

**Frontier and Rural Expert Panel
Annual Meeting
Lodge on the Desert, Tucson, Arizona
March 8—9, 2006**

**MEETING SUMMARY
"Public Health on the U.S.-Mexico Border and the Use of Health Information
Technology"**

Background

In 2004 the Federal Office of Rural Health Policy (ORHP) issued a Request for Proposals for a Frontier Rural Health Care Information Project. The Frontier Education Center bid on this project and was subsequently awarded the contract. The name of the Frontier Education Center has been changed by the board of directors to the National Center for Frontier Communities and will be referred to as such throughout this report. Among the tasks contained in the contract were to establish a frontier issues group and to host an annual meeting of the group. Established in 2005, the Frontier and Rural Expert Panel consists of seven experts in the field committed to providing guidance to the National Center for Frontier Communities as the organization addresses frontier and rural health issues for ORHP. Panel members possess diverse expertise in frontier and rural health care and represent an array of geographical areas. The first annual meeting of the Frontier and Expert Panel took place in Santa Fe on April 14, 2005.

Second Annual Meeting

The second annual meeting was held in Tucson, AZ at the Lodge on the Desert. A full day meeting was held on Wednesday March 8, 2006 and a field trip to the U.S. and Mexico cities of Nogales followed on the next day.

Members in attendance included Patricia Carr, Alaska; Gar Elison, Utah; Caroline Ford, Nevada; Rebecca Slifkin, North Carolina; and Martin Bernstein, Maine. Karl Stauber, Minnesota and Peter Beeson, Nebraska did not attend. Emily Cook, Federal Project Officer, attended. National Center for Frontier Communities staff members Carol Miller, Executive Director; Karen Sweeney, Administrative Assistant; and Betty King, former health officer on the Arizona border, also were present. A list of panel members and their affiliations is included as Attachment A.

Speakers included Alison Hughes, former Director of the Arizona Rural Health Office, and Charlie Alfero, Chief Executive Officer, Hidalgo Medical Services (HMS), Lordsburg, NM. Discussants were Susan Kunz and Andrew Lorentine, both of the Tohono O'odham Nation and George Craig, HMS IT Manager. A list of meeting speakers and discussants is included as Attachment B.

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Introductions

Carol Miller welcomed Panel members to the second meeting. She reminded participants the purpose of the meeting was to discuss issues of importance to ORHP and provide recommendations. A major topic this year is Health Information Technology (HIT) on

the border, focusing on public health. Two other topics for Panel member consideration are: Frontier Extended Stay Clinics and Medicare Part D and Frontier Pharmacies, a continuation of a 2005 topic.

Miller outlined a new format with presentations and discussants this year and asked panelists to provide feedback in their meeting evaluations. Panel members briefly described their work:

- Marty Bernstein has been the CEO for 22 years of a small rural/frontier hospital and health system based in Fort Kent, Maine on the Maine/New Brunswick, Canada border. The hospital provides a wide range of services.
- Gar Elison, Executive Director of the Utah Medical Education Council, is based in Salt Lake working primarily with residency training. The focus now is trying to get training into rural areas.
- Rebecca Slifkin is Director of the North Carolina Rural Health Research and Policy Analysis Center at the University of North Carolina, Chapel Hill.
- Patricia Carr is Unit Manager of the Health Planning and Systems Development Office within the Office of the Commissioner for the Department of Health and Social Services in Alaska and is also a State Office of Rural Health Director. Her office has the FLEX program and many other federally funded rural health programs. She is currently working on the Frontier Extended Stay Clinic Initiative, the Physician Supply Task Force, and the state planning grant for the uninsured.
- Emily Cook, Project Officer, is with the Federal Office of Rural Health Policy in Rockville, Maryland. Cook reported that three National Center for Frontier Communities papers prepared last year should be available through the ORHP web site very soon and that ORHP was pleased with the papers. The papers are on training community health workers using technology, an examination of three communities heavily impacted by seasonal population fluctuations, and challenges related to the recruitment and retention of emergency medical services in frontier communities.
- Caroline Ford is Director of the Nevada State Office of Rural Health in the Center for Education and Health Services Outreach, which she also directs. The Center operates about 25 programs and serves 50-90 underserved communities around the state. They are currently trying to move more training programs into these communities to help improve recruitment and retention. Since Nevada is the second highest growth state for the last two decades, many frontier areas are growing and building hospitals instead of closing them.

Miller discussed three maps provided in the meeting packet (included here as Attachment C) and pointed out that two were prepared showing border facilities using publicly

available data bases, with the caveat that at times these databases contain errors. There are ten states that comprise the U.S.-Mexico border. Sixty-two miles (100 kilometers) north and south is usually recognized as the border area as established by the La Paz Agreement (1984).

The National Center for Frontier Communities uses a matrix that looks at population density, travel times in minutes and distance in miles to health services to define frontier areas. After each decennial census the National Center for Frontier Communities with the State Offices of Rural Health develops a consensus list of frontier areas. The U.S.-Mexico border is characterized by frontier areas as well as major metropolitan areas. For example, approximately four million people live along the border in the San Diego area, while most Arizona, New Mexico and Texas border counties fit the frontier profile.

