

# ARIZONA RURAL HEALTH OFFICE



Photo by Alison M. Hughes

## Cochise County Rural Health Policy Assembly

Bisbee, Arizona | July 19, 2010

What We Learned and What We Recommend

## Contents

Introduction .....	3
Meeting Attendance .....	3
Issues Raised .....	5
Recommendations .....	6
Presentations .....	7
<i>Work Force Issues</i> .....	7
<i>Access to Care</i> .....	11
<i>Health Information Technology</i> .....	18
Presentations Submitted in Written Form .....	20
Assembly Call for Public Comment .....	23
Appendix A: Telemedicine Reimbursement .....	25

## Introduction

The Assembly was sponsored by the Rural Health Office, the Arizona Rural Health Association, the Cochise County Health Department, Copper Queen Community Hospital, and Southeast Arizona Area Health Education Center. The Assembly focused on three issue areas: (1) health care, (2) access to health information technology, and (3) health care workforce. About 75 people attended the meeting, which is the second State Rural Health Policy Assembly; the first Assembly was held in December 2009 in Lake Havasu City. For this meeting, presenters made formal presentations to the conveners, which were followed by questions from the audience. A call to the audience was announced following the formal presentations to allow audience members to address the panel. Eight presenters made formal presentations, and three presenters submitted written presentations. Four members of the public made a public comment to the panel. All presentations and public comments were recorded for submission into the public record.

This report presents a formal summary of the presentations, audience questions, and public comments. It discusses issues that were raised by presenters and members of the public, as well as recommendations by the Rural Health Office and the Arizona Rural Health Association based on the content of the presentations.

## Meeting Attendance

### Presiding

- State Senator Manuel V. Alvarez (District 25)
- State Representative Patricia Fleming (District 25)
- State Representative David W. Stevens (District 25)
- Supervisor Ann English (District 2 Cochise County)
- James Dickson, President-elect, Arizona Rural Health Association, and CEO, Copper Queen Community Hospital, Bisbee
- Alison Hughes, Rural Health Office, Mel and Enid Zuckerman College of Public Health, and board member, Arizona Rural Health Association

### Rural Health Office

- Joyce Hospodar, Rural Health Office Flex Program Coordinator Senior, Assembly facilitator
- Oscar Parra, Rural Health Office Administrative Associate
- Abraham Ater, MPH Student, Assistant Recorder
- Elizabeth F. Costello, MPH Student, Assistant Recorder, and report preparation

**Planning Committee Members**

- Rural Health Office staff members
- Cynthia Aragon, Legislative Staff, Arizona State Legislature
- Vaira Harik, Director, Cochise County Health Department
- Suzanne Davis, Coordinator, Southeast Arizona Health Education Center
- James Dickson, President-Elect, Arizona Rural Health Association, and CEO, Copper Queen Community Hospital

**Presenters—By order of presentation**

- **Joseph A. Tabor**, Ph.D., Assistant Professor of Public Health: The status of the health care workforce in Cochise County
- **Brian Bickel**, CEO, Southeast Arizona Medical Center
- **Julie King**, HR Director, Chiricahua Community Health Center: Healthcare workforce recruitment challenges at the border
- **Mike Albertson**, Partner, Health Solutions and Market Intelligence: Rural health implications of the proposed new federal definitions of “Health Professions Shortage Areas and Medically Underserved Areas”
- **James Dickson**, CEO, Copper Queen Community Hospital: The Status of Telemedicine in Arizona
- **Robert Sorce**, Assistant Director, Division of Behavioral Health Services, Arizona Department of Health Services: The Status of Behavioral Health in Cochise County
- **Jerrod D. Long**, DDS, Private Practice Dentist: Dental Health Challenges at the Community Level
- **Melissa Rutala**, Director, Regional Extension Center, Arizona Health-e Connection: What’s New In Electronic Health Record Implementation In Arizona
- **Galen Updike**, Manager, Communications Development, Government Information Technology Agency: Broadband Implementation Plans for Cochise County
- **Terry Mullins**, Chief, ADHS Bureau of Emergency Medical Services (EMS) and Trauma System and **Ben Bobrow**, Medical Director, ADHS Bureau of EMS and Trauma System: EMS issues in rural Arizona
- **Ronald S. Weinstein**, M.D., Director, Arizona Telemedicine Program: Telemedicine Services in Rural Arizona

## Issues Raised

- *Physician spousal issues:* The employment and social needs of spouses of potential physician candidates are a limiting factor in physician recruitment strategies.
- *Physician recruitment issues:* Long rural commute times, lack of available housing, limited access to businesses and services, distance from major airport, education and recreation opportunities for family members, challenges in adjusting to close-knit small town culture, lack of professional and peer support.
- *Medical residence programs:* There are insufficient medical resident programs in rural Arizona.
- *Patient care challenges:* Some patients have high acuity of illness and low compliance due to lack of resources and insurance, while other patients may access medical care in Mexico and look for follow-up treatment in the US, leading to a lack of coordination in care.
- *Rural designation modifications:* The federal government is exploring the option of combining the formularies for Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA) into a single designation. There is concern that a new federal designation policy could result in loss of existing rural designation for some rural health clinics and hospitals resulting in serious fiscal penalties. There is also concern that the new designation process may permit new rules to be enacted without the normal federal request for comment period.
- *Telemedicine reimbursement:* AHCCCS and other Arizona major insurance companies do not reimburse for many telemedicine procedures currently in use. <sup>1</sup>
- *Reduction in State Behavioral Health Services:* (1) The State Division of Behavioral Health Services lost 50 percent of its funding in 2009 and must now determine how to deliver high-quality care with limited funding, (2) added to the funding reduction issue, is the challenge of providing behavioral health services to non-citizens who are ineligible for state-funded services, and (3) it was noted that by 2014 federal health reform regulations will increase the number of eligible behavioral health services to more people, with the state having to face the challenge of bridging this service gap.
- *Dental health patient education:* Many patients do not see the need for dental care as disease prevention.
- *Access to dental health services:* Underserved and low income families struggle to pay for dental care given the limited Medicaid reimbursement schedule.
- *Emergency Medical Services resource needs:* EMS providers face major challenges in ensuring that first responders have the training, skills, and equipment necessary to care for patients with time sensitive illnesses.
- *Rural hospital board challenges:* Rural hospital charitable boards struggle to support hospitals with a limited charitable base.

