June 9-11, 2002, Bisbee, Arizona

Health Resources and Services Administration
Office of Rural Health Policy

Tucson, Arizona
June 9-11, 2002

Meeting Summary

The 41st meeting of the National Advisory Committee on Rural Health (NACRH) was held on June 9-11, 2002, at the Sheraton El Conquistador in Tucson and at the conference center in Bisbee, Arizona.

Sunday, June 9

Tucson, Arizona

Call to Order

The Honorable David Beasley, Chair

Chairman Beasley convened the meeting by welcoming the NACRH members and guests and by outlining the agenda for the next 3 days. The following members were in attendance: David Berk, H.D. Cannington, Steve Eckstat, Rachel Gonzales-Hanson, Alison Hughes, John Martin, Tom Nesbitt, Sally Richardson, Monnie Singleton, Mary Wakefield, Jim Ahrens, Stephanie Bailey, and Dana Fitzsimmons. Present from the Office of Rural Health Policy (ORHP) were Marcia Brand, Tom Morris, Sahi Rafiullah, and Michele Pray. Keith Mueller and Shelly Crow were unable to attend.

After the acceptance of the March 2002 NACRH minutes, Committee members broke up into either the Workforce Subcommittee or the Quality Subcommittee to discuss how best to present their final reports to ORHP. Members of the Workforce Subcommittee include Mr. Berk, chair, Mr. Ahrens, Mr. Cannington, Dr. Eckstat, Ms. Gonzales-Hanson, Ms. Hughes, Dr. Singleton, and Ms. Richardson. Members of the Quality Subcommittee include Dr. Wakefield, chair, Mr. Fitzsimmons, Mr. Martin, Dr. Mueller, Dr. Bailey, Dr. Nesbitt, and Ms. Crow.

- Following the completion of the workforce and quality breakout sessions, Ms. Hughes, the director of the Arizona Rural Health Office, provided an overview of the topics scheduled for discussion over the 2 days. These topics include the following:
- Health care issues of the Tohono O'odham Nation, particularly at the hospital in Sells, Arizona
- The severe diabetes epidemic affecting the O'odham Nation, as well as other Indian Nations and the entire U.S. Hispanic population
- Construction of a border wall built between Arizona and Mexico by the city governments of Nogales and Douglas, Arizona, in cooperation with the Federal Government
- Chronic disease at the border and the creative interventions that are making a difference
- Impact of undocumented aliens on the health care system, particularly on the Tohono O'odham Nation and the hospitals in Bisbee and Douglas
- Impact of the increasing cost of malpractice insurance on the delivery of babies in Douglas and in other parts of Arizona

After a brief geographic and economic description of the towns of Bisbee and Douglas and their hospitals, Ms. Hughes introduced Eva Moya, who provided a summary of the broad health issues at the United States-Mexico border.

Overview of Health Issues at the Border

Eva M. Moya, Acting Executive Director, United States-Mexico Border Health Commission

Ms. Moya's presentation focused on some of the primary health issues and social and economic problems found in the United States-Mexico border region, the success stories and significant opportunities that address these disparities, and the role of the United States-Mexico Border Health Commission in optimizing health and quality of life along the border.

Socioeconomic and Health Problems of the United States-Mexico Border Region

More than 13 million people inhabit this region, which increases to 78 million when the populations of the 4 U.S. Border States and the 6 Mexican Border States are included. In 1999, the Immigration and Naturalization Service (INS) reported approximately 400 million legal border crossings northbound along the 62.5 miles of legal boundary. No other border can claim this type of movement. Although most of the population movement is northbound, high numbers of people move south to reunite with family, find work, and access health care and pharmaceutical services.

If the population in this area continues to grow at the current rate, researchers anticipate that the Mexican border population will double in 9 years. In the next 25 years, the U.S. Hispanic population in this region also will double, as will the population of all races in the next 47 years.

Both sides of the 2,000-mile border have significant historical, political, and cultural differences. Although the U.S. Border States have a higher population growth than the Mexican Border States, the Mexican side suffers from higher underinsured and uninsured rates, higher unemployment and lower education rates, more health and environmental challenges, and a scarcity of land suitable for residential development.

The poverty and infrastructure conditions along the border are staggering. Between 38 and 40 percent of the communities fall below 200 percent of the Federal poverty level. Unemployment rates are between 2.5 and 3 times higher than the U.S. average. Three of the 5 poorest cities and 4 of the 10 poorest counties in the United States are located in this region. Furthermore, more than 400,000 residents in this area live in "colonias," which are substandard developments that lack running water, sewage systems, and often electricity.