Note: All references to “frontier” use the Consensus Definition of the National Center for Frontier Communities unless otherwise indicated

<http://www.frontierus.org/index.htm?p=2&pid=6003&spid=6109> . This definition has not been adopted by any federal programs but has been adopted as policy by the Western Governors Association

<http://www.frontierus.org/documents/WGA%20Policy%20Resolution%2004.htm> and the National Rural Health Association. The Consensus Definition weights three elements – population density, distance in miles and travel time in minutes - which together, generally describe the geographic isolation of frontier communities from market and/or service centers. The Center understands that various programs will establish their own programmatic definitions and eligibility criteria.

Improving Healthcare Quality Through Health Information Technology (HIT) Presentation by Alison Hughes

Miller introduced Alison Hughes. Hughes has worked in rural health care in Arizona for over two decades, most recently serving as Director of the Arizona Rural Health Office for four years before retiring. She is now working on the rural hospital flexibility program and teaches at the Mel and Enid Zuckerman College of Public Health at the University of Arizona.

Hughes discussed the current status of health information technology nationally and in Arizona and described the issues for implementation in U.S.-Mexico border communities.

National HIT Goals

The goals of the National HIT Initiative are to: avoid medical errors; improve quality of care; accelerate bench to bedside medicine; empower consumers; and reduce costs. The national overarching goal is to create a nationwide interoperable, standards-based network for the secure exchange of health care information available for most Americans within ten years. Some wonder if the ten-year time frame is realistic.

The President's Executive Order (2004) articulates a vision for creating a national HIT initiative including:

- Development of a nationwide interoperable infrastructure;
- Incentives for the use of HIT;
- Establishment of the Office of the National Coordinator for Health Information Technology (ONC) within the Office of the Secretary of Health and Human Services.

HHS Implementation

In May 2005, Health and Human Services Secretary Mike Leavitt announced a 500-day plan to implement the President's executive order. Among Leavitt's key focus areas are "Transforming the Healthcare System" which includes linking "nearly all health records...through an interoperable system that protects privacy as it connects patients, providers and payers – resulting in fewer medical mistakes, less hassle, lower costs and better health."

The ONC has four work groups: bio-surveillance, chronic care, consumer empowerment, and electronic health records. Hughes recommended checking the ONC web site frequently <http://www.hhs.gov/healthit> as the initiative proceeds.

The goal of the ONC is the adoption of national standards. These standards will include:

- Processes to harmonize health information standards;
- Criteria to certify and evaluate health IT products;
- Solutions to address variations in business policies and state laws that affect privacy and security practices that may pose challenges to the secure communication of health information;
- Certification process for vendors.

Arizona HIT

In Arizona there is a Governor's Health-e Connection Roadmap similar to the national initiative. Hughes was not aware of other states with such activities underway. The Arizona steering committee has 39 members and is working on recommendations. Hughes has been a voice for rural issues at the meetings and has organized participation by other rural representatives. The appointed representative from Indian Country is from Phoenix, which means rural tribes are not well represented.

Definitions

Health Information Technology (HIT) refers to local deployments of technology to support organizational business and clinical requirements (e.g., E-prescribe, personal health records, and electronic medical records). Health Information Exchange (HIE) refers to infrastructure to enable data sharing between organizations (e.g., results delivery, shared patient summary, public health alerts, public health query, and clinical

decision support). In answer to a question about personal health records, Hughes responded that people having access to their patient record is a goal of this effort. She then discussed the governance structure.

At this time Arizona has not decided if the system would be a private or government entity. The Steering Committee has stated its intent to adopt any rules that are adopted nationally to assure interoperability.

Broadband Critical for HIT Implementation

Barriers to broadband deployment in rural Arizona include:

- Insufficient leadership, planning and coordination;
- A lack of cooperation among the telecom providers and indifference or lack of public and private cooperation;
- Return on investment for telecoms in rural areas is insufficient to support broadband infrastructure build-out without a technology breakthrough or subsidy support;
- Rights-of-way access including a morass of Federal, tribal, state and local rights-of-way regulations, multiple jurisdictional permitting, lengthy application approvals, unequal and prohibitive fees.
- A lack of funding subsidies.

Broadband is necessary for HIT implementation. The Governor's Office of Information Technology has estimated the cost of broadband services and has learned that it is not prohibitively expensive, especially if Arizona can qualify for the FCC Universal Services program.

An Arizona map illustrates gaps in fiber optic systems as well as in telephone systems. This is a significant barrier to developing statewide HIT. Hughes compared the Arizona map (Attachment D) to maps showing significant connectivity in Georgia and Colorado (Attachment E).

Wireless Pilot

Arizona has a pilot project using WIFI (wireless fidelity) on the CANAMEX corridor funded by a grant to the Government Information Technology Agency. The CANAMEX Corridor extends from Nogales, AZ through Las Vegas, NV, along the I-15 corridor through Salt Lake City, UT, Idaho Falls, ID, Great Falls, MT, to the Canadian Border.