---

<sup>1</sup> See Appendix A for information on national and state policies regarding telemedicine reimbursement.

## Recommendations

- *Rural student access to medical schools.* Arizona’s medical colleges and colleges of allopathic and osteopathic medicine should recruit and admit more Arizona students with rural backgrounds for the purpose of increasing the state’s rural physician workforce.
- *Rural residencies:* Policy makers, hospital administrators, and medical school administrators should invest in more collaborative efforts to increase rural residency programs.
- The educational system needs to better prepare physicians to practice in rural areas – to work more as generalists and not specialists preparing to practice in major metropolitan hospitals.
- The Cochise College nursing program should revise its curriculum by including training units that specifically focus on nursing in a rural environment.
- State legislators should initiate support for federal and state reimbursement for real time as well as store-and-forward technologies for telemedicine consultations.
- The Arizona State Legislature should invest in the design of a behavioral health crisis care system that places a lesser burden on first-responders (police, fire, and hospital emergency room personnel).
- The Arizona State Legislature should adopt a telemedicine reimbursement policy that allows for increased access and quality of health care in rural Arizona.
- School districts should encourage the adoption of curricula which include dental education in grade schools for the purpose of sensitizing children about the relationship of dental care to overall health.
- The Centers for Medicaid and Medicare Services (CMS) should adopt policies that allow for oral health reimbursement rates that are more competitive and comprehensive.
- The U.S. Department of Health and Human Services should advocate to Congress for the creation of an HHS-administered sealant program that can be offered to grade schools.
- Work to make electronic patient care reporting available in every ambulance service and rural hospital to initiate quality improvements in emergency care.
- Broadband infrastructure should be treated as critical infrastructure in law and/or policy.
- *Primary care/behavioral health co-location services:* The Arizona Department of Health Services should promote expansion of primary care and behavioral health services through co-location, in order to make possible dual services to AHCCCS patients at a single location.

## Presentations

### *Work Force Issues*

#### **Joseph A. Tabor, Ph.D., Assistant Professor of Public Health, MEZCOPH, The University of Arizona: The status of the health care workforce in Cochise County**

Dr. Tabor provided health care workforce statistics for Cochise County. He noted that in Cochise, there are 147 active direct care physicians (MDs and DOs)<sup>2</sup>. Of those, 19 percent are DOs and 23 percent are female. There are 116 active direct care physicians per 100,000 people in the county, which is typical for a rural population in Arizona.

Dr. Tabor presented the following additional statistics on the current Cochise County health workforce, noting that he believed these numbers are average in relation to other similar populations.

- 83 physician specialists
- 10 OB/GYNs
- 7 psychiatrists
- 19 physician assistants

Dr. Tabor also commented on the following additional workforce numbers in the county:

- 49 nurse practitioners (slightly above average)
- No midwives practicing in 2007-2008
- 185 RNs
- 443 EMTs (above average)
- 42 dentists, 27 of those general (both above average)
- 29 dental hygienists (average)

While most of the data on healthcare workforce in Cochise County are average, according to Dr. Tabor, he questioned whether the numbers are sufficient to provide good care. He noted that more rural health workforce practitioners are needed to provide better care. Dr. Tabor also pointed out that 39 percent of rural Arizona's active direct patient primary care physicians were

---

<sup>2</sup> **MD--Allopathic medicine:** The system of medical practice which treats disease by the use of remedies which produce effects different from those produced by the disease under treatment. MDs practice allopathic medicine. Also called [conventional medicine](#).

**DO--Osteopathic medicine:** A system of medicine based on the theory that disturbances in the musculoskeletal system affect other bodily parts, causing many disorders that can be corrected by various manipulative techniques in conjunction with conventional medical, surgical, pharmacological, and other [therapeutic](#) procedures.

educated in Arizona compared to other states where 50 percent of their practicing physicians come from the state where they were educated. He added that 69 percent of all primary care physicians in Arizona were educated and served residencies in other states, and that physicians educated in Arizona are going elsewhere for their residencies.

Of the Arizona physicians educated elsewhere, many came from Illinois, Missouri, New York, and California. Forty-eight percent of the MDs and DO students that were educated in the state practice here in Arizona, and of those, 62 percent of the educated medical students here in Arizona went out of state for residency placements. Dr. Tabor says that this is problem, because if they do a residency elsewhere, they tend to stay elsewhere. Generally about three-quarters of the physicians stay in the state where they did their residency.

Dr. Tabor emphasized that Arizona is 22<sup>nd</sup> in the US in available rural primary care positions. Arizona's per-capita state spending in medical education for physicians ranked 42 out of 50. He added, however, that the new Phoenix campus for The University of Arizona College of Medicine recently enrolled 48 students.

