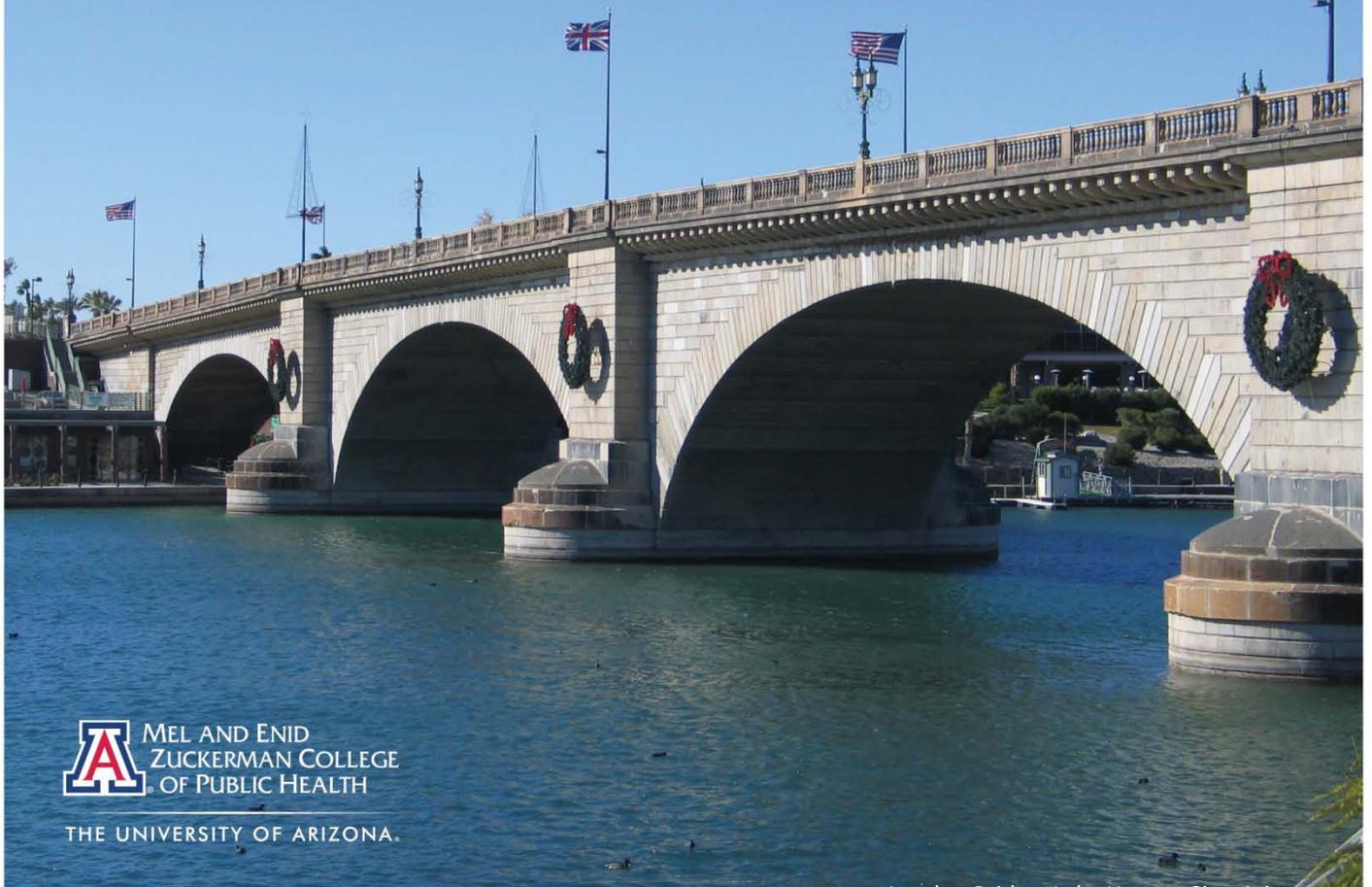


Released July 2010

ARIZONA RURAL HEALTH OFFICE



 MEL AND ENID
ZUCKERMAN COLLEGE
OF PUBLIC HEALTH
THE UNIVERSITY OF ARIZONA.

Arizona Rural Health Policy Assembly

Lake Havasu City, December 12, 2009

What We Learned and What We Recommend

Contents

Introduction 3

Meeting Attendance 4

Recommendations 6

Presentations 7

Health Information Technology and Telecommunications 16

Assembly Call for Public Comment and Discussion 18

Appendix A: Facts and Resources 30

Introduction

This Assembly was the result of a collaborative venture between the Rural Health Office (RHO), the Regional Center for Border Health (RCBH), and the Western Region Area Health Education Center (WAHEC). Its purpose was to bring together stakeholders in health care services to explore regional issues impacting the delivery of care, along with potential solutions to challenges faced in the region. Presenters were encouraged to address any of the following topics: (1) health care workforce; (2) access to health care; (3) disease prevention; and (4) health information technology (HIT). Presentations often covered more than one of the topics.

Members of the public were invited to participate in the Assembly through press releases issued to local newspapers, and radio and television stations. Individual letters of invitation were disseminated by U.S. Postal Service to a listing of physicians provided by the Lake Havasu Chamber of Commerce which also helped to publicize the event. Local and County elected officials were also invited to attend the event. Among these, two indicated a willingness to attend, but were unable to participate. In addition, there was substantial publicity about the event through emails to hospitals, clinics, and other health service agencies in the region. Thirty three (33) people either gave presentations or attended to listen to the presentations. Along with the two elected officials who served as conveners, seven staff members representing the RHO, RCBH, and WAHEC were on hand to assist with meeting logistics and coordination, bringing total participation to 42 people.



Photo by Alison Hughes

The policy assembly was held in Lake Havasu City, Arizona, on Dec. 12, 2009.

The meeting procedure was formal. Questions were posed to the presenters by the conveners, following each presentation, as necessary. A call to the audience was announced at the end of the scheduled presentations, bringing to light some new issues that were not addressed by scheduled presenters.

This report summarizes the meeting presentations, and also presents opinions received by individuals following the event. The recommendations listed below were formed from deliberations by the meeting co-sponsors, in consultation with meeting presenters. It is noted that not all presenters provided verbatim notes, and the meeting was not recorded due to lack of availability of recording equipment at the meeting site. Notes were typed into a computer by a recorder. Presenters were provided advance copies of this report to determine the accuracy with which it reflects their statements.

Appreciation is herewith conveyed to the leadership of Mohave Community College District, and the Lake Havasu Community College campus for their unwavering support in providing the space and resources that contributed to the meeting's success.

Meeting Attendance

Elected officials presiding

- State Senator Amanda Aguirre — District 24, also representing the Regional Center for Border Health, and WAHEC
- House Representative Nancy McLain — District 3

Rural Health Office

- L. Gary Hart, Ph.D. Director, and Co-President
- Alison Hughes, Rural Health Specialist, meeting organizer and moderator
- Kevin Driesen, Ph.D., Planning Committee
- Joyce Hospodar, Assistant Recorder
- Justine Gomis, MPA student, Assistant Recorder

Border Health Foundation

- Keotha Blake, Recorder and meeting logistics coordinator

Meeting Presenters and Participants

- Gary August, Rural Metro Transportation Services
- Blaine Bandi, Executive Director, Arizona Health Facilities Authority
- Merritt Beckett, Regional Coordinator, Mohave Regional Partnership Council, First Things First
- Sheena Benson, Acting CEO, Havasu Regional Medical Center, Lake Havasu City
- Tom Betlach, Director, Arizona Health Care Cost Containment System (written testimony)
- Ben Bobrow, MD, Medical Director, ADHS Bureau of EMS and Trauma System, and Terry Mullins, Chief, ADHS Bureau of EMS and Trauma System (joint written testimony)
- Jim Brouillette, Arizona Western College, Dean, Parker Community College Campus
- Jim Brown, Arizona Western College

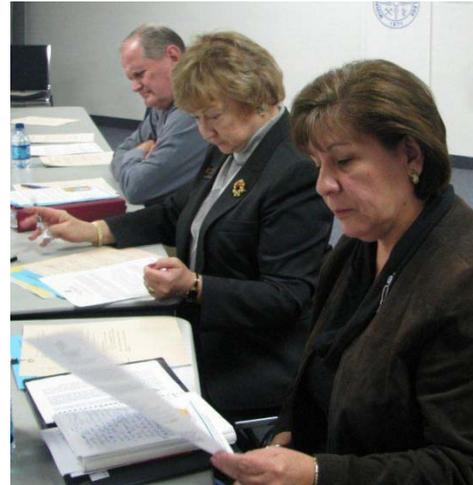


Photo by Alison Hughes

State Sen. Amanda Aguirre, right, State Rep. Nancy McLain, center, and Dr. Gary Hart, Director of the Arizona Rural Health Office presided over the assembly.