These border communities also face significant public health problems. They have a high rate of waterborne, communicable, and infectious diseases and a significant shortage of health care professionals and behavioral-mental health providers. Hepatitis A, diabetes, and tuberculosis are more prevalent in this region than any other region in the United States. Other public health concerns include psychological stressors, hypertension, early pregnancy and inadequate prenatal care, cervical cancer, and suicide.

In 1997, HRSA, with help from the University of Arizona, examined ways to increase and improve access to primary care services. Their findings resulted in the Adelphi Study, which identified a number of issues associated with the access to health care. These issues include the following:

- Lack of knowledge about how to access services
- Language and cultural barriers
- High cost of care
- Denial of access to services for undocumented aliens
- Availability of services in rural areas
- Lack of adequate transportation to health care facilities

Success Stories

A number of organizations have become invaluable resources in the improvement of the lives and health of border-region inhabitants. Among these resources are the California, Arizona, Texas, and New Mexico Border Health Offices and the Commission Outreach Offices, whose expertise in binational border relationships has helped improve health, economic, and living conditions in many border communities. Another important resource for the promotion of adequate health care in this area is the community health worker, or the promotor(a). Although underfunded and overworked, promotoras work closely with the United States-Mexico Border

Health Commission to promote health care and disease prevention in the Border States. Other organizations that are helping to find new ways and new models to increase and improve access to health care are the community access programs, HRSA through ORHP and State Offices of Rural Health, community and migrant health centers, and universities and academic centers.

United States-Mexico Border Health Commission

The United States-Mexico Border Health Commission was formally established in July 2000 by an agreement between the U.S. and Mexican Secretaries of Health. The binational organization, which provides international leadership to promote better health and quality of life among the citizens of the U.S. and Mexico border region, comprises 2 nations, 10 Border States, 26 Commission members, and various groups that support and work with the organization to carry out its mission. Its challenge lies in the implementation of both domestic and binational health and funding activities to support local communities in their efforts to improve public health. To ensure binational cooperation, the Commission is striving to promote the health and well-being of all residents living in this area and to eliminate barriers to health improvement. It also helps to create a consensus between both nations and among all Border States, sets the health agenda for the border area, establishes a coordinated board of health systems and networks, creates procedures for movement of equipment and funds across the common border, and collaborates with nongovernmental organizations and other entities involved in public health activities.

A number of rural health challenges confront the United States-Mexico Border Health Commission. These challenges, as identified by the Commission members, include the enhancement and improvement of the public and private health infrastructure on a binational level; recruitment, placement, and retention of health care professionals and workers in border regions; enhancement of the bilingual and bicultural capacity of the local workforce; and elimination of health and medical reimbursement disparities.

Part of the Commission's health promotion and disease prevention agenda for the United States-Mexico border region is the implementation of the Healthy Border 2010 initiative. This initiative, composed of common elements from two national programs, the Mexican National Health Indicators Program and the United States Healthy Gente Program, focuses its attention on improving health activities on both sides of the border, guiding the allocation of health resources and the development of binational health projects, coordinating public and private action, and developing border and binational community projects. Its primary objective is to reduce substantially cases of breast and cervical cancer, diabetes, adolescent and adult HIV, tuberculosis, and suicide by 2010. Other areas of concentration include heart health,

gastrointestinal diseases, immunization and infectious diseases, physical fitness, mental and oral health, substance abuse, and bioterrorism preparedness for the workforce.

The U.S. members of the Commission include the chief health officers of the four U.S. Border States of Arizona, California, New Mexico, and Texas. Each State has two additional members on the Commission nominated by its governor and appointed by the President of the United States.

Dr. Carlos Gonzales, an appointee to the United States-Mexico Border Health Commission, provided a personal account of the difficulty in accessing adequate medical care in the Douglas and Sierra Vista area, especially for undocumented aliens. He discussed the abhorrent behavior of the INS in denying these uninsured individuals proper medical attention because of cost and the closing of countless numbers of medical facilities because of high malpractice insurance rates, insufficient reimbursement for services, and lack of health care professionals.

Chronic Diseases at the Border

Jill DeZapien, Associate Dean for Community Programs, College of Public Health, University of Arizona
Cecilia Rosales, M.D., Chief, the Arizona Office of Border Health, Department of Health Services

Ms. DeZapien began her presentation by noting that border health care issues have changed dramatically from a focus on public health issues, such as maternal and child health and infectious disease issues, to a concentration on chronic diseases, such as heart disease, diabetes, tuberculosis, and cancer. One reason for this change is that the border population is aging and chronic diseases have now become the leading cause of death among residents. To better understand why chronic diseases are so prevalent in this area, which includes both sides of the border, and why health care resources must be binational, CDC conducted a project simultaneously in Douglas and Agua Prieta, Mexico.