Dr. Tabor also reported that ten percent of active direct patient care physicians in Arizona are doctors of osteopathic medicine. He noted that one of the osteopathic training colleges, Midwestern University, sends most of its graduating students out of state to complete their residency training.

Dr. Tabor emphasized the need for training more family medicine doctors in Arizona. He said that these schools should accept more students with rural backgrounds.

Dr. Tabor offered that the location of residency was the best predictor of where a physician will practice, regardless of where they went to medical school. Therefore, if the state wants more physicians, more in-state residency programs need to be supported. Accomplishing this will need collaboration by policy makers, hospital administrations, and university medical school administrations.<sup>3</sup>

### **Brian Bickel, CEO, Southeast Arizona Medical Center**

Mr. Bickel advised that while Douglas is situated at the U.S.-Mexico border, the issues that he sees in Arizona are the same as those he saw working in New Mexico, Illinois, Arkansas, West Virginia. These issues stem not from being at the border, but because Cochise County is *rural Arizona*. Mr. Bickel said it is difficult to convince people that rural America is a wonderful place to live, raise kids, and enjoy life.

---

<sup>3</sup> NB: Arizona has three medical schools. The University of Arizona College of Medicine, an allopathic medical school which is funded by the state legislature; A.T. Still University, a private college, and Midwestern University, both of which are privately funded schools of osteopathic medicine. The University of Arizona and Midwestern University offer residency programs. A.T. Still University has no residency program at this time. (On Page 7 see the definition for allopathic medicine and osteopathic medicine.)

Mr. Bickel said that when recruiting physicians, the most difficult aspect is finding employment for their spouses, especially if spouses are used to a more cosmopolitan quality of life. He pointed to a different quality of life in rural America, and emphasized that rurality does not make for worse quality. He said the people who live and work in rural Arizona do so because they do not want to live in the metropolitan areas of the state. He emphasized that the recruitment challenge is finding the small percentage of people who do prefer rural life.

Mr. Bickel is concerned about the lack of available rural practitioners, including primary care practitioners and specialists. He noted that today young general internists coming out of residencies expect to have sub-specialty support, but in a rural hospital, they are on their own. New physicians need to learn that they have got to be able to address issues in the same manner as physicians in metropolitan areas, but without the support network.

He said the same issue applies to nursing. Mr. Bickel says he has been advocating for the past 15 months with the people at the nursing program at Cochise College to develop a rural nursing educational program. He needs nurses that can respond to any situation or problem without assistance from a larger team. Mr. Bickel argued that the educational system needs to better prepare people to practice in a rural arena – to work more as a generalist and not as a specialist at a major metropolitan hospital. The challenges of a rural hospital are not better or worse, but they are different from those at a metropolitan hospital.

Mr. Bickel wants policy makers to understand that practicing rural medicine is different from practicing urban medicine. Physicians are expected to do it all, and some find it difficult to cope with that operating philosophy. The challenge is finding the physicians who can work in that environment.

### **Julie King, HR Director, Chiricahua Community Health Center: Healthcare workforce recruitment challenges at the border**

Ms. King spoke to some of the same challenge addressed by Mr. Bickel. She indicated that physician recruitment is one of the biggest issues facing Cochise County, especially in remote locations. She noted that commuting is a major issue, as well as a lack of available affordable housing in small communities. She explained that when she relocated to the area from Denver, she waited six months for an apartment, and would not have been able to accept the position had she not been able to stay with a friend. Ms. King said another issue is limited access to businesses and services. The closest shopping center is Wal-Mart or travel to Sierra Vista (1 hour drive away). She added that buying groceries, finding entertainment, and finding someone to assist in the repair and maintenance of your house and appliances is a challenge. There is no public transportation and the closest airport is a two hour drive to Tucson.

Ms. King said that family concerns are another issue for recruitment. The area has had some controversy around school administration. Families are looking for quality schools, parks and recreation, and activities to entertain their children. Employment for the spouse is another issue. Finally, she highlighted the issue of safety at the U.S.-Mexico border. She pointed to

border safety issues now receiving national exposure, and opined that the media is not presenting an accurate picture of everyday life in the area.

Ms. King also discussed the nursing program at Cochise College. She said the program is wonderful but has limited availability for enrollment. Some medical assistants have been waiting a year or more to get into the program. She predicts that most Cochise College nursing graduates will leave the area after graduation and commented that there is no teaching hospital to recruit new graduates from the UA Medical College.

Ms. King addressed the issue of culture. Some patients in the community are Spanish-speaking, but another cultural aspect is the small town lifestyle. Everyone knows everyone else and this situation is challenging for newcomers. Ms. King said the rural towns need to embrace newcomers and make them feel welcome.

Ms. King mentioned acuity of illness as a challenge. Some patients have high acuity levels and low compliance due to lack of resources, and a large uninsured population. She offered that there is a lack of adequate hospitals, specialists, and home-based services. Professional growth is challenging due to the lack of professional and peer support. She pointed to the issue of people accessing medical services in Mexico and looking for follow up treatment in the U.S. and the lack of coordination of care; Ms. King called for a resolution to this issue.

Ms. King highlighted several positive changes. The Health Resources and Services Administration and the National Health Service Corp recently announced additional funds to support the recruitment of physicians and clinicians in rural areas. The NHSC recently experienced a funding increase to support doctors, nurse practitioners, and physician assistants that come into our rural communities with support of up to \$150,000 for a commitment of 3 to 4 years. Another positive aspect is the dedicated professionals serving the community who are passionate about making a difference. Ms. King recognized the unique, quality programs that help attract quality candidates. This is the case with Chiricahua Community Health Center, the Pediatric Center of Excellence, and Mobile Services that together have helped attract national attention from the Children's Health Fund to enhance staffing in those programs.