- C.S. Carter, MPG Cable
- Marcia Cox, Physicians Weight Management Centers, Lake Havasu City
- Holly Crump, Director, Arizona Rural Women's Health Network
- Victoria Clark, CEO, La Paz Regional Hospital
- Craig Diehl, MD, Lake Havasu Pediatrics, Lake Havasu City
- Joseph Delaney, Silver Spring, Maryland
- James Ehasz, CFO, La Paz Regional Hospital
- Dr. Jon Halling, Anesthesiologist, Havasu Regional Medical Center
- Javier Hernandez, Captain, City of Somerton Fire Department
- Gary Hart, Ph.D., Director, The University of Arizona Rural Health Office
- Alice Garcia, resident, Lake Havasu City (written testimony)
- Michael Kearns, Ph.D., President, Mohave Community College
- Bob Ketner, resident, Lake Havasu City
- Jackie Leatherman, resident, Lake Havasu City
- Jennifer Genua McDaniel, Director, River Cities Community Clinic
- Tara McCollum-Plese, Director of Government and Media Relations, Arizona Association of Community Health Centers
- Patty Mead, Director, Mohave County Health Department
- Jeanie Morgan, Havasu Community Health Foundation
- Linda Riesdorff, Director of Nursing, Mohave Community College
- Nicholas Sanchez, Ph.D., Dean, Mohave Community College, Lake Havasu Campus
- Rita Schoeneman, Ph.D., Executive Director, Health Department, Colorado River Indian Tribes, Indian Health Service
- Brad Tritle, Director, Arizona Health-e Connection (by videoconference)
- Galen Updike, Telecommunications Development Manager, Government Information Technology Agency (by videoconference)
- Ronald S. Weinstein, MD, Director, Arizona Telemedicine Program (written testimony)

Recommendations

- Lake Havasu Regional Medical Center should speed up plans to offer pediatric units at its facilities.
- The State of Arizona should examine existing laws and regulations governing hospital pediatric units to determine what changes could be made that consider the high cost/low volume needs of rural hospitals in the state.
- Mohave County Health Department should explore the use of tele-home health technology to expand home care. This would reduce travel distance for home health workers and allow for increased care opportunities.
- Mohave County Health Department should explore funding possibilities for testing electronic lab order transmission to the state laboratory in Phoenix as a means of reducing travel distance and staff time.
- State and local governments and private sector donors should collaborate to support the establishment of a women's health resource center in the Lake Havasu area. There is a need for free pregnancy testing, and also free services for women and men who need access to health and social service resources in the Western Region of the state.
- Federally supported health insurance companies should fund prevention services for diabetes mellitus patients.
- The State of Arizona should examine state policy regarding school funding formula to ensure rural school parity. The current funding formula impacts rural schools where the student school lunch volume is low. Low funding means fewer teachers. Fewer teachers mean larger classrooms. In addition, physician recruitment is impacted by school capacity to serve the children of physicians.
- The State of Arizona should use the Havasu Community Health Foundation model as an alternative funding mechanism for disease prevention and early detection, and support start-up programs using this model.
- The Arizona Association of Community Colleges should encourage community colleges to collaborate to expand workforce training programs using the Arizona Western College model.
- The University of Arizona College of Medicine should develop an innovative model program that provides incentives for physicians trained in Arizona to work in Arizona.
- More federal and state funding is needed to support rural community health centers (CHC), rural health clinics, and rural CHC look-alike clinics.
- The Arizona state legislature should explore incentives that attract surgeons to practice in rural hospitals.

- The Federal government (e.g., National Highway Safety Administration, and the Health Resources and Services Administration) should support new programs that build models for retaining paramedics in rural areas of the country.
- The Federal government should allocate full funding to the Indian Health Service to allow that agency to expand health care services in rural hospitals and clinics.

Presentations

Dr. Michael Kearns, President, Mohave Community College

Dr. Kearns highlighted the importance of community colleges in preparing the health care workforce. Dr. Kearns pointed to the increasing number of community college degrees awarded in allied health care over the past decade. He noted that public community colleges provided 1.5 million sub-baccalaureate degrees over the past six years, and that the majority of these degrees are in health-related fields. Dr. Kearns also addressed the potential impact of the population living longer on the health care workforce. He noted that 8,000 people turn 65 each day, and that the need for qualified caregivers is expanding to match the need.

Dr. Kearns also addressed challenges in meeting workforce needs of Mohave County. He noted a serious shortage of dental hygienists and radiology technicians, and pointed to positive efforts made by the community college system to train these providers. He also noted that when local residents go to Phoenix for training, it is often difficult to get them to return to the rural areas to practice, and added that when the immediate market need is filled, students go someplace else.

To resolve some of the workforce challenges in the county, a health care summit will be held in March 2010, drawing personnel from hospitals, doctor's offices, clinics, universities, community colleges, and health education centers. Mohave Community College system is working in partnership with two other community colleges to promote new training models that will involve local clinical sites around the state, and use telemedicine technology in training approaches to decrease costs to colleges. He pointed to an example in which three colleges will work together to implement a shared Radiology Technology training program, sharing costs, and allowing students to pay the same price when the cross county boundaries to receive the training occurs. The program will ensure that accreditation standards are met as the new model proceeds.

Jim Brouillette, Dean, Arizona Western College (AWC), Parker Community College Campus, representing Dr. Nigliazzo, President of AWC

Mr. Brouillette emphasized agreement with the points made by Dr. Kearns. He noted that Arizona Western College crosses into Yuma County, location of Yuma, the third largest city in Arizona, and La Paz County, location of Parker, the largest city in that county.

He noted that La Paz County has proportionately a more elderly population in Arizona, but is the newest county in Arizona. There is an urgent need for caregivers in healthcare at all levels, and the challenges faced there are similar to those in small rural cities.

He promoted an increase in relationships between Mohave Community College and Arizona Western College. AWC sends many nursing students to MCC and Palo Verde College. Funding challenges have prevented AWC from offering an Associate Degree in Nursing in La Paz County. AWC/Parker campus is located so far from Yuma County that it is necessary for them to utilize Mohave Community College for nursing education.

Mr. Brouillette also noted that the main problem in La Paz County is insufficient students, and conversely, Yuma does not offer enough classes to train those who want to enroll. Arizona Western College Parker campus is the yin and yang of this concept, he noted. He added that funding is being sought to initiate programs in Parker that involve partnerships in providing these very, very needed programs to La Paz County. He concluded by indicating that, on behalf of the president of AWC, they support the community college collaboration effort totally, and hope to become a major player in the program.

Dr. Gary Hart, PhD, Director and Professor, Rural Health Office, The University of Arizona Mel and Enid Zuckerman College of Public Health

Dr. Hart, a national expert on rural health workforce issues, presented some new and unpublished statistics about physician concentration in the state that are emerging from a current study underway in his office.

He referred to Arizona's rural population as being 35th in the United States, and fifth in frontier geographic areas in the country. He made a strong case for the need to address Arizona's health workforce deficiencies by referring to the following statistics:

- Arizona is 15th in the U.S. in population living below the poverty level.
- Arizona and Mississippi rural areas are tied for the highest percentage of their populations living below the poverty level of all the states.
- Arizona is 22nd in the U.S. in availability of rural primary care physicians, 45th in availability of general surgeons, and 13th in availability of rural registered nurses.
- 86 percent of the active direct care physicians practicing in La Paz and Yuma Counties were educated and trained in other states.
- Arizona's investment in residency training puts the state at 44th in the U.S. for MD practice in rural areas of the state.
- Arizona is 39th in the country for per-capita production of medical schools.
- 69 percent of all direct patient care MDs practicing in Arizona were educated and served residency in other. They tend to come from Illinois, Missouri, New York, and California.

- Arizona per capita state spending is 42nd highest of the states.
- Arizona and Arkansas are tied with the highest national rates of teen deaths, which is more than twice as high as in many states.
- Only 39 percent of Arizona's active direct patient care primary care physicians were educated (including medical school and/or residency) in Arizona, whereas in Washington, for example, more than 50 percent of practicing MDs were trained in that state.
- Of the MD and DO students who are educated here, 48 percent stay. Forty two percent of Arizona-educated MD and DO students received out of state residencies and now practice out of state. Twenty percent return to practice in Arizona.
- The University of Arizona College of Medicine (UACOM) expanded its allopathic physician training program into the metropolitan Phoenix area. UACOM admitted its first Phoenix class of 48 students on March 18, 2010 with a projected graduation date of 2015.
- Eleven percent of the active direct patient care physician workforce in Arizona are doctors of osteopathic medicine. In Arizona, there are two osteopathic training colleges.
 - A.T. Still University located in Mesa is looking to a 2011 date for the first graduating class of 100 students. Residencies will be needed for all of these students. Residencies for these students are largely being located outside the state. (Two out of the seven family medicine residency programs in existence in Arizona in 2009 were closed in part due to funding challenges.)
 - The Arizona College of Osteopathic Medicine (AzCOM) of Midwestern University is located in Glendale, Arizona. This college has expanded its student body so as to contribute to better meeting the state's needs. They expanded to 250 students and are sending students out of state for clinical rotations due to lack of sufficient rotations in Arizona.

In conclusion, Dr. Hart emphasized the need for training more family medicine doctors in Arizona, and supporting more in-state residency programs in order to increase this pool. Residency programs are investments made by policy-makers and supported by local and regional hospitals. He added that medical school administrators who say, "I can't this and I can't that," need to get a new job, and the legislature should make the schools accountable for what they want them to do and what is needed in the state. In Washington (where Dr. Hart previously worked) the medical schools had to go back to the legislature to make changes. We have to expand to keep our numbers at a viable standard. Finally, Dr. Hart noted that, of the MDs trained in Arizona, 65 percent of them go out of state. "The legislature, ASU, UA, and NAU should assist with this issue," Hart said. His final comment was, "Make it a priority to accept students from rural backgrounds into medical school. Medical schools often do not take this into consideration."