The pilot project is a 30-mile stretch from the Pima County line to Rio Rico, Arizona toward the Mexican border. The equipment is mounted on the top of both HAZMAT vehicles and telephone poles. This allows the use of laptops in fire vehicles and police vehicles, etc. so they can access the Internet while they are on the road. One point in the Sells area, capitol of the Tohono O'odham Nation, is included. This system enables a Rural Health Office mobile health clinic to use a non-mydriatic camera for immediate

transmission of ophthalmic images directly to the University Medical Center for consultation with an ophthalmologist. This is very helpful because there is a huge diabetes problem among Hispanic residents that the clinic serves. The pilot has required significant coordination with telephone and electric companies but has great potential for both health care and preparedness.

Tele-Trauma Pilot

There is also a tele-trauma pilot at the U.S.-Mexico border. The pilot began in Douglas, Arizona where a video-conferencing system was installed. If the Douglas emergency room physician or nurse needs assistance with a patient they can call the Level 1 Trauma Center in Tucson where a surgeon monitors the patient's vital signs and provides real time consultation. This reduces transfers to urban areas where there are often shortages of staffed beds. The Douglas hospital has to send patients to Texas when there are no beds in Tucson. Sometimes there are empty beds but no nurses to staff the beds. Based on the success of the Douglas pilot, the Trauma Center has received funds to install video-conferencing systems in 10 small hospitals in the southern part of the state. These will provide access to a trauma surgeon consultation before the patient is transferred or treated in the smaller hospital.

A question was raised about provider reimbursement. This is not currently an issue because there is a surgeon committed to this effort without regard to payment. He is an example of the importance of physician champions to make progress in health care. Arizona also needs bi-national government champions. The pilot benefits rural hospitals because they can keep the patients close to home as well as keep the revenue in the hospital.

Tohono O'odham Nation Spans the Border

Hughes then presented a map of the Tohono O'odham Nation. The Nation has eleven districts and is the largest piece of land occupied by a sovereign nation in the United States. It covers 4,000 square miles and has 23,000 members, with 12,000 living on the reservation. Cattle fencing is all that separates the Nation from Mexico. Members have lived for centuries (long before the Spanish invaded) on both sides of this artificial border that was created by two governments. U.S. physicians used to go to clinics on the Mexican side, but this was stopped some time ago by the Mexican government.

The Indian Health Service Hospital in Sells has thirty-eight beds with an average daily census of eight. The hospital also serves a lot of undocumented workers. Between October 1, 1997 and September 30, 2001, the hospital provided care to 723 undocumented patients.

Bi-National Hospital Policies

Walls separate Nogales, AZ from Nogales, Sonora and Douglas, AZ from Agua Prieta, Sonora. Some legislators would like to build such a wall across the entire border. When the wall was first built in Douglas, the hospital saw a lot of broken limbs of attempted crossers who didn't realize how difficult it was to jump across the wall.

Staff at the San Luis, AZ Health Clinic work with San Luis, AZ and San Luis, Mexico (*Ambos San Luis*) health providers to address health concerns. Amanda Aguirre, a state legislator, obtained funding for this new clinic. The Hospital Santa Margarita is on the San Luis, Mexico side and the Yuma Regional Medical Center is on the U.S. side.

The Clinic has a bi-national insurance program, the CAPAZ-MEX Discount Network. Over 58 health care providers on both sides of the Yuma-San Luis border are enrolled in the program and over 500 members have already enrolled. The CAPAZ-MEX Discount Network includes laboratory tests on both sides of the border provided by Novus Laboratory in San Luis, Mexico and the San Luis, Arizona clinic. Lab tests ordered in the U.S. are reported with range values that are concurrent with both Mexico and U.S. systems. This model has enormous implications for a national electronic health records system. It demonstrates that because patients who live on both sides of the border can have continuity of care with shared records through a system that includes Mexican doctors.

Southeast Arizona Medical Center in Douglas is working with the hospitals in Agua Prieta, Mexico. The population of Agua Prieta is over 2 million people, compared to tiny Douglas with about 15,000 people. There are six hospitals and 140 health care providers in Agua Prieta, Sonora, and one hospital and nine providers in Douglas, AZ. The two communities have formed the International Triple C Committee (Communication, Cooperation and Collaboration). The Committee includes *Cruz Roja* (Mexican ambulance service), Douglas Fire, the Agua Prieta Public Health Director, six hospitals in Agua Prieta and the Southeast Arizona Medical Center.

An example of an issue the committee is addressing is the transport by *Cruz Roja* of a woman in labor to the hospital in Douglas where there is no obstetrical care instead of to the hospital in Sierra Vista, an hour away, where obstetrical care is available. Douglas is a full service telemedicine hospital. Reduction of transfers of patients from Mexico to the Douglas hospital will be helped by telemedicine. They have not been able to do this yet because of international telecommunication policies.

Snowbirds on the Border

In the Yuma area, the town of Quartzsite (pop. 2,500) hosts more than 60,000 winter visitors from November to March each year. These "snowbirds" come from throughout the U.S. in their recreation vehicles, wealthy people and poor people. They are like birds migrating to their same spot every year. In February there can be over 100,000 recreation

vehicles camping out for the annual gem show. This presents serious problems for local health care.