### *Access to Care*

#### **Mike Albertson, Partner, Health Solutions and Market Intelligence: Rural health implications of the proposed new federal definitions of “Health Professions Shortage Areas and Medically Underserved Areas (MUAs)**

Mr. Albertson discussed Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). He said that the federal government created these designations in the 1970s to determine where the health care needs were in communities. A MUA is defined as a location within the community or within the geography (usually census tract or zip code) that had an increased percentage of epidemiological factors such as infant mortality, low birth weight, poverty, access to care. These communities lack health care resources and have a higher incidence of medical need.

Mr. Albertson said HPSAs are areas where people have limited access to care because there is a shortage of physicians, and that the classification is not dependent on poor health outcomes or mortality rates. People in health professional shortage areas may not be receiving care in their community and must travel long distances to access care. HPSAs and MUAs are determined by different methodologies.

Mr. Albertson noted that over the years, the government started to create different formulas for reimbursement and different programs (i.e., physician recruitment) based on those designations. He mentioned other programs, including visa waiver, student loan forgiveness, rural health clinics, and federally qualified health centers. Mr. Albertson said there are specific funds to help these communities.

Mr. Albertson said that a division of the government determines the designations (HRSA), and another (CMS) uses the designations to determine reimbursement methodologies for a community provider. In the 1980s and 1990s, the Health Resources and Services Administration, the entity that does the designations, said there should be one designation and one formula. Mr. Albertson said that they have tried different policies and procedures for bringing these together into one formulary, but each attempt essentially leaves some providers out. Organizations that were a HPSA before, are no longer, and it has drastic affects on those communities.

Mr. Albertson said that in 2008, the new formula was published, allowing groups like his to analyze the formula. The Arizona Department of Health Services also did a study. Based on this analysis, he said that of the 27 areas designated as either a HPSA or MUA, only 17 of those would still be considered under the new formula. Arizona would lose 30 percent of its designated areas.

Mr. Albertson noted this would have an important affect on clinics from a programmatic level and physician recruitment at hospitals and clinics. There are currently 13 federally qualified health centers in Arizona, and this number would be reduced by 4 under the new formula. He also noted that there are currently 15 rural health clinics in Arizona, and he was not clear on

how many of those would lose their designation under the new formula. However, he said some clinics would more than likely lose their qualification, such as Elfrida, Benson and Sierra Vista. Mr. Albertson noted that with the current issues of physician retention, those clinics will have a major impact on the community hospital as these physicians are needed to admit patients to the hospitals.

Mr. Albertson said that the U.S. Department of Health analysis was done with old data, so his firm updated the analysis with current data. According to his calculations, the Bisbee clinic designation would have been lost in addition to Elfrida, Benson and Sierra Vista. He reaffirmed that the new regulations would have major effects in Cochise County.

Mr. Albertson then explained the process of the regulations being passed. The Health Resources and Services Administration drafts a proposed rule, publishes it in the federal register, and then there is a comment period. Unless there is a lot of backlash, HSRA publishes the rules and it becomes new policy. The last three times that HSRA published new regulations on HPSA/MUA designation changes, there has been a lot of backlash, especially from rural communities, providers, and clinics; hence, they have not instituted the proposed rules.

The 2010 federal health care reform bill states that the Health Resources and Services Administration no longer has to publish the new rule. Mr. Albertson said that, instead, there is a process with a “negotiating” committee, and that this committee will design the rules, published them, and will essentially be enacted without a comment period.

In the past, Mr. Albertson said many areas of the state, including the Department of Health, Hospital Association, Rural Health Association, and specific providers themselves have commented back about the negative effects of these policy changes for Arizona. If the new negotiating rule committee publishes the same policy and formulas as they did in 2008, there are going to be some major effects.

Mr. Albertson said this is important to understand because the designations are not only the primary criteria for subsidizing communities to provide health care and resources, but it’s also where the state legislature and different state agencies provide their funding mechanism for loan forgiveness and other issues. So the designations have financial implications for Arizona as a whole as well as Cochise County. If the new regulations lead to a loss of clinics and hospitals, which are primary employers in rural communities, the community on a whole will be affected by a loss of jobs and health care providers.

Panel member Alison Hughes noted that the state used to have the capacity to allow for the use of “necessary provider” in allocating rural health designations, particularly for critical access hospitals. She added that when the Federal Government withdrew that state authority, hospitals already designated could retain their designation, although under the new rules, some would no longer be eligible for critical access hospital designation. She asked Mr. Albertson what would have to happen to return the “necessary provider” designation to state authority.

Mr. Albertson responded that federal funding is a challenge, as there is an issue with having 50 state designation criteria to apply equally when looking at federal funding and programs. On

the flip side, he said that the rural designations apply to statewide programs such as loan forgiveness, so there might be an option for a hybrid between the state and federal governments setting the formulas.