Patty Mead, Director, Mohave County Health Department

Ms. Mead spoke of the challenges faced by a rural county health department, and the ongoing efforts to overcome them. She began by providing a brief history of the roots of public health in the United States and the increasing public health agenda that emerged in the 1800's when infectious disease outbreaks became evident in immigrant populations. She noted that rural health was of little concern then, but when rural areas were impacted by urban disease patterns, rural public health infrastructures began to emerge.

Ms. Mead addressed the transportation challenges in implementing a rural health department. She pointed to the travel required to distribute H1N1 vaccine throughout the Mohave County. She discussed the extensive travel and employee time that was required to distribute medications. She also noted the extensive travel needed for home health visits. Her health department provides transportation to HIV-AIDs victims who must be transported to Las Vegas for treatment. She noted the travel necessary for lab testing – drivers must pick up specimens and drive them to the State Laboratory in Phoenix. Staff members in a rural health department must be generalists, and they have little or no training in public health. Mohave County Health Department employs eight nurses, and if one is off work there is no backup available. Staff absences often mean significant travel for others.

It is also challenging to maintain patient confidentiality in rural areas, as neighbors know when a public health nurse arrives. The confidentiality issue is also critical in relation to pregnancy testing and testing for sexually transmitted diseases, and the fact that separate entrances are needed at the clinics.

Ms. Mead also pointed to funding challenges. Dollars are linked to geographic populations and not to populations served. Ryan White funding for HIV services is allocated through Arizona and also Nevada, but they serve patients from California, Arizona and Utah. Also, there is confusion regarding where funding comes from for healthcare services to Native American communities.

Concerns identified by Ms. Mead were that limited financial resources should be distributed to where they are most needed; that there is a lack of trained professionals and no training opportunities for them; that most hospitals have little excess capacity, and that when capacity is reached, few other options are available; and finally, that there is little impetus for planning for how rural areas can prepare if a disease outbreak occurs in an urban area and people migrate to rural areas.

Tara McCollum Plese, Director, Government and Media Relations, Arizona Association of Community Health Centers (AACHC)

Ms. Plese noted that AACHC represents all members including community health centers, look-alike clinics, and rural health clinics. She indicated that many member clinics are the only providers of care in isolated rural areas where they are located, and that these clinics are critical to the health and well-being of the entire area served. She identified funding and

investment as two barriers to delivery of care, but added that the federal stimulus activity has infused money into Arizona's clinics.

Ms. Plese addressed current funding challenges, indicating that the FQHCs experienced funding cuts from \$14 million to \$8 million, with the legislature and Governor refilling the funding level back to \$11 million with funds through the American Recovery and Reinvestment Act (ARRA), with sliding fee services for those between 100 and 200 percent of poverty level. The major impact here is on citizens without health insurance or access to healthcare, but who can pay a percentage of their earnings for health services.

State budget cuts have caused public health programs to be reduced. Ms. Plese foresaw 70 percent of public health funds being cut. She also predicted cuts in vaccine availability, perinatal healthcare, and prenatal healthcare. She noted the profound impact that cuts in Kids Care programs will have, with no reimbursement for services rendered.

Ms. Plese also noted that House Bill 2008 will have an indirect impact on reimbursement due to its reporting requirements for illegal immigrants. She emphasized that sick people are afraid to present themselves in clinics due to fear of being deported. They are not bringing kids in and kids are at risk. This policy is promoting angst among providers because they are required to report illegal residents. Patients are showing up at hospital emergency rooms in critical states. During her presentation, Ms. Plese also addressed the potential impact of a temporary suspension of Proposition 105, the Voter Protection Act. She noted that an initiative on medical marijuana was passed and ignored by the legislature, and as a result we saw passage of the Voter Protection Act in 1998 requiring a three-quarters vote of the legislature to overturn a voter initiative. The current proposal is to suspend the Voter Protection Act for three years. If that happens, Ms. Plese reported, it will eliminate the health-related services allowable through Proposition 204 which was also passed by the voters. Proposition 204 expanded eligibility for receiving services through the Arizona Health Care Cost Containment System (AHCCCS), which is becoming unsustainable due to its member growth from 200,000 patients to today's enrollment of 1.5 million people. The current financial recession is adding to the enrollment as many businesses are dropping health insurance. Thus, the system promotes the delivery of more uncompensated care on the part of healthcare providers. Ms. Plese closed by emphasizing that all healthcare providers will see increased numbers of people wanting quality care without having the ability to pay.

Dr. Jon Halling, Anesthesiologist, Havasu Regional Medical Center

Dr. Halling addressed the issue of physician workforce practicing in the local area. He noted that Arizona is below the national average of 207 doctors per 100,000 people, and noted that this ranges from 46 in Apache County to 233 in Pima County. He emphasized that it is lower in Lake Havasu City, and the largest problem is retention and recruitment of doctors. He noted that MDs practice for about seven years then leave, and that the average doctor's age in the area is 50. Between ages 50 and 65 doctors tend not to practice full time. He emphasized that the geographic area is looking at a big retirement pool of MDs.

Dr. Halling further noted that remoteness is a barrier to maintaining good MDs, and that patients have to travel too far for specialty care. There are medical malpractice issues, but this is a state's right issue. Dr. Halling indicated he plans to leave the area in a few years to go to a state with a good medical malpractice policy that is more protective of the MDs and not the lobbyists. In the past year, they have lost three surgeons to attrition, and in three years, they have lost six surgeons. This resulted in a surgery decrease of 66 percent. He added that it is difficult to maintain physician practices during the summer months when the population decreases. Dr. Halling concluded by indicating that he does not see funding coming from stimulus funds, and that he prefers that Washington, D.C. leave him alone. He emphasized the need for Arizona to protect MDs for medical malpractice.

Holly Crump, Director, Arizona Rural Women's Health Network

Ms. Crump opened her presentation by applauding the Rural Health Office's efforts to improve health for rural women and their families. She pointed to the challenges rural women experience in seeking treatment – transportation, insufficient or no insurance, and limited access to services due to cultural and language differences. In addition, there is a need for family physicians and specialists. She noted that in Gila County's rural environments many women are the caregivers of their families' health and often have low health literacy skills. She noted that many women, as well as service-oriented groups, do not know what resources and services are available. Collaboration of efforts among service and care providers would benefit the community.

Ms. Crump lauded the partnership that exists among the five Area Health Education Centers, (AHEC), and the other network members of the Rural Women's Health Network. This alliance allows for grassroots programs to provide different levels of knowledge to promote rural women's health throughout the state. Their mission is to improve and coordinate health outcomes for rural and underserved women in Arizona. They are currently creating a Patient Advocacy Toolkit for Healthcare Providers, women seeking health, and caregivers. Trainings for healthcare providers will focus on health literacy, cultural competencies, and available services and resources. Patient information will encourage dialogue with healthcare providers to improve clarity and comprehension of health concerns. Patient safety, patient compliance and satisfaction can improve.

Ms. Crump emphasized the role women play as caregivers and stewards of the family's physical, social and emotional well-being. The health network can assist women in finding a voice to help create and advocate for health education, and to take responsibility for their own health and well-being. Increased education and support could establish new habits around meal planning, nutrition, exercise, and family behavioral patterns. Heart disease, cancer, stroke, obesity and medical costs would decrease. She requested that state policy makers support health education and programs that would increase health promotion and decrease health challenges faced by our rural and underserved women and their families.

Jennifer Genua McDaniel, Executive Director, River Cities Community Clinic

Ms. McDaniel addressed the services provided by the community health center in Bullhead City that provides comprehensive healthcare and makes sure financial barriers do not affect access to healthcare. She indicated that 61 percent of the patient population served by River Cities were patients enrolled in AHCCCS, but this is now down to 50 percent. She noted that the rate of the uninsured population went up from 10 to 20 percent, and that 80 percent of the patients work for the gaming industry. She emphasized the extent to which gaming affects the area population and that there is a shift in the payer mix. She added that she does not see many medical students going into family practice, physician recruitment is extremely difficult, and the new doctors are coming in from out of state. She questioned where they can send uninsured people to receive mental health care and oral health care. She felt that the best solution to some of these problems is to “grow our own” [health workforce].

Ms. McDaniel concluded that they want to be able to provide comprehensive healthcare, to work with local agencies to provide care at lower rates and to include oral health care and mental health care. She pointed to the number of people who cannot afford to buy their medications even with AHCCCS which provides medications with co-pays costing between \$50 and \$250 a month for people with HIV. Finally, Ms. McDaniel emphasized that a community health center is about the community and its partners – hospitals, health departments, legislators, dentists, business, and non-profit agencies. The community model is to rally together, to join as one and make as much noise as possible to support the area.

Merritt Beckett, Regional Coordinator, Mohave Regional Partnership Council, First Things First

Ms. Beckett indicated that her program is funded through First Things First. Comprehensive programs are provided for children ages birth to five. She emphasized the importance of service strategies coming from and by the community, and noted that First Things First does that. Council members live in La Paz County, she added.

In their case, strategic planning was accomplished by stakeholders and all partners who convened to design services for children and to implement needs assessments that provided invaluable information regarding what programs and support was needed by the children.