These visitors are mostly elderly, but often healthy elderly. There used to be a physician who provided care each winter out of his truck. Now two doctors come and set up a temporary clinic each winter. It is unclear how temporary doctors will tie into a national electronic health record system.

Many of these seasonal visitors go to Mexico for medicine. For hospital care they go to hospitals in Yuma or Parker, Arizona or Blythe, California. The western Arizona border area includes this primarily white community of winter visitors, the Hispanic community and the Native American community.

Bi-National Planning

To address HIT along the border, international policies have to be addressed. The Mexican government needs to install broadband, and telecommunication companies on both sides of the border need to cooperate. Once there is ubiquitous Internet and broadband there could be cross-border transmission of electronic medical records.

Congress is currently reforming the Telecommunications Act of 1996, which includes the Universal Service Fund. In early March 2006, Senator Ted Stevens (AK) held hearings on the rural health care part of the Act. Hughes noticed a lack of rural advocates on the hearing panel, and encouraged rural organizations such as the National Organization of State Offices of Rural Health to participate.

Senate Rural Telecommunications Hearing panelists include Mark Johnson, Regulatory Commission of Alaska; the Senior Vice President and General Counsel for the Blackfoot Telephone Cooperative; a QWEST Vice President and a representative from Microsoft. Hughes noted there was no broad rural input.

The Universal Services Fund is seen as a means of funding broadband services for rural America. Universal Service Fund issues include:

- An AARP challenge on behalf of senior citizens to the mandatory one-dollar monthly telephone bill fee. AARP believes senior citizens should pay less.
- The way that funds are distributed for rural health. Rural schools and libraries are funded for installing their systems, while rural clinics receive only a discount on their Internet service (25 percent) and a discount on monthly telecommunication costs.

Regional Health Information Organizations and HIT

Regional Health Information Organizations (RHIOs) are entities that coordinate HIT systems. ONC defines them as entities that support state and other regional projects that help harmonize the privacy and business rules for health information exchange.

According to ONC there are over 100 RHIOs that have been federally funded including the Hawaii Quality Healthcare Alliance and Colorado Health Information Exchange. Few are rural focused. A Tucson RHIO is forming, but rural interests are not represented. Hughes sees a need for an Arizona RHIO that focuses on rural data exchange issues. Staff of the Arizona Health-e Connection Roadmap Initiative has recognized the need to develop a mechanism for rural health information exchange.

Border HIT/HIE Issues

- Patient Transfers. Communication of service availability among hospitals as well as tele-trauma guidance will help assure that the most appropriate facility will receive the patient. It is expected that this will improve patient outcomes. Wireless and tele-trauma availability are essential for these functions.
- Telecommunications. Telecommunication limitations between the U.S. and Mexico impact the capacity to provide care. Bi-national telecommunication policy and collaboration is vital to this effort.
- HIT Champions. HIT/HIE champions; hospitals, clinics, physicians and nurses are needed. Hospital CEOs are installing electronic health records systems with support from the FLEX program, but often the physicians are not involved. The Arizona medical society is starting to educate physicians. These efforts are developing separately, but need to be synchronized including physicians who are in private practice but contract with the hospital.

Carr stated Alaska discussions have been around how to connect the larger systems to the smaller systems. She asked for ideas on connecting the rural RHIOs to urban RHIOs.

Hughes pointed out the importance of incremental capacity building and the importance of certifying vendors. The Arizona group is considering limiting the number of vendors and having them work together to develop compatible software systems.

- Multiple Records. Patients often have records at more than one hospital. Indian Health Service (IHS) hospital patients may have records at multiple clinic sites. IHS is installing the VISTA System developed by the Veteran's Administration. They have been working on a pilot at Fort Defiance for close to a year. In the future, IHS is going to create a complete patient record by connecting their VISTA System to a national interoperable system.
- Rural Healthcare Facility Needs. The small rural hospitals and clinics need orientation, education and training in:
 - Readiness assessments for electronic medical records and e-prescribing.
 - Analysis of existing IT infrastructure and work flow.

- Business plans for electronic health record implementation.
- Coalitions for health information exchange.
- Selection of vendors committed to interoperability and price negotiation.
- Systems installation.
- Sources of Funding
 - ONC
 - HRSA Grant Programs:
 - Office for the Advancement of Tele-health
 - Office of Rural Health Policy
 - U.S Department of Agriculture, Rural Development Grants
 - Agency for Health Quality Services and Research
 - Universal Service Fund
 - Department of Commerce

Tohono O'odham Discussants

Andrew Lorentine and Susan Kunz, Health Planner, work with the Tohono O'odham Department of Health and Human Services. The Department provides services that are not clinic or hospital based.

The Tohono O'odham Nation (Nation) is unique because it is divided by approximately 75 miles of the U.S.-Mexico border, with tribal members on both sides. Many tribal members living in Mexico come into the Indian Health Service Hospital on the Arizona side for services. When asked about homeland security, Lorentine responded that he often shows a photo or takes people to see the three-strand wire fence that divides the Tohono O'odham Nation at the U. S. and Mexico border.