**Jim Dickson, CEO, Copper Queen Community Hospital: The Status of Telemedicine in Arizona**

Mr. Dickson recommended that the way health care services are delivered in Arizona has to change. He suggested that federal health care reform will not supply more doctors or fix the situation of physician mal-distribution. He pointed to an earlier presentation about the average number of doctors in Cochise County, and noted that most are in Sierra Vista, not in Douglas, Bisbee, or Northern Cochise County, areas which are medically underserved. He explained that when the Copper Queen Community Hospital (CQCH) completed its planning five years ago, they were told they needed more specialists to survive. Mr. Dickson pointed there is no way that a town the size of Bisbee<sup>4</sup> can support a specialist at the income that they're used to. He noted that CQCH faced a challenge in providing dermatology services, adding that there is no dermatologist in Cochise County that will treat an AHCCCS patient or a new Medicare patient. Their solution was to partner with Carondelet Health Services and arrange for tele-dermatology services to be provided at a distance. Mr. Dickson added that CQCH has added tele-neurology services in collaboration with the Mayo Clinic, and received funding from the Arizona Department of Health Services that allows CQCH to administer a clot-busting treatment called TPA to stroke patients through the STARS (Steps Against Recurrent Stroke<sup>5</sup>) program. Blood clots in the brain can cause dysphasia, long-term permanent brain damage, and death. Mr. Dickson shared the story of the mayor of Bisbee who was brought to CQCH after a stroke, at which time hospital personnel were able to administer TPA, using the telemedicine system to access neurologist consultants at the Mayo Clinic. The treatment was successful and resulted in the Mayor's recovery.

Mr. Dickson noted that only two percent of people in rural areas get clot-busting drugs, while in cities, 30 percent of patients get this treatment. He said that the teleneurology program has eliminated a disparity without recruiting a rural doctor, and the hospital is able to do neurological consults in the emergency room.

Mr. Dickson also noted that in rural Arizona, the number one killer is heart disease. He said that in this case, CQCH collaborated with Carondelet Medical Group to develop a telecardiology program with the Marshfield Clinic in Wisconsin, which has 600 doctors and is well-practiced in telecardiology. After visiting the Marshfield Clinic, Mr. Dickson redesigned the CQCH system with up-to-date web-based equipment resulting in the hospital saving lives and money through the use of the telecardiology services. The financial savings are significant. He said in the first three months of operation, the hospital saved \$217,000 in transportation fees because the heart disease patients normally would have been transferred to Tucson.

<sup>4</sup> The Bisbee population was 6,389 people in 2008, according to the Arizona Department of Commerce.

<sup>5</sup> STARS is a program that focuses on educating and empowering stroke survivors about how -- with a doctor's help and advice -- to reduce risk for a recurrent stroke by making lifestyle modifications and managing medical conditions that increase stroke risk.

Mr. Dickson cited the case of an 81-year-old man who came into the emergency room with an irregular heartbeat. Normally the patient would have been flown to Tucson, but instead there was a cardiologist consult in the ER, he was admitted to the hospital unit and discharged the next day with a halter monitor. The hospital saved \$12,000 by not transporting that patient.

Mr. Dickson said six hospitals in the area have joined together to form the Southern Arizona Telemedicine Alliance. This Alliance received a grant from United Health Care for \$150,000 to implement the program. He said they are saving a significant amount of funds and that telemedicine is the solution to the situation in Arizona. The solution is not grants from HRSA to recruit doctors - the solution is to bring the patients to the telemedicine doctors. Mr. Dickson said the hospital will next work to bring educational services in its rural health clinics so that patients will be able to see their cardiologist on a regular basis. Next, the hospital will work towards pulmonary medicine.

Mr. Dickson said the hospital had saved almost \$250,000 because it charges less than Tucson hospitals. For the first three to four months, the hospital saved between \$500,000 and \$750,000 in costs. He said that the patients that are being served have better lives as they are better maintained in their homes, and they can live in rural Arizona.

Mr. Dickson reiterated that money was not the solution to rural health care problems. To solve problems, rural providers need to think differently and deliver differently. There are no government funds to request from legislators. He said that further cuts will come due to federal health care delivery, so rural hospitals will be constrained by limited resources and a need to create immediate access and maintenance care to handle disease management. He said Copper Queen Community Hospital is engaged in a program to do that and they have the foresight to work towards a virtual hospital system in rural Arizona, equal to larger cities. He said this program increases quality of care immeasurably.

Mr. Dickson later added that AHCCCS and all of the other major insurance companies currently do not pay for telemedicine. He has been speaking with United Health Care and Blue Cross executives, and they are in favor of doing it, but Mr. Dickson said he is recommending legislation that is being processed through the Arizona legislature to require every insurance company in the state of Arizona to provide parity. He said this doesn't mean additional coverage – it means if you have coverage in the hospital, and the doctor is present, you should receive reimbursement for telemedicine use at an equal level so the doctors use telemedicine services. He asked for the support of the legislators present at this Rural Health Policy Assembly so that CQCH can continue with the programs that they have already developed.

**Robert Sorce, Assistant Director, Division of Behavioral Health Services, Arizona Department of Health Services: The Status of Behavioral Health in Cochise County**

Mr. Sorce said that the issues Mr. Dickson brought up in his talk were some of the same issues he is facing at the Department of Health Services, Division of Behavioral Health. He said specifically they are trying to determine how to continue to deliver high quality care with shrinking funds. Over the last year or two the Division of Behavioral Health's budget has been

cut dramatically. He said he would talk about the specific challenges and the difficulties the state faces in delivering behavioral health care in rural communities, and that they do pay attention to these unique needs in Phoenix.

Mr. Sorce said that his department's budget was cut by 50 percent last year. The department receives funds from three sources: AHCCCSS for Medicaid patients; block grant funding for special populations (substance abusers, pregnant women, intravenous drug users); and some state-only funds, which were dramatically cut last year. The budget went from \$108 million to \$62 million. Mr. Sorce said the challenge is in how to absorb the large budget reduction and continue to maintain high-quality care.