Ms. Beckett emphasized that rural needs are not always the same as those in urban areas, and that services in rural areas should be matched to rural needs. Therefore, this is about developing solutions by our communities for our communities. She pointed to the successful partnerships in which River Cities Community Clinic participates. She noted that they will reach 300 families by providing in home developmental screenings and transportation. She lauded the County Health Department for its help for children with special health care needs, and its capacity to send a nurse to the home to help the families in need.

She concluded by offering advice regarding providing access to rural communities: (1) talk with the community and ensure a local decision-making process is followed to ensure relevant services are provided, and (2) develop partnerships that enable community programs.

Ms. Beckett added that there are many barriers to patients seeking care—transportation, insurance, and undocumented parents.

Javier Hernandez, Captain, City of Somerton Fire Department

Captain Hernandez reported that 85 percent of their calls are medical related. He pointed to the impact on EMS response capacity of city and state funding shortfalls. He also emphasized that many paramedics are lost to other cities or larger EMS agencies. They send the paramedics for training, then they move to larger areas.

The Captain noted there is only one hospital in the county, and that it is a 20 minute drive from Somerton. He further stated that the hospital is often overcrowded, and the ambulance has to wait 30 minutes with patients until a bed is ready. He added that they serve two Indian reservations, and often an ambulance run is one to two hours long.

Finally, Captain Hernandez indicated that Somerton is a small community, and that paramedics and firefighters have lost 4.6% of pay due to budget constraints. They have a second ambulance but insufficient staff to operate it. Their ambulance also serves as back-up to San Luis, AZ.

Gary August, Rural Metro Transportation Services

Mr. August indicated that Rural Metro provides ambulance services for Yuma County. They station one ambulance one block from the U.S.-Mexico border. He indicated that they face similar issues to those presented by Captain Hernandez. They lost four paramedics who left to work for the federal fire department where more benefits are offered.

Training of EMTs and paramedics is constant, and occurs in partnership with Arizona Western College. Their staff members are home grown, Mr. August indicated. It is difficult to get people from the outside. They work with the fire departments in Somerton, Yuma, and Tri-Valley on issues at the border. They see a surge from Mexico to get American medical care, and they get patients who are pushed across the border whether they are covered [by health insurance] or not, and the company must deal with them because they are in the U.S. The EMS system is a primary care network for many of these patients. Mr. August indicated that Rural Metro is fine with this, but the service is straining resources, and places a burden on real emergencies resulting in call time lags.

Mr. August described the reimbursement system and its realities. There is an overlapping service area with Somerton, in which case they cover for each other. Payer mix impacts rates and are set by the State for ambulances. He made the following points regarding reimbursement.

- They have a 47 percent collection rate for ambulance transportation. Ambulance rates are affected by AHCCCS/Medicare rates.
- 35 percent of patients are AHCCCS enrollees.
- 35-40 percent of patients are Medicare enrollees.
- 16 percent of patients are private pay.
- 10 percent do not pay, resulting in a lot of uncompensated care which is a huge burden.

Mr. August concluded that it is becoming difficult to sustain services due to cuts and service payer system. AHCCCS provides 80 percent of the state rate, but this will probably go away and the ambulance system will have to raise rates. This will have a huge affect on being able to put gas in the ambulance and service the fire trucks. Finally, he indicated that the Yuma County collection rate is below 50 percent.

Dr. Rita Schoeneman, Ph.D., Executive Director, Health Services Department, Colorado River Indian Tribes (CRIT)

Dr. Schoeneman has served as Executive Director for the Colorado River Indian Tribes (CRIT) Department of Health Services (DHS) for almost a year.

Dr. Schoeneman reported that the CEO for the Indian Health Service (IHS) facility at Parker, Dr. Lynnae Lawrence, regretted that she could not attend the assembly.

Dr. Schoeneman then presented some population statistics regarding Indian tribes. There are 564 federally recognized tribes in the United States. Arizona, New Mexico, California, and Alaska have higher numbers of native groups than other states. Nationally, 1.5 percent of US population is Native American. In Arizona, Native Americans comprise 5 percent of the State population and 8 percent of the State's youth population. The Colorado River Indian Tribes have approximately 3,500 registered members, representing Mohave, Chemehuevi, Hopi, and Navajo. Twenty five percent of the land mass of Arizona is tribal land, making tribes the number one land-owners in the State.

All services of CRIT DHS are funded by tribal government, federal government, and state government funds. AHCCCS support has been extremely important.

Services include: social services, special diabetes program, diabetes prevention for pre-diabetics, Behavioral Health Services, Alcohol and Substance Abuse treatment services, Child Protective Services, Elder Services, and Community Health representative services. The Women, Infants and Children (WIC) program is countywide as are food services through the Food Distribution Program. All other programs are targeted for the reservation. Approximately 10 percent of the CRIT population is composed of elders who are age 55 and over.

Dr. Schoeneman directed attention to current challenges in the delivery of care and the health disparities among Native Americans. Native Americans suffer higher levels of cardiovascular disease, asthma, depression and anxiety than other groups. She pointed to a 2008 Arizona

State statistic indicating that the average Native American dies 20 years before their non-native counterpart.

She also spoke about problems experienced with Colorado River Indian Tribes:

- Injuries impact 62.9 per 100,000 adults
- CRIT has the highest rate in the state of Type II Diabetes Mellitus, and
- Seventeen percent, or 600 members, have some type of diabetes, and children become diabetic at very early ages.

Dr. Schoeneman noted that the 20-bed I.H.S. hospital in Parker is not legally able to provide detoxification services. She noted that a Tribal resolution was recently passed approving the establishment of an adult residential treatment center for men and women that will be constructed on a half block in Parker.

Community Health Representatives provide transportation, home health care, health education, emergency health related services and optometry. CRIT members needing specialty services not provided at Parker I.H.S. hospital must be transported elsewhere to hospitals such as Phoenix Indian Health Services in Phoenix and Sunrise in Las Vegas.

The Tribe received a \$26,000 grant from First Things First to focus on diabetes and general health related education and prevention for young mothers and children from birth to age five.

Dr. Schoeneman concluded by indicating that the Health Department leadership team has agreed to hold quarterly health fairs in health promotion and disease prevention activities, starting in 2010. They need presenters from health centers to participate, probably in March (25), June, September, and December. Interested persons may contact her directly to make a presentation.

Health Information Technology and Telecommunications

Brad Tritle, Director, Arizona Health-e Connection, and Galen Updike, Telecommunications Development Manager, Government Information Technology Agency (by videoconference)

Mr. Tritle described the mission of the Arizona Health-e Connection, a private non-profit organization formed to facilitate the design and implementation of an integrated statewide Health Information Technology and Health Information Exchange. It will support the information needs of all healthcare stakeholders to reduce healthcare costs, improve patient safety, and improve the quality and efficiency of healthcare and public health in Arizona. He discussed the health information technology stimulus funding opportunities that were available to Arizona's hospitals and private provider offices. He also addressed the upcoming federal rules that will apply to the meaningful use of electronic health records, and the importance of this federal initiative to Arizona's healthcare providers. He further explained two major grant applications in which Arizona Health-e Connection has been involved: A Regional Health

Information Technology (HIT) Extension Center (REC), and a state Health Information Exchange Cooperative Agreement¹ (\$9.377 million).¹

Mr. Tritle indicated that the REC purpose is to furnish assistance (education, outreach and technical assistance) to providers to select, successfully implement and meaningfully use EHRs. He added that, if funded, the center must support a minimum of 1000 primary care providers or 20 percent of priority primary care provider population (whichever is greater) in the first 24 months of funding, with an Arizona target of 1285. Other target populations include individual or small group practices, public and Critical Access Hospitals, Community Health Centers and Rural Health Clinics, and other settings that predominantly serve uninsured, underinsured and medically underserved populations.

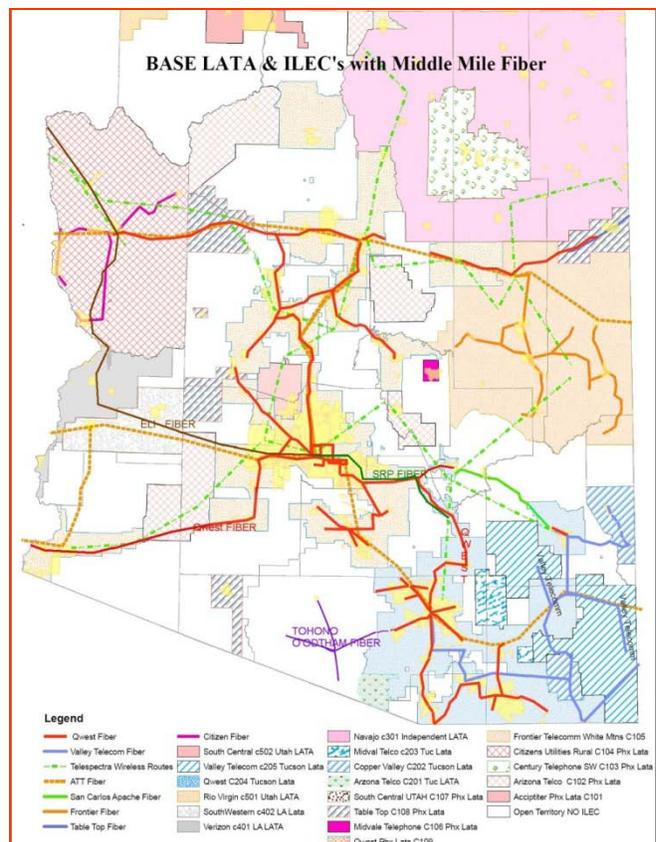
Mr. Tritle explained that the purpose of the HIE Cooperative Agreement is to facilitate statewide health information interoperability and the availability of competitive health information exchange functionality to Arizona’s healthcare providers, and also to develop and implement statewide HIE strategic and operational plans.