The project's primary intent was to increase rates of routine chronic disease screening and to promote disease prevention strategies among uninsured women aged 40 and older. Researchers compared factors such as level of education, place of birth, occupation, sociodemographic and health behavior characteristics, difficulty obtaining health care, frequency of clinical exams (including Pap smears), and chronic disease screening history for a select group of women living in Douglas and Agua Prieta. Tests were performed for blood pressure, blood sugar, obesity, and cholesterol level. Results showed that women from Agua Prieta received more regular screenings for chronic diseases than did women from Douglas but had greater difficulty obtaining health care services such as mammograms and Pap smears. The

researchers strongly recommended eliminating barriers from Federal money for binational interventions to address problems of health care accessibility in these areas.

Other initiatives related to these projects include two CDC-funded interventions taking place at the Rio Grande Valley and Arizona-Sonora border-the Border Health Strategic Initiative (Border Health ¡SI!) and the Research 2010 Initiative. The Border Health ¡SI! is a Federal appropriation that designates the University of Arizona to develop interventions for chronic diseases. The Research 2010 Initiative is a competitive 4-year project designed to help communities in the Rio Grande Valley area address health disparity issues regarding chronic diseases. The University of Arizona is the evaluator for this initiative. Both projects are training community health workers, or promotora(s), to provide education intervention to border residents on how to prevent and manage chronic diseases such as diabetes. Promotora(s)-based diabetes management programs now extend to all border counties. Ninety percent of the enrollees who are have diabetes have never previously received any management education. These initiatives also teach family members of people with diabetes how to be supportive and inform them that they too are at risk for the disease. Other program activities include establishing community walking and nutrition clubs, creating a school health index to help set up good nutrition action plans as part of school policy, and forming special action groups to promote access to healthier lifestyles.

Dr. Rosales spoke about the role of the Arizona Border Health Office in coordinating and integrating public health program efforts to identify, monitor, control, and prevent adverse health events in border communities. Specifically, the mission of the Office is to protect all border residents living in the Nogales and Sonora region and to strengthen cross-border public health collaboration. To do this, the Border Health Office has developed strong relationships with a number of government and nongovernment organizations to help address issues such as children's health, access to health care, disparities in health outcomes, and quality of life as it relates to the environment.

Through the Healthy Gente Program, the Arizona Office of Border Health promotes several projects in the Nogales and Sonora region. One project fosters the creation of a triage and stabilization unit in the Nogales hospital to facilitate the continual flow of patients traveling from south to north for services. The project will concentrate on improving the hospital's infrastructure in terms of equipment, services, resources, training, and transportation capabilities. Other projects supported by the Healthy Gente Program include the school health index in Naco, Binational Council activities in Yuma, a health services inventory, an Arizona-Sonora communications system developed through the Department of Health Services, and an electronic database for cross-border prenatal care. Many of these projects fall under umbrella

organizations such as the Board of Governor's Conference and the Arizona-Mexico Border Commission.

Other binational projects promoted by the Arizona Border Health Office include (1) a tuberculosis program that includes outreach and therapy activities, (2) a program that ensures the release of INS detainees to a Sonoran public health facility and to the Nogales hospital for followup treatment, (3) a system that works with the INS and the department of health to ensure that individuals seeking health care services inform the consulate in the area before being transported to a treatment facility, (4) asthma training and a diabetes survey, and (5) dengue and border infectious disease surveillance programs. The Arizona Border Health Office also supports the Binational Health Councils that work closely with the Tohono O'odham Nation and that are active in border communities in Arizona and Sonora, Mexico, and the Arizona Binational Health Office located in the Nogales-Sonora area and cosponsored by both departments of health.

Undocumented Aliens and the Health Care Infrastructure

Taylor Satala, Tucson Area Director, Indian Health Service
Darell Rumley, Tucson Area Office, Indian Health Service, Sells Service Unit
Mark Adams, Head of Emergency Medical Services, Sells Hospital

Mr. Satala prefaced the presentation on undocumented aliens with a brief history of the Indian Health Service (IHS), the sister agency to the Bureau of Indian Affairs. Created in 1954, the IHS is responsible for providing Federal health services to American Indians and Alaska Natives. The agency, originally housed in the Department of the Interior, is now under the Department of Health and Human Services (DHHS) but receives much of its funding from the Department of Labor.

Mr. Rumley presented slides of the border area to illustrate its desolate and rough terrain, and he provided information about Sells, Arizona, and the Tohono O'odham Nation. He noted that Sells is made up of 11 districts, each with 2 representatives and its own legislative council. Because the town is only 28 miles from the Mexican border, the Sells hospital receives a considerable number of immigrant patients suffering from dehydration, malnutrition, and exhaustion resulting from their 4- to 5-day travel north through the desert. The Sells hospital, which is the only medical facility in the vicinity that has an emergency room open 24 hours a day, also serves as the primary hospital for the Tohono O'odham tribal population. A significant number of the tribal-enrolled members are employed at the hospital. The 32-bed facility is federally funded to care for about 24,000 tribal members, half of whom live on a local

reservation. The hospital receives additional funds through third-party reimbursement from State Medicaid programs and private insurance.