Mr. Sorce continued that last year, the Department was given \$40 million for a medication-only benefit to the non-Medicaid seriously mentally ill (SMI), \$16 million for a crisis system, and another \$5.3 million for supported housing. He said that when his Department heard about the cuts, they formed a number of work groups to examine the new benefit and how to administer it.

Mr. Sorce said that crisis system funding is critical because until last year, the Department never had dedicated funds for its crisis system. When the legislature cut their budget, they did not realize they were also cutting crisis, but that they now have a dedicated budget line for this purpose.

Mr. Sorce said the medication-only benefit is a real sea change because if a person was determined to be SMI diagnosed, they got the full benefit - everything that a Medicaid-eligible person got, including housing, medication, counseling, support services, transportation, and many other services. The challenge for the state was to transition about 37,000 individuals statewide to a medication-only benefit. In order to do that, they created a generic formulary, which is different from the Medicaid formulary and includes brand name drugs. The Department is still in the process of that transition.

In regards to Cochise County, Mr. Sorce said that last year the state put out a new contract for all of the geographic services areas (GSAs) throughout the state. Each GSA is run by a Regional Behavioral Health Authority (RBHA). The RHBA acts as managed care entity that contracts with providers to deliver the services. In Southern Arizona, the RHBA was formerly the Community Partnership of Southern Arizona (CPSA), and one of the main providers was the Southeast Arizona Behavioral Health System (SEABHS). He added that this contract has been awarded to a new vendor. He pointed out that the new contract is currently under protest, and that a "stay" order is in effect. Until the protest is worked out, CPSA will continue to be the vendor. He noted that a hearing is scheduled for September to decide who will receive the RHBA contract.<sup>6</sup>

Mr. Sorce then continued to discuss some of the ongoing challenges they are facing at the Department, such as recruitment and retention in rural areas. He mentioned that greater compensation is one of the ways the state is able to bring qualified professionals into rural

---

<sup>6</sup> The Arizona Department of Health Services, Division of Behavioral Health, awarded the contract to Cenpatico Behavioral Health Services (Cenpatico Arizona), a subsidiary of Centene Corporation which is a Fortune 500 corporation based in Clayton, Missouri.

areas, but this becomes challenging with less money. He said another challenge is using technology in a beneficial way. He said that they are looking into telemedicine as an option, as well as electronic medical records.

Mr. Sorce said another challenge is maintaining the crisis system with limited funding, as well as serving people who aren't eligible for any services. Mr. Sorce added that this is particularly critical in the border counties where many of the individuals are non-citizens. Mr. Sorce said the funding levels are creating a caste-system of benefits so that the funding drives the care. He questioned how to maintain the same quality of care with a different benefit package. He said another challenge is to bridge the gap between now and 2014 when the national health care reform kicks in. Many individuals who are currently AHCCCS ineligible will be eligible when the criteria change, but the challenge is serving them in the short term.

Another challenge Mr. Sorce raised is health integration - treating the person as a whole. He gave an example of a patient who is AHCCCS eligible that has to go to one clinic for behavioral health and another for physical health, and the two systems don't coordinate well. He said they are exploring co-location - partnering with federally qualified health care centers to merge behavioral health services.

Mr. Sorce noted that they are currently heavily dependent on the federal government stimulus funding to help bridge the gap for Medicaid funding, so they are dealing with potential budget gaps of \$4 million in 2012 if Congress does not approve additional funds. This will put additional services at risk.

Mr. Sorce said stigma reduction is another challenge. He said that there is a tremendous amount of stigma attached to behavioral health, and they are working on reducing the stigma. He indicated that another challenge is to involve peers and families in the process, a procedure they have already started through the creation of a parent/family coalition with membership from all over the state.

Mr. Sorce concluded by commenting that the biggest challenge is convincing policy makers, and specifically the legislature, that investing in indigent healthcare, particularly behavioral health care, is a good policy because simply removing funding does not eliminate people's need for care. He added that they are going to get care somehow, but it is just a matter of where and how much it costs.

**Jerrod D. Long, DDS, Private Practice Dentist: Dental Health Challenges at the Community Level (Presentation submitted in writing)**

Some issues facing public oral health

1. Patient education and need for preventive care.
  - a. This is a dental perception issue.
  - b. Many people don't realize dental care is preventive in nature.
  - c. Many patients do not see the need for dental care in disease prevention
  - d. As much as 50% of the population only seeks dental care when they are in pain.

- e. If patients wait for pain to seek care, then the actual office visit is much more traumatic. It can become a self-perpetuating cycle.
  - f. Routine checkups can catch decay while it is minimal, before it results in tooth loss or pain.
  - g. Tooth sealants are very effective if placed immediately after adult teeth erupt.
2. Another issue affecting public health is access for underserved (low income) families.
- a. Medicaid (AHCCCS) is not funded well, especially in these trying economic times.
  - b. State and local governments are often forced to limit funding to balance the budget.
  - c. The reimbursement schedule for Medicaid is much lower than many providers can afford to accept for treatment, often 50% or less than fee schedule.
  - d. And Medicaid only authorizes limited treatment, which can lead to compromised treatment plans.
  - e. Also, transportation to the limited number of offices accepting Medicaid can be an issue for low income families.
3. Some proposed actions to address identified needs.
- a. Address the patient education issues beginning with grade schools.
  - b. I offer free screenings at the local grade school each year and help identify need for care.
  - c. This also helps to desensitize children to dental care in general, with an easy and positive experience.
  - d. We also give toothbrushes and toothpaste to the children after the screening.
  - e. Ask other dental providers to perform this annual service until all grade schools are covered.
  - f. Ask for more funding for Medicaid. The reimbursement rate could be made more competitive. And more comprehensive care procedures could be authorized.
  - g. Some funding from health and human resources could be obtained to create a sealant program. Identify children in school, and place sealants on children in appropriate age group based on some economic need/criteria (i.e. qualifies for free school lunches).