Lorentine observed that Hughes' presentation raises issues with the HIPAA regulations and concern about the ability to communicate with counterparts in Mexico, both written and oral. As an example, there is a bi-national Bio-terrorism project. Recently, they have been talking about electronic and radio communication. They have purchased TACPACs, a unit in a case that has a satellite phone and fax capability and computer. The idea is that, using technology, you can communicate anywhere, but not when users do not speak the same language. In Santa Cruz County, they work with Nogales, Sonora providers, yet U.S. regulations forbid use of the system in Mexico. Lorentine anticipates problems using these systems in Mexico when responding to emergency situations.

Arizona has established SIREN, a closed, secure system for communication through the Internet to transfer information about possible terrorist activities. Arizona has issued licenses for use to the Nation with both tribal and border portals. Arizona also licensed providers in Hermosillo and Caborca, Sonora to communicate through the Internet. This system has not been used yet because language is a barrier.

Systems have been tried before and failed. STARPAC (Space Technology Applied to Rural Papago Advanced Health Care), which began in the mid-Seventies, was the first

telemedicine program in the U. S. It eventually closed when funding stopped. *Segura Popular* is insurance based on income available in Mexico. Recently, the Nation learned of tribal members on this insurance. The Nation has been researching a way to insure all tribal members.

Border states have the Early Warning Infectious Disease Surveillance System. This system is operating in Arizona and being developed in Sonora. The IHS has a medical records system, but individual patient records are not shared across the three Tohono O'odham clinics even though they are in the same service unit.

In response to a question regarding the border fence, Lorentine replied that tribal members don't recognize the border since members live on both sides. On the other hand, there is concern about the criminal element (drugs) and undocumented immigrant crossings. This is becoming more important than the ability to cross back and forth freely. Today there is a lot of crime and environmental damage (trash, abandoned cars) left by undocumented immigrants. Approximately 1,500 undocumented immigrants cross the Nation's land daily. Last year, the tribe turned down water stations because they did not want to encourage more traffic and place their members in increased danger.

Elison asked if the World Health Organization or any other organization was trying to create a standardized medical record. Kunz said they have worked on that but there is no conclusion. Hughes pointed out the President just made new appointments to the U.S.-Mexico Border Health Commission. This could be a recommendation to the Commission. Elison pointed out the need for a portable medical record. Miller stated that undocumented immigrants are coming from many other countries in Central and South America.

Hughes told of a Dr. K. Riddle who, when working in India, began a program to give patients their own health records. Today, in many villages of India and Africa, nomadic peoples carry their records with them as precious belongings wherever they go. It has become more common for individuals in the U. S. maintain their own health records. It is important to assure that the poor have equal access to their health records.

Kunz pointed out the need for ongoing communication to keep up with constant change.

History and Status of HIT and Hidalgo Medical Services Presentation by Charlie Alfero

Charlie Alfero is the Chief Executive Officer of Hidalgo Medical Services and Hidalgo Area Development Corporation based in Lordsburg, New Mexico. This community health system includes nine clinics in a two county area serving 36,000 people. The annual average is 50,000 patient visits and 35,000-40,000 family support visits. Hidalgo Medical Services has a hospital-based practice, delivering babies and the full range of primary care. George Craig, HMS IT Manager, also attended the meeting.

Alfero described the establishment of Hidalgo Medical Services. Historically, the University of New Mexico was reluctant to sponsor rural health services. When Alfero went to work with the University included in his contract was the time to help the community start a clinic in Lordsburg, county seat of Hidalgo County. Coincidentally, the Dean of the Medical School at that time is the father of the current Arizona Governor. Hidalgo Medical Services began in 1995 with a \$35,000 contract from the state to provide medical services. In 1997, two HRSA grants were funded (rural health outreach and community health center) increasing the clinic's budget from \$200,000 to one million dollars in one day.

Early Inclusion of HIT

The development of telecommunication and telemedicine services was written into the outreach grant. HMS, in collaboration with the University of New Mexico, became the first teleradiology site southwest of Albuquerque. They did some televideo conferencing, and at one point there was intermittent telepsychiatry support, but these were much more of a challenge than the teleradiology. Originally, there was no T-1 line connectivity to Lordsburg. HMS had to install a line to get high speed access. With this access, they could get radiology readings in 25 minutes. When the head of the teleradiology program retired, the program ended, and it took a year to find another partner. Currently their affiliation is with their local regional hospital in Silver City. HMS has spent a lot of time and money on connectivity.

The town of Playas is south of I-10 and 50 miles south of Lordsburg. It was a Phelps Dodge company town and copper smelter. The Playas clinic had a satellite connection to an HMS clinic in Silver City. The satellite connection was set up so the physicians could supervise physician assistants in Playas but ended when the physicians found they preferred personal contact with the physician assistants. The Phelps Dodge contract changed to fly the physicians down once a week. HMS had a clinic in Playas before the smelter and town closed completely. The entire town of Playas has been sold to New Mexico Institute of Mining and Technology in Socorro to be used for Homeland Security training.

