5 year expansion period, boards designated counties as full service, mid-level service or minimum service. By 2003 there were 254 counties with the Choices Employment Program.

In Texas, TANF applicants are either required to participate in Choices employment services, or are exempt from participation. The 2 federally established exemptions are with a child under 1, caring for an ill or disabled child or adult and parent receiving social security insurance/child receiving TANF. The State of Texas has a law that exempts non recipient parents in child only cases. Several other state exemptions include people who are incapacitated, pregnant and unable to work, age 60 and older, single grandparent age 50 or older caring for a child fewer than 3 and severe hardship.

There are slightly fewer TANF recipients in rural counties than urban. While 59% of rural recipients are mandatory Choices participants, 66% of urban recipients are mandatory Choices participants.

TANF Choices operates on a work first design. The message they send is that government assistance is temporary and that everyone is personally responsible for supporting their family and employment is the goal. Most of their customers are either searching for employment or working. If someone is working for minimum wage, they receive transitional benefits so people are encouraged to go to work and get post-employment benefits.

Subsidized childcare is located in the Texas Workforce Commission. There is an easy link since they administer TANF and childcare in the same office. If someone is not doing what they are supposed to in order to demonstrate personal responsibility, their childcare is terminated immediately. Texas Workforce Commission did a survey of the number of licensed childcare centers comparing rural and urban areas and the numbers were similar. Not all providers accept subsidized children but the numbers that do are about the same comparing urban and rural.

There are Job Access and Reverse Commute (JARC) Grants that assist with transportation challenges in rural areas. The assistance may include gas cards and minor car repair expenses. Other assistance may include carpooling, tax services and contracts with private transit providers.

TANF Choices recipients receive post-employment services and are eligible to continue receiving benefits for 4 months after they begin work, under the “Earned Income Disregard (EID)”. Transition Medicaid and child care is available for a minimum of 12 months for TANF recipients who find employment.

The self-sufficiency grant fund is a state fund program aimed at TANF recipients and populations. It provides funds to community based organizations and colleges who partner with businesses who agree to hire people who successfully complete training. Former TANF recipients who are working may be eligible for Unemployment Insurance (UI) so that system has become a "safety net".

In Texas, they are moving away from the traditional work participation rate. In 2006 and 2007 there was a federal law and regulations that created paperwork difficulties. If a person was in a job search, they had to come to the resource center and staff members would have to watch them search the internet and looking for employment. The flexibility now allows them to move away from documenting the hours. They now document the hours of employment, subsidized employment and on the job training. Now people do not have to travel to workforce locations to be viewed as they look for work and it is less paperwork. Texas has established new program parameters and the boards are now given more flexibility to design and deliver services that assist Choices Employment Program customers in entering employment quickly.

There is also a Choices non-custodial program. It is focused on the fathers with children on TANF. Many of the mothers receive TANF because they are not getting child support payments. The Choices Program is partnering with the courts, the Office of the Attorney General and the child support collection agency. The court identifies the non-custodial parents and requires them to participate in the program as part of a court order. There has been over $6 million in child support collections due to the program. 75% of the collections are based on earned income which is steady income that the custodial parents can depend on.

Don Baylor, M.A.
Senior Policy Analyst, Economic Opportunity
Center for Public Policy Priorities

Don Baylor said that Regan Miller's presentation was a great introduction to what he would begin speaking about to the Committee. A critical part of making families more financially stable is income. Getting income to low-income families is not always enough. Child support is a great way to get income to custodial parents but sometimes it is received in a lump sum and that can be a problem. The lump sum child support issue is being considered. The child support system in Texas is efficient and gets most of the money that is owed to custodial parents. One in five children in Texas is in the child support system. $4 or $5 billion dollars is transferred each year. There should be a link between employment and the child support system. The Attorney General's Office has begun to think about the financial security of low-income families that are on child support in particular that there is a pot of money that is going from one point to another and that there are children in the household. Research shows that a child that has a savings account in their name is more likely to attend college. A large percentage of custodial and non-custodial parents show an interest in having a shared savings account

for their child.

The Center for Public Policy Priorities has started the Child Support for College Pilot and they try to intervene when there is a lump sum child support payment to have the conversation about college savings. They are also working with fathers to connect them not only to work but to tax preparation services and to provide incentives for custodial and non-custodial parents to participate.

Trying to simplify the rules around TANF Choices is important. It is important to focus on what creates positive outcomes. There needs to be pathways to creating careers, not just jobs. There need to be ways for people to make higher wages. Texas is a low wage state for hourly employees. The educational attainment is a large part of the issue. It is important for individuals to obtain post-secondary education and training. People who had jobs and not careers have had a difficult time in this economy. If a person has skills or credentials in demand then it increases employability and financial stability.

The self-sufficiency fund is something that can be used as a model. Workforce development takes cooperation from the community and collaborations between the community colleges, adult education providers and financial coaches. There are local and regional partners that benefit from a model that entices people to collaborate and use a partnership model to meet their goals, especially in rural areas.

TANF caseloads have been declining in good and bad economic times. Statistically TANF has not been that responsive when it comes to economic conditions. When unemployment and poverty are going up and TANF caseloads are going down, it raises important questions about the role of the program in helping people move out of poverty. They are serving a much smaller percentage of those who are considered poor. The income eligibility standards are very low, about 12% of the federal poverty line. The population of people who qualify for TANF is a smaller group and a group that has much higher needs than precious years.

States have used TANF block grants in various ways. Texas uses some of the block grant on child protective services and foster care. It is a legislative decision and has become the norm that over 50% of TANF block grant is used on child protective services and foster care.