### *Health Information Technology*

**Melissa Rutala, Director, Regional Extension Center, Arizona Health-e Connection:  
What's New in Electronic Health Record Implementation In Arizona—Presentation delivered  
by videoconference.**

Ms. Rutula opened her presentation by noting that the Arizona Health-e Connection (AzHEC) exists to convene, coordinate, and communicate for health information infrastructure improvements that affect every Arizonan. AzHEC works in three areas: education, policy development, and coordination of health information technologies across the state. Making health information electronic will improve quality care and increase patient safety, which requires the intersection of personal health, health care delivery, and public health information. Personal health information is really health and wellness information that you may know and use in your daily life to improve your health.

Ms. Rutula said that AzHEC received a \$10.8 million federal grant to establish a health information technology Regional Extension Center (REC) in Arizona. There are 60 centers across the US. The goal of the Center is to assist 2,000 primary care physicians (PCP) by April 2012 to implement electronic health care record systems by providing the PCPs and other providers with education and technical assistance. She explained that an electronic health care record is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare organization.

The AzHEC will assist providers with the challenges of adopting health information technologies. The ultimate goal of AzHEC is to develop an entire infrastructure for all of Arizona that will eventually be linked nationally and allow PCPs to see a complete picture of the health care a patient has received over the years.

Ms. Rutula provided an overview of the provider assistance process. The first step is for the health care provider to join the REC. During step two, the REC assesses where the provider is in the process of adopting EMR in order to determine if the health care entities meet the federal requirements for meaningful use. If eligible, the provider receives \$40,000 to \$64,000 in incentive payments. AzHEC works to support Arizona's providers to take advantage of the incentives for adopting EMR. Other focus areas are electronic prescribing and secure, private health information exchange.

An audience member asked Ms. Rutula if Arizona Health-e Connection had certified any vendors for the state to help rural hospitals, and how soon such certification will occur. Ms. Rutula replied that AzHEC will be relying on the Federal meaningful use criteria to certify vendors, and they would start accepting applications from vendors by mid-July. She said AzHEC projects that services through the REC will be available in the early fall, as the REC will be operational within 45 to 60 days. Ms. Rutula also noted that the federal government recently issued the final rules defining meaningful use, which essentially entails a multi-stage approach. Then she pointed out that providers will have to meet a series of criteria to be considered a meaningful user.

**Galen Updike, Manager, Communications Development, Government Information Technology Agency (GITA): Broadband Implementation Plans for Cochise County— Presentation delivered by videoconference.**

Mr. Updike reported that Cochise County has a better broadband infrastructure than other Arizona rural areas, but it still had a long way to go. He said that the same laws of supply and demand apply to end user costs for telecommunications broadband – with high supply and low demand, prices are low; with low supply and high demand you have high prices. Prices for broadband, including the broadband that supplies the telemedicine program, are high. He said that GITA is trying to provide some guidance with regards to how broadband can be increased in the state.

Mr. Updike discussed policy barriers about which citizens need to inform their elected representatives. He said that Broadband is currently not treated as critical infrastructure in law or policy. He also noted that citizens pay for Right-of-Way continuously, when they should only pay for this once. He said there are currently governmental policy and provider sales imperatives that create separate networks for government and private citizens, causing citizens to pay twice.

Mr. Updike detailed some of the Broadband infrastructure needs in rural areas, such as lack of middle mile infrastructure and local off-ramps. He also noted that time-to-market is a major barrier and cost element in deployment of projects. Another issue is diffused leadership. Until now, there was no collective voice or plan for Broadband development, and few leaders were tasked to engage in discussion.

Mr. Updike said that Broadband policy should be an aggregation of public and private demand. He went on to discuss the Broadband Mapping Project and Planning Initiative with the National Telecommunications and Information Administration. The first project phase is mapping, which is a five-year effort that started in February 2010. The second phase is planning, which is a statewide effort led by the Government Information Technology Agency to develop a state strategic plan, facilitate policy discussions, and enhance the organizational capacity of local communities, including outreach and funding for technical assistance for local communities.

An audience member asked Mr. Updike about the timing of Broadband expansion in Cochise County. Mr. Updike responded that they will have a plan by next year, in addition to setting up eight regional councils for Broadband. He said they would be working closely with area providers, including Verizon.

Another audience member asked if the rural health discount program running out of USAC [Universal Services Administration Company] had been made available for Broadband services yet. Mr. Updike said this program would be very advantageous, but before it is up and running, he believes there may need to be some legislation in place. He said that a national Broadband plan will be patterned after the USAC program. He also encouraged audience members to visit the Arizona Government Information Technology Agency website at [www.azgita.gov](http://www.azgita.gov).

## Presentations Submitted in Written Form

### **Terry Mullins, Chief, ADHS Bureau of EMS and Trauma System and Ben Bobrow, Medical Director, ADHS Bureau of EMS and Trauma System: EMS issues in rural Arizona.**

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.

**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

**Ronald S. Weinstein, M.D., Director, Arizona Telemedicine Program: Telemedicine Services in rural Arizona**

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.