Mr. Updike focused his presentation on broadband resources and issues in Western Arizona.

He emphasized that up to 1 million residents in Arizona do not have access to Broadband (New FCC Definition at 768 Kbps download, 200Kbps upload) with more than half of these living in rural Arizona. He noted that in rural communities of under 20,000 people, there is a 50/50 chance those residents do NOT have access to Broadband services (with Yuma being an exception). Mr. Updike added that rural residents, especially rural commercial and health entities, pay two or three times what their urban (Phoenix or Tucson areas) counterparts pay for Broadband.

Mr. Updike showed the following map that provides a visual impression of the areas of Broadband gaps in the State. This map represents data from 2006.

Mr. Updike next explained the goal for expanding Broadband services in the state



¹ Since the date of the Rural Health Policy Assembly, Arizona Governor Jan Brewer was notified that the state’s HIE Cooperative Agreement has been fully funded. This project will be administered through the Governor’s Office of Economic Recovery in partnership with Arizona Health-eConnection. Pre-award due diligence is underway regarding the Regional Extension Center application.

with funding assistance through the American Recovery and Reinvestment Act (ARRA) also known as “stimulus funding”. He explained the Governor’s proposal to create five wireless SONET rings in the state with Western Arizona being one of the targets. He referred to this as a \$35 million “middle mile” project that he believes will solve some of the communications difficulties in the targeted regions.²

Assembly Call for Public Comment and Discussion

Senator Amanda Aguirre thanked the presenters and participants for attending the meeting, especially during the holiday season. She recalled visiting legislators in 1993-1994 to present cases on many of the same issues heard during the Assembly, including public health, transportation, accessibility, and recruitment and retention of health care workforce. She expressed appreciation to Dr. Sanchez and Dr. Kearns for their hospitality in hosting the meeting. She pointed to the importance of partnership and its importance in Western Arizona in addressing the issues and exploring solutions. The Senator noted that she would not be able to offer many answers due to the current wait for a special session to examine budget cuts. She expressed concern for families living in poverty in Arizona, and the possibility that budget cuts will impact them. She promised to work closely with the communities to search for solutions to the issues.

Senator Aguirre noted that her real job is at the Regional Center for Border Health. She thanked her staff members who were assisting with the Assembly, and for their work in the Center’s offices in Lake Havasu and in Yuma.

Representative Nancy McLain addressed Gary August. She confirmed with Mr. August that Rural Metro Transportation Services is a for-profit agency. She next asked Captain Hernandez for confirmation that Somerton Fire Department has taken a 4.6 percent pay cut, to which the Captain responded that they took a 2.3 percent cut last budget, and 2.3 percent cut this budget.

Representative McLain next addressed Jennifer McDaniel, asking if they have problems getting patients their prescriptions. Ms. McDaniel responded that they run into problems when they have to use the brand names instead of generic drugs.

Representative McLain sought clarification from Dr. Schoeneman regarding CPS funding by both the Tribe and by the federal government. Dr. Schoeneman clarified that she should have responded with the word “government.” Representative McLain next asked Dr. Schoeneman if they receive state funds, to which she responded yes, at about 20 percent.

Representative McLain next asked Mr. Brouillette about Quartzsite. He responded that he sees this city growing exponentially over the next 10 years.

² Since the date of the Rural Assembly, notification was received that the “middle mile” project was not funded in Round One. Arizona is a candidate for Round Two funding. Should update!!

Ms. Vickie Clark, CEO, La Paz Regional Hospital

Ms. Clark indicated that La Paz Regional Hospital operates the only clinic in Quartzsite, and that this clinic serves winter visitors who are largely Medicare enrollees and provides year-round services to the local population. Quartzsite residents usually come to La Paz Regional Hospital for hospital services. Ms. Clark addressed the continuing challenge of attracting doctors to the area. She emphasized the need for additional rural medical resident programs and noted that these programs often impact physician decisions to remain in the area. She pointed to the need to reinstate the funding that is being withheld by the state for rural residencies. Ms. Clark added that the medical malpractice issue has been another challenge, but that they were able to get some modifications regarding lawsuits around emergency room care.

Dr. Schoeneman directed a question to Galen Updike regarding the state telecommunications infrastructure map he discussed. She asked about the accessibility for Tribal nations in the state, in particular the Parker area. She added that the senior center used Hughes Net Internet service, and that it takes six days to get a message from her manager and it is not a very effective email system. She added that CRIC invested \$30,000 on an electronic medical record system, and needs additional opportunities to increase broadband capacity. Mr. Updike responded that their plan is to help CRIT get a grant in this next period. He indicated that he and Roz Boxer visited CRIT to establish relationships and gain understanding about what the needs are. He advised that the best way to handle the problem is a wireless system, and noted that they are currently examining different alternatives such as wired, copper, broadband, and fiber. He indicated he would like to talk further with CRIT about their participation in a federal broadband grant that is being submitted. Dr. Schoeneman noted that they could not get a T1 line installed, to which Mr. Updike indicated there is no T1 in the area, nor is it scheduled in the regulated area. He added that there is no T-1 schedule pricing for the area. He advised Dr. Schoeneman that he was willing to help them offline. The two discussants exchanged contact information and agreed to generate further contact.

Dr. Hart next commented that, relevant to what was said about the residencies in rural areas, Dr. Ed Paul is building a residency program in Yuma. He noted that the Rural Health Office will do a feasibility study on the efficacy of that plan. He emphasized the importance of strategically planning to provide additional services, as when the infrastructure is expanded, someone must be available to provide the care.

Jeanie Morgan of Havasu Community Health Foundation

Ms. Morgan described the purpose of the Havasu Community Health Foundation as supporting prevention and detection activities that promote wellness in the Lake Havasu area. The Foundation conducts fund raising activities to support medical testing for basic health screenings like Complete Blood Count (CBC), Complete Metabolic Panel (CMP), Vitamin D deficiency, urinalyses. The local Cancer Association, functioning under the foundation umbrella, provides free prostate cancer screenings for men, CA 125s related to ovarian cancer

screenings for women, and also makes mammograms available for a \$10 fee. The Foundation does not provide medical care directly. Rather, contracts are completed with the local hospital and local laboratories to provide the services. They, in turn, bill the Foundation for reimbursement. No federal funds are sought for this community service.

Ms. Morgan emphasized that many single-income households have very high insurance deductibles, and that these services are beneficial when people are in need of extra assistance.

Ms. Morgan also addressed the relationship of insufficient funding for the area schools to physician recruitment. She advised that it is important that the state return to the “whole school funding formula.” She felt that it will harm taxpayers if we have to ask them to support additional funding. She sees disparity in state education funding distribution to rural schools, and noted that lack of adequate funding means insufficient teachers. Physicians being recruited to the area look to the strengths and weaknesses of the local education system as they determine what communities best meet their children’s educational needs.

Sen. Aguirre addressed the co-payment of insurance premiums. She indicated that in Yuma County many families go to Mexico to get primary care. She added that the infrastructure is not adequate and that is why Rural Metro sees people crossing the border for high diagnostic services and treatment. She asked Ms. Morgan if they provide services at a pro-rated or discounted rate. Ms. Morgan responded that they had to increase blood screening charges to cover costs.

Sen. Aguirre spoke about forming discount services for healthcare with providers and families that are willing to pay cash for the services provided at a discounted rate. She recalled a challenge her office faced when proposing that doctors provide discounted services, and empathized with the situation faced by the Foundation. She referred to a health network that she established as part of the rural health clinic she operates, and indicated that the doctors wanted to participate because they could receive cash “up front” and expect less paper work. The network offers discount services which has resulted in an overall cost decrease of 50 to 60 per cent. She added that many uninsured working families in Yuma County are using this network.

Jackie Leatherman, Resident, Lake Havasu City

Ms. Leatherman rose to describe her personal experience in obtaining health care in the Lake Havasu area, but before doing so expressed concern that she did not wish to overstep any professional ethics by doing so. She noted the need for a single agency to be established where women can go for information about health care availability, health insurance eligibility and general help when they face dire circumstances like the one she experienced.

Ms. Leatherman described the situation in which she found herself when she moved to the area in September [2009]. Health care insurance was not available to her, and shortly after her move she discovered that she was pregnant. She approached the Care Center but was told she needed to wait one month to receive a health check due to some recent medical history. She

was advised to contact local physicians but found she would need to pay \$250 in full, and she did not have the money. She was also advised to seek care through the emergency room, where she was assigned a MD following pregnancy confirmation. She added, however, that her existing medical symptoms prevented the medical staff at this facility from providing care. She also sought care in the Bullhead City area and other areas in the region. She was referred to the Arizona Department of Economic Security (DES) to apply for assistance, but learned that she was not eligible.

Ms. Leatherman emphasized the importance of the availability of an agency that can help women who face problems such as those that she experienced. She is committed to helping to establish such a center.