Hospital care is fragmented in Hidalgo County. The Lordsburg hospital closed in the early 1980s, and most people go to Silver City for hospital care. Trauma patients west of Lordsburg are taken by ambulance to the Arizona border where a helicopter picks them up and takes them to Tucson or sometimes El Paso, Texas. If the trauma occurs north of town, typically the ambulance will go to Silver City or the patient will be flown to Albuquerque.

As an example of the difficulties people without insurance have getting health care, Alfero shared the story of a patient. Several months ago, there was a 22 year-old uninsured patient in Silver City with a suspected brain tumor and it took ten days to find a hospital placement. With the help of a Silver City private practice physician, the patient was accepted by a for-profit hospital in Albuquerque.

A few years ago, HMS added five clinic sites in Grant County, north of Hidalgo County, and the location of Silver City where the hospital is located. One clinic is thirty miles north of Silver City in Cliff; another is thirty miles east in Mimbres. Next month a clinic is being opened in Bayard, ten miles east of Silver City. Bayard will have both a school-based clinic and a community-based clinic. There are also community and high school clinics in Silver City.

Developing HIT Support

HMS has used a variety of strategies to get broadband to all their sites for the transmission of patient information to the main office in Lordsburg. T-1 lines now connect Lordsburg to the rest of the world. The next challenge was connecting Silver City, with 30,000 patient visits a year. HMS later added Bayard and Silver City High School via two T-1 lines to Lordsburg. The other locations have DSL broadband. Tele-radiology is now wireless through Duncan Valley, AZ Electric. Getting all of these sites connected has been a very complex endeavor.

In answer to a question about interoperability, Craig replied that while it is really one system based in Lordsburg they have to work with three phone companies. Alfero added that interoperability is connecting the hardware and software to other institutions.

All of the HMS systems such as patient information and billing are connected internally through high-speed communication. The systems are in place to transition to electronic medical records.

Four-County Wellness Coalition

HMS used a Network Development Grant from the Office of Rural Health Policy to set up a four county collaborative in southwestern New Mexico, comprised of Hidalgo, Catron, Grant and Luna counties, with a combined population of about 60,000. A separate non-profit corporation called the Wellness Coalition Healthy Community Access Program was established with two people from each of the four counties and an at-large president on its board. The collaborative created a critical mass of population to qualify for more funds. Their first grant was a million dollar Bureau of Primary Health Care Community Access Program (CAP) grant to purchase high speed access in the four county area and connect health providers in the southwestern part of the state. In the first year about thirty percent of the budget was hardware and software related. In subsequent years, the grant supported the new information system.

The mission of the Wellness Coalition is to provide uninsured and underinsured patients with access to a comprehensive and coordinated system of health services in the four counties of southwestern New Mexico. The Coalition has broad health agency participation, although public health is not participating.

New Mexico is one of only two or three states organized with a state health department operating programs in each county. There are multi-county district offices but every county is required by law to have at least one public health office. The county's only

obligation is to provide a facility. Even when public health offices are co-located in other health facilities, there is often little communication. HMS spent three years of monthly negotiations to integrate medical records among the agencies. A contract was agreed to at the state level, but at the local public health department level, the Director of Nursing decided not to do it, so it never happened.

HMS operates an online medication assistance program to help eligible patients get free drugs directly from wholesalers and pharmaceutical manufacturers. This program is staffed by HMS community health workers.

Electronic Family Support Services

Community health centers are required to have a portion of their budget dedicated to "enabling services" such as patient support, eligibility determination, discharge planning, home visits and health education. Ten years ago, HMS decided that support services needed to be a major emphasis creating a Family Support Department. This department is about twenty-two percent of the HMS budget (a \$1.8 million program). The program includes 15 community health workers, exercise kinesiologists, and nutritionists.

Anyone in the community can access Family Support Services for assistance with anything they need to help them in their lives. CHASSIS is a shared information system connecting all the partners in the four county area. It includes an eligibility database for forty different programs. Using computer software called the MEDICAIDER, HMS does a three minute Medicaid screen at its clinics and the computer program populates forty different applications for other programs, such as housing assistance and food stamps. The MEDICAIDER is an important piece of health information technology for southwestern New Mexico. The hospital in Silver City is not currently participating even though they are a major provider in this area. Generally they are an excellent partner, but they have concerns about HIPAA assurances, and hospital staff was reluctant to have HMS do their financial eligibility work for them.

HMS has been part of a national chronic disease collaborative for diabetics and hypertensive patients for about six years. HMS has been working on cardiovascular health issues for two years. All of the HMS sites are connected to the diabetes and hypertension databases. The basic functions are the MEDICAIDER enrollment, case tracker and case analyzer. HMS is also part of an anonymous donor fund, which allows them to provide up to \$7,000 in cash assistance to patients with financial emergencies. Any partner can find HMS patient information in the Family Support System, and the data sorting capability is excellent. There is also a system of email and follow-up reminders for referrals. This part of this state often feels disconnected from the rest of the state, but this system has the state's attention.