Mr. Adams discussed the composition of the Sells Service Unit and the services provided. The Unit comprises the Sells hospital, the Santa Rosa Health Center, and the San Xavier Health Center. Built in 1954, the Santa Rosa Health Center is 35 miles northwest of the hospital and provides services to the west side of the Tohono O'odham Nation. A former tuberculosis sanatorium built in 1933, the San Xavier Health Center offers services to approximately 32,000 patients a year. Both centers are accredited as hospital-sponsored ambulatory health facilities, and all three units have rate quotation methodology agreements with providers in Tucson, as well as contracts with the Phoenix Indian Medical Center and the Veterans Administration, to bring in needed health services.

Mr. Adams noted that the Sells Service Unit does not receive enough funding from the Federal Government to cover the medical costs for the three facilities. Fortunately, each component of the Unit has the ability to bill from third-party resources, which covers about one-half of the personnel costs, as well as travel, training, and joint-commission-related project costs. Even after factoring in third-party resources, the amount of funds available per patient averages $1,200, which is below the national average.

The Sells Service Unit provides a significant amount of emergency medical care to undocumented immigrants. The primary types of emergency care include mass casualty incidents and heat- and cold-related injuries. Last year, the total cost for emergency treatment at the three facilities was $321,693; the total reimbursement payment was only $40,380. From October 1, 2001, to April 30, 2002, the number of undocumented immigrants reported to the Tohono O'odham police department was 34,500, which is probably only 10 percent of the total number of undocumented immigrants who cross the border.

Severe problems due to the continuous influx of undocumented aliens across the border have led to frequent meetings between tribal members, the INS border patrol, the IHS, and other interested groups. These problems include the impact on tribal land due to large amounts of litter deposited by fleeing immigrants, desert vegetation trampled by INS and border patrol vehicles, land erosion caused by drag lines created by the border patrol for tracking purposes, and the dilution of medical services available to tribal members because of the increasing health needs of the local transient population. Other issues under review by the IHS include (1) clarification of the custody policy of undocumented aliens requiring medical attention, (2) improvement of the relationship between the INS and the border patrol, (3) the need to increase border presence, (4) establishment of new health care reimbursement procedures and

resources, and (5) the need to solicit more help from Mexico to educate its population about the potential dangers of crossing the border illegally.

The current budget for the INS is $3 billion, but the agency believes this amount is not enough to cover the inevitability of losing two trauma centers in Tucson and the potential public health and bioterrorism threats caused by the increased number of daily border crossings. Senator Tom Daschle (D-SD), Representative Jim Kolbe (R-AZ), and Senator John McCain (R-AZ) are aware of the need for additional INS funding and have proposed legislation to increase the budget substantially.

September 2002 Onsite Visit

Jim Ahrens, Committee Member

The next onsite meeting will be held September 8-10 at Chico Hot Springs in Pray, Montana. Committee members can fly into Bozeman, where prearranged transportation will take them to Chico. Members are encouraged to make their airline reservations early because of the limited number of daily flights into Montana. The meeting agenda is still in the planning stage.

Office of Rural Health Policy Update

Marcia K. Brand, Ph.D., Director of ORHP
Tom Morris, Policy Analyst, ORHP

Dr. Brand provided an update of ORHP activities and a discussion of the Secretary's Rural Initiative and the Farm Security and Rural Investment Act of 2002. Mr. Morris gave a legislative update of rural issues under discussion on Capitol Hill.

Update of ORHP Activities

ORHP is sponsoring two new grant programs: the Rural Access to Emergency Devices (RAED) grant program and the Small Rural Hospital Improvement (SHIP) grant program. RAED is a $12 million grant program that will provide funding to rural communities for the purchase of automated external defibrillators (AEDs) and will support training in their use and maintenance. Legislation requires that this grant be awarded to community partnerships. Preferences will be made to those grantees that are statewide partnerships and to those whose leads are State emergency medical service agencies or some other State entity. Priority also will be awarded to those applicants that place their AEDs with first responders. Letters of intent are due to ORHP by July 15; the awards will be announced in September.