*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 the Department of Corrections sites in Buckeye, Douglas, Florence (2), Safford, Tucson-St. Mary’s Hospital, Yuma and Phoenix.

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.

Last October the Arizona Telemedicine Program hit another milestone with its 1,000,000<sup>th</sup> 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.

### *Assembly Call for Public Comment*

The following presentations were made following the scheduled presentations, and the readings of the written presentations.

#### **Michael Groves, Sierra Vista Hospital Foundation Board Member**

Mr. Groves said that charitable dollars are different in rural areas than they are in urban areas, and that charitable efforts will be impacted by the budget cuts. Currently, he noted that the Sierra Vista Foundation contributes to the hospital by raising funds to purchase critical and up-to-date equipment needed to operate. He said that in urban areas this is offset by many charitable donations received, but the rural areas do not have the same charitable base to offset costs. Mr. Groves reiterated that his board spends a lot of time raising money to purchase and make equipment available to the hospital. He said they recently bought a digital mammography machine and cardiac monitors. He added that they expect a lot of it [needed equipment] will not be available with the budget cuts that are happening for rural hospitals, and that foundations and charitable groups will have a harder time contributing than in urban areas because they have a larger charitable base.

#### **Faye Hoese, Outgoing Clinical Director, Arizona Children's Association**

Ms. Hoese indicated that she has worked in behavioral health services for many years. She is the outgoing clinical director for Arizona's Children Association, Pantano Behavioral Health Services, which provides children's behavioral health programs that cover all of Cochise and Santa Cruz Counties, along with the incoming Compass Behavioral Health system. Ms. Hoese said she wanted to reinforce that the behavioral health needs are not going to go away, no matter whether there is funding or not. She said that for behavioral health, especially for SMI (Seriously Mentally Ill), either they will continue to send people like her or her staff out to do de-escalations on site, in the home, with the family, with the children, and with the parents, or they will send police and firemen and it will just be another huge load on the local hospital.

Ms. Hoese said she has lived in Bisbee for almost 40 years and worked professionally in the community for almost that long, and that people who live in the city really don't have a clue what the environment is like in Bisbee. She reiterated that without funding for behavioral health, especially crisis, the load on local hospitals, police, sheriff and the fire department will be absolutely overwhelming.

#### **Jack Cook, Cochise County Resident**

Mr. Cook said he lives on Naco Highway, and said that in the year 2000, there was a fire station and an emergency medical technician located at the red light where Naco Highway hits Highway 92. Mr. Cook said some rich people came in and turned the fire station into garage storage. He said he always felt this decision was a tax payer botch for the health of the area because it increased the time of ambulance transport.

#### **Vaira Harik, Director, Cochise County Health Department**

Ms. Harik said the county needs the assistance and support from its elected officials, particularly at the legislature, because they ultimately control how resources flow to their constituents. She said that the coalitions that legislators join at the state capitol are as meaningful as the individual decisions that they make for their local district. Ms. Harik said she hoped that legislators would understand that the safety net in Cochise County is only one layer thick. She said while the available health care workforce in the County is not as deep as needed due to lack of resources, there is talent, compassion, and passion among those who currently serve.

## Appendix A: Telemedicine Reimbursement

Written by Patricia King, JD

(As presented in netdoc.com and reprinted here with permission of the author)

Currently, Medicare pays for telemedicine only in limited areas: the originating site must be located in a rural health professional shortage area, or in a county that is not included in a Metropolitan Statistical Area (Ref. 1).

In these areas, Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and neurobehavioral status exams (Ref. 2).

In these areas, Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and neurobehavioral status exams (Ref. 2).

To qualify, the physician/practitioner at the distant site must be licensed to furnish the service under state law and must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional. The originating site must be a physician/practitioner office, a critical access hospital, a rural health clinic (RHC), a federally qualified health center (FQHC), or a hospital. In addition to the general payment rules, Medicare also sponsors a demonstration projects in telemedicine for diabetes education.

The Medicaid rules allow states to choose to cover telemedicine, and many states have taken advantage of this. Illinois, for example, recently broadened coverage of telehealth services to cover services rendered not only by hospitals, but also by physicians, advanced practice nurses, podiatrists, FQHCs, RHCs and Encounter Rate Clinics, and also to cover telepsychiatry (Ref. 3).

The Medicaid rules allow states to choose to cover telemedicine, and many states have taken advantage of this. Illinois, for example, recently broadened coverage of telehealth services to cover services rendered not only by hospitals, but also by physicians, advanced practice nurses, podiatrists, FQHCs, RHCs and Encounter Rate Clinics, and also to cover telepsychiatry (Ref. 3).

Some private payers cover telemedicine services, and twelve states<sup>7</sup> require insurance companies to cover telemedicine (Ref. 4).

---

<sup>7</sup> NB: To date, the Arizona Legislature has not adopted a telemedicine reimbursement policy.

**References**

Ref. 1 42 C.F.R. § 410.78(b)(4).

Ref. 2 42 C.F.R. § 410.78(b).

Ref. 3 Illinois Department of Healthcare and Family Services, Informational Notice, Expansion of Telehealth Services, Jan. 12, 2010.

Ref. 4 The states are California, Colorado, Georgia, Hawaii, Kentucky, Louisiana, Maine, New Hampshire, Oklahoma, Oregon, Texas and Virginia.

**About the Author**

Patricia King is a health care attorney in Illinois, and principal of the web-based business Digital Age Healthcare LLC (<http://www.digitalagemd.com>).