Marcia Cox, Physicians Weight Management Center, Lake Havasu City

Ms. Cox addressed the issues of obesity and disease. She lauded the sponsors for holding this Assembly in the area, and spoke to the importance of partnerships to resolve challenges. She explained that the Physicians Weight Management Center opened in January [2009] for the specific purpose of treating bariatric patients.

She noted that 60% of the U.S. population is obese, and between 2007 and 2008, Arizona saw a slight reduction from 26.4 to 25.9 percent. She noted that in Mohave County 184,000 people are in the 60% criteria and that she has many patients to take care of. She also explained that Medicare and AHCCCS recognize and cover some bariatric surgery interventions. She explained that non-surgical medical intervention practices have very good results.

Mr. Cox addressed the issue of caring for DM [diabetes mellitus] patients. She noted that in 2007, 53% of the adult population between ages 18 and 74 was obese, and indicated there is a correlation between DM and obesity. She recommended that if federal health insurance programs provided better reimbursement obesity could be resolved and the dollars then used for other medical needs. Her company is not recognized by the federal insurance programs for its obesity control services. They promote exercise, education and DM management. She asked for assistance in being recognized as a legitimate treatment alternative that prevents the patient getting to the state of needing surgical or medical intervention.

Senator Aguirre noted that she will look into this issue. She cited the importance of making the case that education and prevention reduces the cost of health care. She also emphasized the importance of comparing the cost of providing care for DM and obese patients with the cost of prevention programs. She added that AHCCCS is spending \$200 million annually for treatment of diabetic patients.

Dr. Craig Diehl, MD, Lake Havasu Pediatrics, Lake Havasu City

Dr. Craig Diehl addressed the lack of pediatric health facilities in Lake Havasu. He indicated that he has practiced pediatric care in the community for 23 years, and has had a working relationship with the area hospital for 21 years. He noted the need for legislation that allows for pediatric services in the hospital and equips it appropriately.

Dr. Diehl indicated that pediatrics care does not make money for the hospital, and that over that past two years, the privately run hospital does not permit pediatric admissions except for 24-hour observation. He noted that

the majority of his respiratory patients cannot be put in the hospital. He added that a majority of the kids are AHCCCS eligible and are airlifted to Las Vegas for care. He further said that recently they got access to road transportation that is enabling transfers to Kingman. Dr.

Diehl expressed feeling helpless when he has to tell parents he cannot put their kids in the local hospital when they need to go.

Dr. Diehl added that the hospital told him they are working on this issue, but he is hopeful the state legislature can do something about it. He pointed to the need for rural physicians that has been discussed in the Assembly, and indicated that it is very difficult for him to practice in the area³.

An unnamed audience member called out that Valley View Hospital is opening a pediatric department.⁴

Representative McLain noted that there is no legislation that prevents pediatrics from being provided by a hospital.

Blaine Bandi, Executive Director, Arizona Health Facilities Authority

Mr. Blaine Bandi addressed the issue of rural health facilities and the resources available through the Arizona Health Facilities Authority (AHFA). He indicated that his agency has been



Photos by Alison Hughes

Dr. Craig Diehl spoke about the absence of pediatric hospital care in the Lake Havasu area.

³ Since the date of the Rural Health Assembly, a new CEO was appointed to head Lake Havasu Regional Medical Center. Sandra Podley, CEO, indicated in a telephone conversation with Alison Hughes, Assembly Coordinator, that their Prenatal Committee is currently examining the possibility of offering pediatric services at the hospital.

⁴ Valley View Medical Center opened in November 2005 in Ft. Mohave South of Bullhead City, Arizona. This hospital plans to open six pediatric beds in the fall, 2010. Lake Havasu Regional Medical Center and Valley View Medical Center are both owned by Life Point Hospitals, Inc., of Brentwood, Tennessee.

directing more resources into rural Arizona through private investor sources and not state funds. He indicated that he attended this Assembly to get a sense of what the community needs are. He expressed frustration over the extent of the need for health care and the lack of resources to meet the needs. But he also said he was inspired by listening to the remarks made at the Assembly.

Mr. Bandi explained that AHFA provided financing for the hospital in Kingman, and for the first and only dental school in Arizona. They have provided funding support for the rural health conference, and provided many grants and loans to community health centers in the state. AHFA was one of the first organizations to provide grants to provide primary care services in rural parts of the state. They have also worked with Indian tribes and provided the first financing of Tuba City Hospital located on a reservation.

Mr. Bandi concluded that while there is much satisfaction with the support they have been able to provide, he recognizes it is not enough. He offered assistance to the area, and emphasized that assistance does not always mean money. It includes information and technical assistance.

Alison Hughes introduced the four written statements submitted. She gave an overview of the presentations which are presented in full on the following pages.

THE FOLLOWING PRESENTATIONS WERE SUBMITTED IN WRITING AS THEIR AUTHORS WERE UNABLE TO ATTEND THE ASSEMBLY.

Ronald S. Weinstein, M.D., Director, Arizona Telemedicine Program

Telemedicine is the use of telecommunications technology to provide training for healthcare providers and specialist consults to providers and patients who are located in areas that do not have that level of service available. Arizona has one of the largest state-wide telemedicine programs in the United States. The Arizona Telemedicine Program operates its own telecommunication network, has provided the infrastructure for over 1,000,000 telemedicine cases, and has evolved into a major distance education program. Lake Havasu City has participated in several programs, especially in the area of telepathology. Over 1,000 patients at Lake Havasu City have received high quality, subspecialty laboratory services through the use of robotic telepathology. That's right, pathologists at the University of Arizona in Tucson could control a motorized light microscope here in Lake Havasu City and other communities in Western Arizona, view video images of pathology slides, and rendered second opinions on the cases of over 1,000 patients from the Lake Havasu City area.

With this innovation, instead of having a single general pathologist diagnosing all of the biopsies for cancer and other disease in Lake Havasu City, the people in Lake Havasu City now had access to 10 subspecialty pathologists, on a regular basis. Undoubtedly, this improved health care services in this community, over the past five years.

What were the origins of the Arizona Telemedicine Program. In 1995, Arizona State Representative Robert "Bob" Burns (now Senate President Burns) worked with legislative

staffer John Lee to develop the Arizona Telemedicine Program model (ATP). In 1996, the Legislature of the State of Arizona funded Telemedicine and mandated that it provide telemedicine services to a broad range of healthcare service users including geographically isolated communities, Indian tribes, and Department of Corrections rural prisons. Leveraging the state startup funds, the Arizona Telemedicine Program succeeded in obtaining additional funding and support from many healthcare systems, state agencies, federal grant programs, and third party payers.

The University Of Arizona College Of Medicine was directed to establish a pilot telemedicine program with eight sites to serve the Arizona prison system and rural underserved communities. The U of A recruited Dr. Ronald S. Weinstein, an international expert on telemedicine, to be director of the new Arizona state-wide program. Senator Burns and Dr. Weinstein have partnered in developing and managing the Arizona Telemedicine Program since its inception, 14 years ago.

The original eight-site program began in July 1996, and has been augmented by federal grants from the Departments of Agriculture, Commerce, and Health and Human Services. Multi-specialty sites now include Douglas, Ganado, Nogales, Patagonia, Payson, Springerville, St. Johns, Tuba City, Whiteriver, as well as Department of Corrections sites in Buckeye, Douglas, Florence (2), Safford, Tucson-St. Mary's Hospital, Yuma and Phoenix. In addition to telepathology in Lake Havasu, which ended last month, the program has also supported telepathology sites in Cottonwood and Kingman.

In 1999, connections were added to the Flagstaff Medical Center and to the Northern Arizona Behavioral Health Authority (NARBHA). Through the NARBHA network, behavioral health sites in Bullhead City, Cottonwood, Holbrook, Kingman, Lake Havasu City, Page, Prescott, Show Low, Springerville, St. Johns, Winslow and the Arizona State Hospital (ASH) in Phoenix can participate in Arizona Telemedicine Program activities.

Today, the Arizona Telemedicine Program is a large, multidisciplinary, university-based program that provides telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout Arizona, the sixth largest state in the United States, in square miles. The program has succeeded in creating partnerships among a wide variety of not-for-profit and profit healthcare organizations, and has created new interagency relationships within the state government. Functioning as a "virtual corporation," the Arizona Telemedicine Program is creating new paradigms for healthcare delivery over the information superhighway. The program is recognized as one of the premier programs at the University of Arizona College of Medicine, and has received numerous awards at the national level for its research and innovations.

The Arizona Telemedicine Program has been highly successful in the planning and implementation of a unique horizontally integrated healthcare telecommunications infrastructure (serving 160 sites in 71 communities, and many healthcare organizations in the public and private sectors), in delivering over 200,000 teleconsultations per year over the network, in developing telemedicine training programs for national and international

participants, in using telemedicine for distance learning, and in exploring the efficacy of specific telehealth applications such as tele-colposcopy and telepathology.

This October the Arizona Telemedicine Program hit another milestone with their 1,000,000th teleconsultation encounter, including tens of thousands of teleradiology cases. 25 hospitals, mostly in Arizona receive teleradiology services, on line, 24/7, from radiologists at the University of Arizona. This has improved the standard of care in many rural communities. The completion of the millionth telemedicine cases was announced at the dedication ceremony of the Arizona Telemedicine Program's T-Health Institute in Phoenix, to a crowd of 200, which included the University of Arizona President Robert Shelton, Senate President Burns and national experts on telemedicine and inter professional education.