The SHIP grant program will assist small rural hospitals (SRHs) of 49 beds or less in (1) payments related to the implementation of the prospective payment system (PPS), (2) compliance with the provisions of the Health Insurance Portability and Accountability Act, and (3) the reduction of medical errors and support of quality/performance improvement. The Medicare Rural Hospital Flexibility Program will provide funds totaling $15 million to SHIP. About 1,300 small hospitals are currently eligible; a list of these hospitals is posted on the ORHP web site. The Office has set up an appeal process for those hospitals that believe they are eligible for grant money but are not included on the list. ORHP has asked the 50 State Offices of Rural Health to serve as applicants on behalf of the SRHs and to submit 3-page applications to the Office in bulk. Because of the limited amount of award money available for individual hospitals (about $11,000 per hospital), ORHP is encouraging hospitals to apply as consortia, with State offices acting as the coordinators for the purchase of consultants and training programs.

Secretary's Rural Initiative

In July 2001 Secretary Thompson created the DHHS Rural Task Force to (1) examine how the Department's health and human service programs currently assist rural communities, (2) determine the locations of its investments and the amount being invested, and (3) identify some of the barriers (i.e., regulatory, legislative, and administrative). The task force has completed its review of these areas of concern and has set five goals:

- Improve access to health and social services
- Strengthen rural families
- Support community and economic development
- Improve coordination with local, State, and Tribal governments
- Improve the decisionmaking process and consultation

The task force is currently determining the proper venue for sharing these findings.

Farm Security and Rural Investment Act of 2002

The "Farm Bill," which includes a number of amendments of interest to ORHP, requires President Bush to establish a National Conference on Rural America to look at health services in rural America over an 18-month period. Congress fully supports the importance of each Department's examination of its rural activities and, in a Sense of Congress, stipulated that the White House should designate a Special Assistant to the President for Rural Policy. Furthermore, each agency should appoint a senior officer who works specifically on rural issues and who is part of an intergovernmental work group that coordinates across all Departments. The Farm Bill also establishes the National Rural Development Partnership as a Federal program, providing the Partnership with a ceiling of $10 million per year. Other activities

supported by the bill include a grant program for rural fire fighters and emergency personnel to assist in the preparation for handling hazardous materials and biological agents and a pilot research program to combine medical and agricultural research.

Mr. Morris provided an overview of some of the CMS hospital payment changes that help rural communities and an update of congressional activities affecting rural health care policy.

CMS Hospital Payment Changes

Recently, CMS made changes, which were published in the Federal Register on May 9, to its Medicare inpatient PPS proposed payment. These changes include the following:

- Provides protection for sole community hospitals whose status is imperiled because of the recent openings of "boutique hospitals."
- Increases certified registered nurse anesthetist (CRNA) pass-through for rural hospitals. Currently, a hospital qualifies for this pass-through if it has 500 or fewer CRNAs.
- Simplifies the Emergency Medical Treatment and Active Labor Act (EMTALA). Unfortunately, this change also updated the market basket, resulting in the adoption of the labor share. The labor share is the portion of the wage index that is applied to the diagnostic related groups (DRGs). The wage index was increased from 71 to 72 percent, which hurts all rural hospitals. ORHP's North Carolina Research Center is working with CMS and MedPAC on some different methodologies that involve the labor share issue.

Other Medicare issues of concern include the following:

- Impact of the Medicare ambulance fee schedule on small rural ambulance services.
- Anticipated CMS final rule on rural health clinic (RHC) payment changes at the end of the summer.
- Large payment cuts in emergency room and clinic visits to compensate for new technology payments. To cover the cost of these payments, funds were taken from the low-end services on which most rural hospitals rely. ORHP will continue to follow this issue closely.

Legislative Update

Recently, the House Ways and Means Committee reached an agreement with the American Hospital Association and the American Federation of Health Systems on a Medicare reform bill that includes several good provisions for rural health care. These provisions include

- Changes to the critical access hospital (CAH) designation
- Cap increases on rural disproportionate share hospitals (DSHs)
- Regular review of the market basket methodology by CMS
- Redistribution of unused residency slots to underserved areas on the basis of need

Mr. Morris noted that Dr. Wakefield has been reappointed to MedPAC. In addition to Dr. Wakefield, two rural health care advocates, former Minnesota Senator Dave Durenberger and Nick Walter, were appointed to the committee.

Dr. Brand closed the ORHP presentation by emphasizing that because of Secretary Thompson's strong commitment to rural health care regulations and programs, together with strong commitments from SAMHSA, HRSA, and CMS, rural issues are now more center stage in Washington than ever before.

Monday, June 10

Chairman Beasley spoke briefly to the members about salient topics to include in the NACRH letter to Secretary Thompson. The group recommended the following topics for possible inclusion: public health issues prevalent in the border region, the strain on the health delivery system resulting from migration of illegal immigrants across the border, the impact of increased malpractice insurance rates on obstetric services and the lack of available prenatal care on both sides of the border.

After a discussion of each suggested topic, the Committee members toured the Copper Queen Community Hospital in Bisbee. The hospital provides a medical surgical unit; emergency room services; rehabilitation, physical, and occupational therapy services; speech pathology services; cardiopulmonary services; diagnostic imaging; laboratory services; and home health care and social services.