All HMS clinics are Federally Qualified Health Centers (FQHCs) operated by a single board of directors.

Since initiating the MEDICAIDER program, the percent of Medicaid clients in the HMS system has gone up from 24 percent to 33 percent of patient visits. This means for a \$100 visit, HMS gets \$100 from Medicaid instead of using grant funding, which increases the ability to provide more services.

A lot of funding comes from the U. S. Department of Health and Human Services to state primary care associations to do integrated services networks. HMS doesn't participate in the New Mexico Primary Care Association data sharing system. Alfero feels it is more important to connect with other providers in the local community such as the hospital than to link to clinics across the state.

Discussion

Slifkin discussed the similar challenge for a rural community health center in North Carolina on whose board she sits. The area hospitals had different data priorities so it was difficult to develop a shared record to get the information required for reporting and tracking clinic care. Alfero sees an ongoing challenge in integrating hospital medical records with the current HMS patient information system. The vendors need to be pushed to develop programs that let different types of providers talk to each other.

Frontier Specific HIT Issues

The group discussed which HIT aspects the border health paper should focus on, for example, only issues unique to frontier areas. Miller noted that there is a continuum of rural that extends out to frontier but there are similar characteristics among small rural and frontier communities.

Alfero pointed out that unique issues include:

- Challenges of connectivity to broadband;
- Cost;
- Logistics of maintaining a system across multiple distant providers;
- Ability to recruit highly trained technical support to a frontier community;
- Achieving critical mass.

If HMS took Silver City out of its clinical mix, there would be insufficient critical mass to sustain a well functioning electronic medical record system, the system would be too expensive for the small clinics alone.

In North Carolina one community health center organization has all bilingual providers. The numbers of uninsured Latinos are providing critical mass, but finances are getting harder and harder to sustain. Electronic medical records are being rolled out in one clinic site located in a new building, where it was possible to include the costs in a construction loan and have the building designed to support all the hardware.

Private Practitioners and HIT

Ford pointed out that in Nevada, especially in frontier areas, care is often provided by the private sector, and that the gap between public and private providers threatens to become even larger with the implementation of electronic medical records. Private practitioners don't have the resources to equip their offices, and they are not participating in various coalitions or the policy debate of how to connect communities, create electronic medical records or have access to data storage. Isolated, individual providers will probably never be at the table unless they are required to be there. A challenge is how to engage the private sector to prioritize telehealth and HIT.

Carr suggested that the will to make it work is a key factor to success. Bernstein pointed out that payment rules by the government will drive the process. Many insurers (Blue Cross of Maine and Medicare) are implementing "pay for performance." They are beginning to ask questions like, "Do you have electronic medical records or other services on line?"

Special Health Care Issues in Frontier Areas

Panel members then discussed the ongoing demise of rural solo practitioners and agreed that HIT may "be the nail in the coffin." More rural and frontier physicians are becoming salaried. The increase in salaried providers may affect access because some solo practitioners are in communities that FQHCs or other institutions won't support. As older physicians retire, people in those communities have to travel farther for care, or systems come in and replace the private physicians with salaried providers.

There are different kinds of communities in frontier areas. Those with aging populations are more in need of local health services because of lack of access to transportation. Yet these are the communities that appear to be losing providers and services. Options discussed include enhancing emergency medical service providers and training community health workers.

An ongoing issue is the variation of state licensure laws for independent practice by physician assistants and nurse practitioners. In some states this is a huge barrier to getting primary care to remote areas. Facility remodel costs to meet federal licensure rules can also be prohibitive.

Panelists brought up funding difficulties associated with frontier service areas. Programs to provide resources should include broader criteria than just underservice. Justification other than cost-benefit must be used when providing health care in isolated areas because costs are high and volume is low. Many sites fly in providers on a regular basis and there is often a low income population and a lot of uncompensated care. Volume is not a feasible standard in frontier areas; perhaps market penetration is a more viable measurement or visits per user rather than total number of visits.

Community health center business plans should address how to subsidize sites located where services are needed. There has to be accountability by community health centers to fulfill their mission to serve their area. HMS loses \$40,000-50,000 a year providing services at two clinics in its service area and has to make this up at other sites. Some clinics will never be self-sustaining but their services are essential.

Role of HIT

Carr responded that HIT needs to be used more to expand and continue services in rural and frontier areas. There is a trend toward telemedicine and video conferencing. Rural health professionals need to be participants in that dialogue.

HIT can help by tying community health workers into larger systems. An effective system to disseminate information about effective HIT tools is needed.

Elison asked if HMS has established any home monitoring services. Alfero replied that type of service fits more with home health, which is done by the hospital. Elison suggested that we have been discussing connecting units of the system to tie the patient to the system helping to resolve the problem of volume.

Lorentine mentioned that as the Tohono O'odham Nation discusses how to identify health indicators for families across and within communities, they need to consider how technology might help. There is a concern that HIPAA may be a barrier to community-based intervention and prevention activities.

Panel Discussion

Miller began by posing the question, "What is different about doing HIT in a small rural/frontier community?"