Going forward it is important that the Center for Public Policy Priorities put together family budgets that give information about the average cost of living in various metropolitan statistical areas across the state for a variety of household sizes. The Center for Public Policy Priorities will also look at the top 5 occupations in those areas and whether they pay enough to allow families to live within a comfortable cost of living range in the area.

Center for Public Policy Priorities is creating the Texas Regional Opportunity Index. The county is the main source of measurement and they are reviewing education outcomes, savings and assets, credit and debt, family budgets and nutrition and health. This will be a

way to compare rural areas.

The workforce commission earned income tax credit outreach is important to supplement low wages. The refund will be huge for low income families in Texas. Groups are working with workforce partners to provide incentives for people to save a portion of their refund for emergencies, to pay debts and for the future.

Announcement of Subcommittees

Steve Hirsch, Executive Secretary, announced subcommittee information in preparation for site visits.

Thursday morning the Subcommittees' depart for site visits as follows:

- Scott & White Hospital-Llano (Hospital Subcommittee—Group 1) Llano, Texas
- Seton Edgar B. Davis Hospital (Hospital Subcommittee—Group 2) Luling, Texas
- Workforce Solutions of Bastrop County (Human Services Subcommittee—Group 3) Bastrop, Texas

PUBLIC COMMENT

There was no public comment.

Thursday, September 27, 2012

Thursday morning the subcommittees' depart for site visits as follows:

RURAL HEALTH CARE INFRASTRUCTURE
Scott & White Hospital-Llano (Hospital Subcommittee—Group) Llano, Texas
Subcommittee members: John Cullen , Christy Whitney, David Hartley, Phyllis Fritsch, Tom Hoyer, Roger Wells, Roland Gardner and Karen Madden.
Staff Member: Steve Hirsch

Seton Edgar B. Davis Hospital (Hospital Subcommittee—Group 2) Luling, Texas
Subcommittee members: Larry Gamm, Shane Roberts, Wayne Myers, Karen Perdue, John Rockwood and Michele Juffer
Staff Member: Nathan Nash

RURAL WORKFORCE SOLUTIONS
Workforce Solutions of Bastrop County (Human Services Subcommittee—Group 3) Bastrop, Texas
Subcommittee members: Eugenia Cowan, Pam deRosier, Barbara Fabre and Barbara Morrison

Staff Members: Tom Morris and Emily Schlichting

The subcommittees' returned to Austin and attended break-out sessions for discussions.

PUBLIC COMMENT

There was no public comment.

Friday, September 28, 2012

The meeting was convened by Governor Musgrove, Chairman of the Committee.

REVIEW OF SUBCOMMITTEE VISITS

Rural Health Care Infrastructure
Scott & White Hospital-Llano (Hospital Subcommittee—Group) Llano, Texas
Subcommittee members: John Cullen , Christy Whitney, David Hartley, Phyllis Fritsch, Tom Hoyer, Roger Wells, Roland Gardner and Karen Madden.
Staff Member: Steve Hirsch

Seton Edgar B. Davis Hospital (Hospital Subcommittee—Group 2) Luling, Texas
Subcommittee members: Larry Gamm, Shane Roberts, Wayne Myers, Karen Perdue, John Rockwood and Michele Juffer
Staff Member: Nathan Nash

The subcommittees' visits to rural hospitals in Texas were informative and assisted the Committee in outlining topics that need to be addressed. The subcommittees' discussion included:

Rural Health Care representatives' concerns about upcoming changes in rural health care infrastructure:

- In Luling and Llano, Texas the system of protections had been effective because rural hospitals have found a way to adapt broad Federal programs to meet local needs. One Federal policy will not work for all local, rural communities.
- Innovation should be encouraged at ground level and provide regulatory flexibility.
- There is confusion and a lack of understanding about the future direction of U.S. health care and how rural health care systems fit into the plan.

Health and Human Services rural health policy should be proactive, educating rural health care providers about upcoming changes and encouraging innovation while providing support for the present system.

Rural Workforce Solutions
Workforce Solutions of Bastrop County (Human Services Subcommittee—Group 3) Bastrop, Texas

Subcommittee members: Eugenia Cowan, Pam deRosier, Barbara Fabre and Barbara Morrison
Staff Members: Tom Morris and Emily Schlichting

The need to Integrate Work Programs for Low-Income Rural Residents was discussed by the rural workforce solutions subcommittee. Some of the topics included:

- Rural Challenges in the Current Environment
- Moving to a Regional Approach
- Work Challenges for People in Rural Communities

Some possible recommendations that were discussed by the subcommittee included:

- Mine the Administration for Children and Families (ACF) Temporary Assistance for Needy Families program (TANF).
- Use the Center for Medicare and Medicaid Innovations (CMMI) to focus on entry level workforce jobs that offer career pathways.
- Recognize broadband challenges: job search engines require it but dial up is still broadly used in rural communities.
- Link workforce programs to the benefits of the Labor Trade Adjustment Assistance programs. While eligibility is limited, the infrastructure created for these may benefit the TANF population.
- Encourage the White House Rural Council to take up ways for Health and Human Services, Labor and Ed to work together focus on rural integration of workforce and training.

COMMITTEE BUSINESS

Governor Musgrove stated that the next committee meeting will meet in Grand Junction, Colorado in April, 2013. The Committee discussed dates for the September, 2013 meeting that is planned to be held in Lewistown, Montana.

Future topics that may be considered by the Committee are: Rural Hospice, anti-poverty, and graduate medical education.

Governor Musgrove announced that Larry Gamm and John Rockwood would be leaving the Committee. He noted that they have been two very important members of the Committee and their presence and input would be missed.

PUBLIC COMMENT

Ron McMurray, M.D, Chair of the Texas Medical Association Committee on Rural Health thanked the Committee for visiting Texas and for their commitment and expertise as National Advisory Committee Members for Rural Health and Human Services.