Ms. Hughes introduced Ginger Ryan, the founder and CEO of Chiricahua Community Health Centers, Inc. The health centers comprise one health center in Elfrida, Arizona, one in Douglas, and a mobile outreach unit that provides health services to migrant farmworkers in the field. Dr. Ryan also is president of the Arizona Rural Health Association.

Effects of Obstetrics Closure on Area Clinics

Ginger Ryan, Ph.D., CEO, Elfrida Community Health Center

Dr. Ryan began her presentation by explaining some of the difficulties encountered by her health center in Elfrida. First, the center had difficulty receiving medical and technical equipment after opening because shipping companies, such as UPS and FedEx, would not make deliveries to such a rural area. Second, the Douglas Hospital, located on the border of Mexico, and the Copper Queen Community Hospital, located very close to the border, discontinued their labor and delivery services because of staffing difficulties and high malpractice insurance rates, thus, drastically increasing obstetric patients at the Elfrida Community Health Center. To illustrate the

problem of too few health facilities offering obstetric care in Cochise County, Arizona, Dr. Ryan introduced a young mother who recently gave birth in a car that was transporting her to the nearest hospital 43 miles from her home. Among the traditional barriers that health facilities in this area are facing, such as time, money, language, and cultural diversity, one of the most troublesome is the incredibly long distances patients have to travel to receive care. A third problem encountered by the Elfrida Community Health Center is the difficulty of finding skilled, bilingual medical support staff, such as nurses and technicians.

To help alleviate the shortage of health care facilities that offer obstetric services, Dr. Ryan, together with the Copper Queen Community Hospital, is conducting a feasibility study to determine the cost-effectiveness of creating another community health center, complete with a birthing unit, near or on the campus of the Copper Queen Community Hospital. If building this facility proves cost-effective, much-needed health care services will be provided to the southeast corner of the county.

The primary reason that the Elfrida Community Health Center, which operates under an annual budget of $2.5 million, is still providing obstetric care is that as a federally qualified health center (FQHC), it is not required to carry malpractice insurance. The center is covered under the Federal Torts Claim Act. Furthermore, the increasing number of Hispanic women who cross the border to give birth is covered under Federal emergency services.

Impact of Immigration, Malpractice and EMTALA

Jim Dickson, CEO, Copper Queen Community Hospital

The primary topics covered in Mr. Dickson's presentation were immigration, malpractice, and EMTALA and their effect on rural health care. He began by noting that the Arizona health care system is currently very fragile because of Government policy and events stemming from the September 11 tragedy. According to Mr. Dickson, the Federal Government made a conscious decision 3 years ago to funnel illegal immigration through the rural areas of Arizona and New Mexico instead of through California and Texas. This decision has resulted in more than 1.5 million immigrants crossing the Arizona border annually and in the creation of "boom towns" in Agua Prieta, Sonora, and Naco. The population in these towns has grown 400 percent, and the health care system is now struggling to support this growth. Furthermore, Government policy, under its "compassionate entry policy," dictates that the health care system in southern Arizona serve as the uncompensated trauma system for Sonora.

The total undocumented migrant population crossing the border into Cochise County has increased by 48 percent since 1999. The 30,000 immigrants who cross the border weekly

severely tax a health care system that already has to provide a significant amount of uncompensated medical services for at least 125,000 patients.

Arizona is currently facing a severe malpractice crisis, primarily due to the events of September 11 and its rippling effect on the State's malpractice insurance market. As a direct result of the impact of the losses incurred in the re-insurance market by the September 11 tragedy, more than 40 percent of the malpractice insurance carriers pulled out of the market, leaving Arizona physicians scrambling for malpractice insurance. This type of insurance is mandatory for all physicians practicing in Arizona because the State's constitution prohibits the abridgement of a person's right to sue. Consequently, 80 percent of the physicians in Cochise County lost their malpractice coverage and were forced to pay huge sums for "tail coverage." The malpractice insurance issue increases the amount of money that area hospitals are losing to $51 million a year. The Tucson Medical Center is losing $10 million a year, the University Medical Center is losing close to $12 million a year, and the Copper Queen Community Hospital is losing $300,000 million a year, up 300 percent.

The malpractice insurance crisis has had a significant affect on family practitioners who offer obstetric services. The liability cost for tail coverage for the first year is $45,000. The cost for malpractice per delivery rises from $816 to $1,900 per delivery, and reimbursement from Medicaid and Access is only $1,600 for prenatal care and delivery per patient. In addition to these increases, Medicare is planning to reduce physician fees by 4 to 6 percent in January 2003. Consequently, because they have no way of recouping these increased costs, physicians are either quitting their practice or leaving the area, thus affecting the availability of obstetric care in Cochise County.