Currently the Arizona Telemedicine Program is providing medical services to over 55 healthcare organizations both in rural and urban communities. In addition, the ATP has provided over 15,000 hours of continuing medical education and continuing education to its communities using bi-direction video conferencing. In addition, the Arizona Telemedicine Program is doing research in areas of technology assessment and cost-benefit analyses of telemedicine. The program also operates a telemedicine training center which offers instruction in telemedicine procedures to healthcare professionals throughout the state.

To date, the Arizona Telemedicine Program has received 10 national awards for excellence in innovation, clinical research, and clinical services. From the perspective of the Director of the program, what has been achieved by the Arizona Telemedicine Program to date could actually represent the early phases of a growth curve, now that many large companies are getting into the telemedicine business.

Mr. Terry Mullins, Chief, Arizona Department of Health Services (ADH)S Bureau of EMS and Trauma System and Ben Bobrow, M.D., Medical Director, ADHS, Bureau of EMS and Trauma System

Ben and I would like to draw attention to the following challenges and opportunities that are common to all emergency care providers in rural Arizona. Each is relevant to Western Arizona.

Access to Care: Timely access to critical injury and illness care: Patients suffering from illness or injury that are time sensitive in nature (trauma, heart attack, stroke and cardiac arrest) benefit from specific interventions and tests. In rural areas of Arizona it takes longer for ambulances to get to patients and it takes longer to transport patients to hospitals. Therefore, a major challenge is to ensure that EMS providers have the training, skills and equipment necessary to care for patients with time sensitive illnesses. It is also necessary for rural hospitals to be capable of training their staff to recognize, treat and in some cases transfer patients to specialized centers.

Electronic Patient Records: Rural health care providers, whether they are hospitals, ambulance services or clinics are especially dependent on being able to recover costs from insurance providers. Currently, electronic health record charting is cost prohibitive in facilities and

services that have low customer volume. As CMS moves forward with quality based reimbursement, these services and agencies will be at an added disadvantage if they are unable to utilize electronic patient records. As the State of Arizona defines its electronic health record technology goals, special consideration should be given to the needs of rural Arizona.

Quality Improvement: the provision of emergency medical care has historically been performed without a scientific basis for its efficacy. Over the past 5 years this has changed substantially as clinical scientist have begun to evaluate the outcomes of patients suffering from illness and injury. It is now clear that EMS makes a real impact, both in terms of improving outcomes and in reducing the financial impact of disease. Arizona has stepped to the forefront and has instituted a number of quality improvement measures. In order to continue to improve the quality of care provided to the citizens of Arizona it will be necessary that electronic patient care reporting is available in every ambulance service and rural hospital.

Telemedicine: The utilization of telemedicine technologies in rural Arizona has not yet met its full potential. Broad adoption of this technology would benefit rural hospitals and patients by helping to identify patients that could be cared for locally. This reduces the costs of care, the burden on the patient and family and allows local facilities to extend their capabilities without significant costs. The benefit of having expert consultation capability at the bedside in a rural area, if broadly adopted, would have significant positive impacts in rural Arizona.

Thank you again for this opportunity to share these challenges and opportunities facing rural Arizona with your group of experts.

Respectfully,

Terry Mullins, Chief

ADHS, Bureau of EMS and Trauma System

Ben Bobrow, Medical Director

ADHS, Bureau of EMS and Trauma System

Tom Betlach, Director, Arizona Health Care Cost Containment System (AHCCCS)

Access to medical care in Arizona's rural communities presents unique challenges. The current economic situation has made access to care a chief concern. Some of the challenges that Arizona faces with respect to the AHCCCS program are described below.

State Budget Crisis: Arizona has been greatly impacted by the current recession. State General Fund revenues continue to decline. The State's budget deficit for FY 2010 is currently \$1.5 billion, while the deficit for FY 2011 is expected to be over \$3 billion. One of the most pressing issues is the State's structural shortfall – the State's revenues are just about \$6.4 billion, while General Fund spending is near \$10 billion. Costs for the AHCCCS program alone are nearing 20% of the General Fund and AHCCCS will require over \$600 million additional dollars to support the increased caseload growth for FY 2011 and the elimination of federal stimulus funds.

Through its efforts to balance the budget, the legislature has made numerous reductions in the AHCCCS budget, with the biggest of those being in the area of provider reimbursement. In

Medicaid, there are essentially three areas to which reductions can be made – eligibility, benefits and provider reimbursement. Because of federal maintenance of effort requirements under the American Recovery and Reinvestment Act (ARRA), states are not able to make any reductions to eligibility as a condition of receiving stimulus dollars in the Medicaid program. With regards to benefits, the AHCCCS administration worked with a group of experts to review the benefits package for adults. Though recommendations were made to the legislature, no real cuts in benefits were enacted. Thus, the primary area through which the legislature has made reductions in the AHCCCS budget has been through reducing provider reimbursement.

In 2009, the legislature mandated a five percent across the board reimbursement rate reductions to providers, except hospitals and nursing facilities. Hospital rates were frozen for the second consecutive year and nursing rates were also frozen. The AHCCCS administration also experienced administrative reductions of almost 20% in staff and resources. AHCCCS contracted health plans have also taken administrative reductions. In total, the AHCCCS program is \$644 million smaller today as a result of policy actions taken to address the ongoing budget crisis.

These reductions have placed a strain on the system. Traditionally, AHCCCS has enjoyed the reputation of being one of the best payers among Medicaid programs in the country, many of its professional rates keeping pace with Medicare. Even if policy makers pursue additional revenue generation, more reductions can be expected. Other states that have cut deeply into provider reimbursement levels have seen providers elect to end their participation in the Medicaid program or be involved in lengthy expensive litigation. AHCCCS is monitoring this issue and the impact to access to care, which is of particular concern for our rural members.

Increased AHCCCS Enrollment: Because Medicaid is a counter-cyclical program, enrollment has increased in step with rising unemployment rates. In June of 2007, Arizona's unemployment rate was 3.6%, compared to 9.3% today. During the same time period, AHCCCS has added more than 300,000 new members – a growth of nearly 30%.

This enrollment growth comes at a time when the State is looking to make reductions in spending in light of declining state revenues. This pressure, coupled with federal stimulus maintenance of effort requirements, has led policymakers to scale back other state-funded programs, including the areas of education, public health and safety.

The increased enrollment also places a burden on the AHCCCS managed care plans and their provider networks to provide services to a growing number of Arizonans while they both find ways to absorb funding reductions. As these tensions persist, it may be easier for AHCCCS health plans in urban areas to absorb these new enrollees because they can access a larger network of providers to meet the increased demands. In rural communities, however, AHCCCS plans are competing for the same limited number of providers as other payers in those communities. These challenges make it potentially more difficult for our plans to contract with sufficient numbers of providers to meet the increasing demands for services. Attracting additional providers in those areas often results in increased costs. Those, in turn, result in

increased costs to the AHCCCS program and the State, costs the State can ill-afford in this economy.

Federal Health Care Reform: While states like Arizona do not have the resources to pay for the current Medicaid program, lawmakers in Washington are debating federal health care reform, which currently includes a mandated Medicaid expansion. The House proposal would expand Medicaid to 150% of the federal poverty level (FPL) while the Senate version would expand Medicaid to 133% of the FPL. Both proposals include a maintenance of effort requirement, severely restricting state flexibility, which will also impact states' ability to contain costs in the program. For instance, the State of Arizona currently pays approximately \$3 billion in costs for optional Medicaid eligibility categories. (The vast majority of these eligibility categories are currently voter protected through the Proposition 204 expansion). This \$3 billion in optional eligibility coverage will now be a federally mandated funding requirement, making Medicaid an all or nothing proposition.

The House bill acknowledges the fiscal realities many states are facing and provides for increased federal financial participation for this expansion as well as the woodwork effect, which is individuals currently eligible but not enrolled that would be added as a result of the individual mandate. The House bill also offers increased federal match to cover childless adults for early expansion states like Arizona. Under the House bill, the State would save nearly \$7 billion through 2020. However, in its efforts to contain the overall cost of health care reform, the Senate proposal requires states to take on more of the cost of the mandated expansion. The Senate proposal would only provide Arizona enhanced federal match for those individuals between 100% to 133% FPL who are not otherwise currently eligible. This approach requires states that expanded coverage to the Medicaid program to subsidize the cost to those states that did not expand coverage. The Senate's proposal would cost the State of Arizona an estimated \$4 billion more through 2020.

We continue to track the progress of reform efforts and its impact to Arizona. More detailed information on the current proposals can be found on our website at www.azahcccs.gov. Regardless of which approach is taken and its cost to the state, federal health care reform, if enacted, could result in significant demands for new services by previously uninsured individuals. In areas with relative health care shortages, such as the State's rural areas, these new demands may overwhelm the current health care infrastructure, making it even more difficult for those currently insured through private insurance or AHCCCS to obtain health care services in a timely manner.

Manpower Shortage: Several studies have shown that Arizona, in general, lacks sufficient medical professionals to meet its current needs. Even when non-physician providers, such as nurse practitioners and physician assistants, are included, Arizona has a shortage of medical professionals. This shortage is more pronounced in rural communities. Although Arizona has successfully attracted new providers to the State over the last decade, those increases have not kept pace with our growing population. The gap between our needs and our provider community continues to widen. This provider-gap is more pronounced in our rural communities.