Mr. Dickson then explained how the malpractice insurance dilemma has affected obstetric services at the Copper Queen Community Hospital, which provided the only obstetric services in a 4,000-square-mile area. Four family practitioners who offered obstetric care had their insurance carriers pulled from the market, and the new insurance carriers increased their rates 500 percent over a 3-year period. These physicians have been forced to cease obstetric coverage immediately, thus, virtually shutting down maternity services at the Copper Queen Community Hospital.

This malpractice problem also has had a severe effect on other specialty providers. Two general surgeons who currently serve the Copper Queen Community Hospital are considering leaving their practices because the cost of malpractice insurance increased to $80,000 a year. Their departure would eliminate general surgery from the surrounding 4,000-square-mile area. Patients will have to travel to Sierra Vista for surgical services, a 28-mile trip from Bisbee.

Overall, the increased cost of malpractice insurance, together with reduced revenue, has created an adverse climate for traditional medical care in southern Arizona.

Another problem that the health care delivery system in southern Arizona is facing is the overcrowding of its emergency rooms, which are the primary care providers in many communities. For the past 3 years, the Copper Queen Community Hospital has experienced a 20 percent growth in emergency room volume. The wait for service is about 4 to 6 hours. Both the University Medical Center and the Tucson Medical Center considered closing until a State "bail-out" of $6 million kept them open, albeit temporarily.

Arizona also is facing a crisis in its ability to obtain providers to staff its emergency rooms. This shortage in professional staff includes nurses and physicians. Many physicians are not available to cover emergency rooms in rural areas because of their increased malpractice exposure encountered in emergency care and the related malpractice insurance costs. CMS adds to this problem by the issuance of a new interpretation that a doctor cannot cover two emergency rooms at the same time. If this interpretation goes into effect, Cochise County would face a shutdown of general surgery services because the county now shares general surgery calls and surgical specialties such as orthopedics and urology.

Next, Mr. Dickson spoke about EMTALA and its effect on Arizona hospitals. EMTALA requires that all hospitals provide services to those persons who come to the emergency room for treatment regardless of their ability to pay and that physicians provide treatment to the level of stabilization for discharge and transfer. Although hospitals in Arizona strongly support EMTALA, the regulation is enormously complex to comply with and creates a very tenuous situation in already stressed and overcrowded emergency rooms. In rural Arizona, where emergency rooms act as the primary care provider, EMTALA virtually increases the cost of care. Compounding this situation is the threat that CMS is going to expand the scope of the Act to include inpatient transfers. This change and others to the regulation would make it almost impossible for small rural hospital to comply.

In general, EMTALA creates the problem of applying one standard of practice to all health care systems. It fails to recognize the diversity of health care delivery systems as they vary from rural to urban areas. Furthermore, the regulation does not provide for regional or local interpretation of acceptable practice or allow appeal at local levels.

Mr. Dickson concluded his presentation by offering recommendations or a "wish list" that would help improve rural health care in southern Arizona. These recommendations included the following:

- The Federal Government and DHHS should continue to support RHCs and FQHCs.
- The Federal Government must work with the Mexican Government to identify health care zones; health care must be funded in gray zones.
- The INS should be responsible for an immigrant's health care when they are injured during "hot pursuit."
- The tort/malpractice exemptions should be extended to FQHCs.
- The Health Act, introduced on April 12, 2002, must be supported. This piece of legislation would bring tort reform out the Federal Government and would limit damages and restrict attorney fees in malpractice cases.
- EMTALA's scope and coverage should not be expanded. The Act should allow regional appeal mechanisms.
- Contractual versus legal obligation should be resolved at the Federal level.
- HMOs and PPOs should be required to pay for stabilization and basic emergency room care, especially in rural areas.
- A guest worker program should be initiated that requires employers to pay for health care for workers in transit.
- Exemption from the APC Medicare payment system must be extended to rural hospitals regardless of whether they have critical access designation.

Challenges Facing the Douglas Hospital and other Area Medical Facilities

George Hooper, M.D., CEO, Southeast Arizona Medical Center, Douglas

The Southeast Arizona Medical Center, which includes the Douglas Hospital, 15 CAHs, and a 24-hour/7-day-a-week emergency room staffed by physicians, was pulled out of bankruptcy more than 2 years ago by becoming part of a nonprofit community cooperative that now owns and operates the hospital. The 43-bed skilled nursing facility was in bankruptcy for more than 3 years and was operated during this period by the Community Health Association of Mid-America, which also operated 4 other hospitals throughout the Midwest.

The Douglas Hospital faced numerous problems when moving from a bankrupted facility to an accredited medical center under new management. Almost all available money was spent fighting bankruptcy. Vendors were unwilling to sell equipment on credit, and the hospital had no collateral to purchase extended loans. Although the hospital today is more secure operationally than before, financial problems still plague the facility. One such problem involves the financial drain from the continuous treatment of undocumented aliens and other foreign nationals from Mexico.

From August 1995 through February 2002, the Douglas Hospital has written off over $9.5 million in charges due to treatment of undocumented aliens and other foreign nationals. From February 2002 to May 15, 2002, the Douglas Hospital already has doled out $155,754 in service charges, 99 percent of which is not collectable. The hospital averages about 23 to 24 no-payment

patients per month. The extent of this problem is attributed to INS's refusal to accept responsibility for any undocumented aliens they transport to local medical facilities for treatment. It is well-known that if INS agents take undocumented aliens into custody, they are responsible for all medical costs.

Another problem closely related to the treatment of undocumented aliens is the routine transfer of patients by Cruz Roja ambulances (Mexican ambulances) from Agua Prieta to the Douglas Hospital. To avoid treating uninsured patients, hospitals in Agua Prieta instruct ambulances to transport patients across the border, knowing that the border patrol will offer little resistance. Adding to the already excessive cost of treating illegal immigrants is the high cost of helicopter service from the Douglas Hospital to Tucson ($7,000 per trip) and from Douglas to Phoenix (from $15,000 to $20,000 per trip). If rural hospitals in the area become financially strapped and are unable to pay for this type of transportation, helicopter services will be forced out of business, plummeting health care services in rural areas back to their 1980's status.

The shortage of health care workers, such as nurses, x-ray technicians, laboratory technicians, and physical therapists, is another problem that health facilities are tackling in southern Arizona. The Cochise County hospitals are understaffed and have less than 300 beds combined. One or two physicians can make a difference in maintaining or closing a service, such as the operation of a 24-hour emergency room. The Douglas Hospital cannot afford to pay the higher wages that nurses receive in Tucson and Sierra Vista hospitals or even afford to promote the $2,000 or $3,000 sign-on bonuses to attract more nurses to the area. Many of the nurses educated at Cochise College or at the local nursing college are seeking nursing jobs in urban areas where the pay is higher and the work is less demanding.

Discussion

Initial discussion focused on how the Douglas Hospital, under the direction of the nonprofit community cooperative, pulled itself out of bankruptcy. Dr. Hooper noted that the hospital first paid the bankruptcy court and then assumed all debts incurred by the Community Health Association of Mid-America while it operated the facility for 3 years. These debts included a number of outstanding vendor and supplier invoices.

In response to a question about the elimination of hospital services because of the high rates of uncompensated care and the increase in malpractice insurance rates, Mr. Dickson reiterated that obstetric services at both the Copper Queen Community Hospital and the Douglas Hospital had to be discontinued because of these two problems. He explained that approximately 90 percent of the obstetric patients received by the Douglas Hospital were Access patients and therefore usually paid a delivery fee of only $85. Most of these obstetric patients had received

no prenatal care, so any health problems were unknown before delivery. Consequently, malpractice suits became common in circumstances in which physicians delivered imperfect babies. As malpractice cases increased in southern Arizona, malpractice insurance rates skyrocketed (up 300 to 400 percent), causing the cancellation of obstetric privileges throughout the area, with the exception of Sierra Vista. Overall, the Douglas Hospital paid over $300,000 in uncompensated care last year. The only medical facilities that can afford to take the increased volume of uncompensated care and survive financially are FQHCs and RHCs.

Mr. Dickson admitted that the receipt of Medicaid rates for undocumented aliens would make a difference in whether a hospital is in the red or black. He also noted that Medicaid DSH payments are distributed by the State and therefore the majority of the money goes to State institutions, making it difficult for independent health care facilities to budget or plan for this type of funding.

In response to a question about long-term health care, Dr. Hooper noted that the Southeast Arizona Medical Center's long-term care facility has a 43-bed capacity and that the county pays according to patient severity. Currently, the cost for patient care averages between $135 and $140 a day, but the county reimburses the hospital only about $97 a day. Dr. Hooper foresees the eventual closure of the facility because of its high operational costs versus the county's low reimbursement rate.

In closing the meeting, Chairman Beasley thanked Mr. Dickson and Dr. Hooper for their insightful presentations, which will have a direct impact on his letter to Secretary Thompson. With the Committee's permission, Chairman Beasley suggested that the letter emphasize southern Arizona's impossible situation of not only trying to deliver quality health care to rural communities but also trying to provide uncompensated care to large volumes of people who across the U.S.-Mexico border daily. This problem will require focused attention from various Federal agencies, as well as from the Mexican Government. The letter also will include a set of general awareness provisions and suggestions from NACRH members about what the first steps might be to address these serious issues.