This is not just a problem for AHCCCS members, but for all Arizonans. Spikes in acute illnesses, such as those seen during flu season, exacerbate access problems. The inability to be seen in an office within a few days often drives individuals needing more immediate care to local hospital Emergency Departments as an alternative for their medical needs. Use of Emergency Departments for non-emergency care increases the pressures on the health care system as well as its over-all costs.

Unfortunately there are few short-term fixes for this manpower shortage. Over time the State may be able to attract sufficient numbers of providers, but those solutions cannot be achieved for a number of years and may require increased resources from the State.

Efforts have been made over the past few years to expand Graduate Medical Education funding through the AHCCCS program. Funding has grown from roughly \$20 million in FY 2006 to over \$80 million in FY 2009. This has been a great opportunity to hospitals to develop and expand new programs. However given the budget crisis noted earlier any reductions to programs like Graduate Medicaid Education supported through AHCCCS will only exacerbate that problem.

Conclusion: In short, the challenges to our existing health care system are serious. The reduction of Medicaid dollars that help support the basic infrastructure of the health care delivery system upon which we all rely will have serious effects that may be more pronounced in rural communities. It is necessary to consider the needs of rural communities when planning for future changes to health care and to acknowledge that in many cases a “one size fits all” approach will not solve these problems.

I apologize that I am not able to be with you today but I do want to wish everyone Happy Holidays.

Alice Garcia, Resident, Lake Havasu City

Ms. Garcia wrote a letter indicating her concerns over the lack of a pediatric or children’s unit at Havasu Regional Medical Center. “This is a city of over 50,000 people and a lot of children. I have heard of numerous cases where the sick child has to be “airvac’d” to Vegas or Phoenix for lack of a facility to care for the child here. Our hospital here was able to open up a cardiac unit. Why not a pediatric unit? Maybe you would be able to push the hospital here to consider seriously this growing problem.”

Appendix A: Facts and Resources

The following information was copied from national resources and represents some of the current national conditions related to rural health care.

WHAT IS RURAL AND WHY IS THIS IMPORTANT?

Federal and state definitions of rurality impact funding eligibility, therefore they are very important at the local level. There is more than one definition of rural. Federal and state guidelines often use different versions. There are two principal definitions of rurality used for federal health care policy:

The Census Bureau bases its definition on a combination of population density, relationship to cities, and population size.⁵

The Office of Management and Budget (OMB) classifies counties on the basis of their population size and integration with large cities.¹

Other examples of rural definitions follow:

Rural Urban Commuting Areas (RUCAs), by ZIP code and Census tract⁶

Core Based Statistical Areas²

Rural Urban Continuum Codes (RUCC)²

Federal Communications Commission (FCC)²

Urban Influence Codes (UICs)²

Goldsmith modifications to the Operational Definition of "Rural Areas" for Federal Programs²

HPSA (Health Professions Shortage Areas) - These cover medicine, dentistry and mental health providers.⁷

MUP (Medically Underserved Population)³

MUA (Medically Underserved Area)³

⁵ Definitions of Rural: A Handbook for Health Policy Makers and Researchers - Thomas C. Ricketts, Ph.D., Karen D. Johnson-Webb, M.A., Patricia Taylor, Ph.D. June 1, 1998

⁶ <http://www.raconline.org>

⁷ <http://bhpr.hrsa.gov/shortage/muaguide.htm>

RURAL HEALTH WORKFORCE

For at least a decade, the United States has experienced worsening workforce shortages in the health professions. Analysts now are projecting a nationwide shortage of almost 100,000 physicians, as many as one million nurses, and 250,000 public health professionals by 2020.⁸

Rural healthcare workforce shortage include but are not limited to primary care physicians, nurse practitioners, licensed practical nurses, physician assistants, dentists, registered nurses, certified nursing assistants, home care aides, lab technicians, pharmacists, optometrists, chiropractors, allied health personnel, public health personnel, and radiology technicians.⁹

Health care workforce shortage problems are prominent in rural areas due to several reasons. These include: An aging workforce population; high retirement eligibility; difficulty in retention of workers; difficulty in recruitment of workers; lack of educational and training opportunities; high vacancy rates; high turnover rates; lack of opportunities for career advancement; financial concerns including lower pay as well as lack of benefits; and/or increased work load demand.¹⁰

20 percent of the nation lives in rural areas spreading on approximately 80 percent of the land and only 9 percent of country's physicians are rural.⁶

Salaries, lack of full-time positions for nurses, and a competitive job market are barriers to both recruitment and retention. Rural administrators also reported the local economy and unmet family needs as barriers.¹¹

HEALTH CARE INFRASTRUCTURE

The health care infrastructure in much of rural America is a web of small hospitals, clinics and nursing homes (frequently attached to the hospitals) often experiencing significant financial stress.¹²

Telepharmacy in rural hospitals is a solution to bring pharmacy expertise in order to increase medications safety when there is a lack of pharmacy services in rural hospitals.⁸

Less than 10 percent of emergency department of rural hospitals are equipped to handle pediatrics emergencies, this results in poorer pediatric health care by rural physicians versus urban physicians.¹³

⁸ <http://bhpr.hrsa.gov/healthworkforce/>

⁹ http://www.raconline.org/info_guides/hc_providers/workforcefaq.php#face

¹⁰ http://www.raconline.org/info_guides/hc_providers/workforcefaq.php#face

¹¹ Online Journal of Rural Nursing and Health Care, vol. 1, no. 1, Spring 2000

¹² http://ask.hrsa.gov/detail_materials.cfm?ProdID=4294

¹³ <http://www.ahrq.gov/research/apr09/0409RA18.htm>

Adoption of health information technology is slow in rural areas. 95 percent of critical access hospitals computerize their administrative and billing functions, but only 21 percent use electronics health records forms.¹⁴

Broadband and high-level telecommunications technology coverage in rural areas is a significant barrier. Without a national commitment to provide accessible and affordable broadband and high-level telecommunications technology in all rural areas, rural use of health information technology will likely remain limited.¹⁰

Lack of effective Rural Emergency Medical Services due to inadequate communications infrastructure that make many EMS providers often isolated from the rest of the health care delivery system.¹⁰

ACCESS TO HEALTH CARE

Rural residents are more likely than urban residents to have a usual source of health care (USC), particularly the rural versus urban uninsured.¹⁵

Rural residents are somewhat more likely to report long travel times to reach their USC and have greater difficulty getting care after hours.¹¹

While rural access to care is not uniformly worse than urban access, the burden on rural providers in delivering this care may be high, especially since rural physicians are twice as likely to work in solo practices.¹⁶

Rural hospitals show a greater shift toward outpatient services, and greater declines in admissions and lengths of stay than urban hospitals. Economic pressures have driven rural hospitals to shift rapidly to outpatient care.¹⁷

DISEASE PREVENTION/HEALTH PROMOTION

Many families in rural areas pay out-of-pocket for health care, leading them to postpone or forego preventive health care.¹⁸

Alcohol is the first substance abused in rural health. Youths living in rural areas are more likely to engage in binge drinking than their urban counterparts.¹⁹

¹⁴ “The Top 10 Rural Issues for Health Care Reform” - Jon M. Bailey, Center for Rural Affairs No. 2 · March 2009

¹⁵ Rural-Urban Differences in Health Care Access Vary Across Measures - Maine Rural Health Research Center – June 2009

¹⁶ <http://www.ahrq.gov/research/rural.htm>

¹⁷ <http://www.ahrq.gov/research/ruraldisp/ruraldispar.htm>

¹⁸ Wealth Building in Rural America: Programs, Policies, CSD Draft Report- 2006

Suicide is the second leading cause of death in states with primarily rural populations, especially states in the rural mountain west and Alaska. Adolescent males in rural areas have higher suicide rates than their urban counterparts.²⁰

Rural residents generally fare worse than their urban counterparts in regards to obesity, which is opposite to the situation that existed prior to 1980. Rural residents are older, less educated and poorer than urban residents. All of these demographics increase the risk for obesity.¹⁰

Research has shown that for rural patients in need of mental health care, general medical care only is significantly more likely and specialty mental health care is significantly less likely to be given.¹⁰

From leaders, providers, and case managers of chronic disease management programs interviewed, 95 percent responded that diabetes disease management was important to patient health care, while 88 percent regard Child Health and family Disease Management as important to patient care; Other disease management programs rated highly important to patient care were COPD (73percent), Asthma (70percent), and depression (55percent).

Prevalence of diabetes is higher in rural areas (3.6 percent compared to 3.2 percent), and overall rates of diabetes are higher in the Southeast and Southwest and among migrant farm workers

Heart disease, cerebrovascular disease and hypertension are more prevalent in rural areas (heart disease and stroke affect 4.9 million individuals in the U.S).²¹

Rural adults were less likely to have had a dental visit in the past year than were urban adults (58.3 vs. 65.8 percent, respectively).¹⁵

¹⁹ <http://ruralcommittee.hrsa.gov/NAC07Report.htm>

²⁰ National Children's Center for Rural and Agricultural Health and Safety / Rural Suicide Prevention

²¹ Rural Health Research Center - Policy Brief: Chronic Disease Management in Rural Areas - May 2004