Craig responded that people with technical knowledge are often few in number making it difficult to discuss problems and share ideas. He suggested that the National Center for Frontier Communities could be the vehicle to encourage isolated technical experts to network.

Slifkin raised questions of technical support for communities that don't have nearby expertise or small practices that don't have a dedicated information technology person.

- Would some sites duplicate paper records or have delayed entry that would affect real time use of records?
- What about systems that can not connect all sites or single sites that can not afford the hardware and software?
- Once technology is funded and installed how can it be maintained, since it doesn't maintain itself.

Elison pointed out the importance of finding expertise with specific rural experience.

Cook suggested checking with the staff planning an HIT meeting for the fall to see if they are compiling information on available expertise.

Elison asked about communicable diseases unique to the border. Tuberculosis and hepatitis rates are elevated along the border, and recently, Sonora reported an active case of polio that had crossed into the United States. Carr pointed out that in Alaska they are using funding for technology to strengthen surveillance systems in preparation for a possible avian flu outbreak. They are working with rural providers to help them prepare.

Ford wondered if any of the Border Health 2010 goals could be linked to HIT efforts. She mentioned that increased injuries and other public health issues exist for Latino immigrants who have migrated to Nevada. Miller attended a hearing by Senators Larry Craig (ID) and Jeff Bingaman (NM) in Washington recently to discuss HV-2 visa forestry worker (*los pineros*). These workers have phenomenal injury rates because they have no training or prior experience and are expected to cut down trees with chain saws.

Kunz described how historically, the Tohono O'odham Nation has been somewhat isolated. Because of concerns along the border and increased technology, the Nation is now interacting and exchanging more with its neighboring counties in both Arizona and Mexico. This has given the Nation new information for thinking about how they would like to grow and change their health care system. Miller noted that there is another tribe along the border in California and that it would be useful to contact them to see if their perspectives were similar to those of the Tohono O'odham Nation.

Bernstein questioned whether pregnant women coming across the border for delivery so that the child becomes a United States citizen was a big issue. King responded that while it does occur it doesn't overwhelm the health care system; uncompensated care is a much larger issue for hospitals. Over 70 percent of undocumented immigrants do not have health insurance.

Miller wondered if the people who have tuberculosis and go back and forth between the United States and Mexico are in both systems. Border rates of hepatitis A and diabetes may also have implications for HIT. This might be an example of public health conditions that will be looked at more in depth.

Slifkin stated it makes sense to focus on those things that really are related to the fact that there is a dividing line between two countries and people crossing that border. For example, North Carolina may be the leading state for increase in Latino immigrants in the country and many issues are similar to those of Latinos on the border. But in North Carolina people are not going back and forth across a border and potentially being in two different health care systems. Language is a barrier unique to the U.S.-Mexico border health providers.

Many health issues do not honor borders:

- Communicable diseases and environmental issues.
- Immunizations.
- Records - United States citizens are being treated in Mexico and their Medical information is either duplicated or lost.

Ford noted that HIT initiatives are being funded in every state and that it would be helpful to make those involved at the state level aware of these border issues. For example, could providers within the 100 kilometer line on both sides develop shared electronic health records to serve people who are within this area.

Miller would like to know what kind of HIT planning is being done in border states and what kind of involvement there is by rural, frontier and border representatives.

Other Topics under the Current Contract

Frontier Extended Stay Clinics

Cook described efforts to develop a new type of provider, the Frontier Extended Stay Clinic (FESC) to fill the gap between clinics and hospitals. There are primary care clinics located quite a distance from a hospital and in locations that make it difficult for the patient to get from the clinic to the hospital. Patients present at the clinic in need of hospital services and clinics provide services because they have to, but are not reimbursed. These clinics need the capability and reimbursement opportunities to provide necessary services.

ORHP has funded a demonstration in Alaska and Washington State for two years to look at communities where these services are being provided. The demonstration will answer questions such as: "What do they look like?" "How much does it cost?" "How much equipment is needed?" "How should they be staffed?"

Concurrently, the Center for Medicaid and Medicare Services (CMS) is finalizing a congressionally mandated demonstration program to look at reimburse for FESC services through Medicare. It is anticipated that the CMS Demonstration program will be announced to the public later this summer.

The ORHP demonstration has been primarily Alaska-focused. In the lower 48, there may be few situations where patients can not be transported to a hospital for two or three days, but there are situations where clinics need to do observation and monitoring. ORHP would like information about clinics outside of Alaska that are providing extended services. What are the similarities and differences? The Office has asked the National Center for Frontier Communities to prepare a paper looking at this topic.

Miller first became interested in extended stay because she was working at a clinic with three licensed in-patient maternity beds that were no longer used for obstetrics. Staff

began using the beds for things like rehydrating elderly patients because a hospital bed is much more comfortable than an exam table.

Hospitals originated for poor people who had no one to care for them. In the 1950s and 1960s communities began to build hospitals under the Hill-Burton program. Since the 1980s there has been a twenty-year plus rural hospital crisis with many different fixes tried.

In the early 1980s the frontier movement began in Sand Hills, Nebraska when Larry Jeter, a community health center director, read an article about the continued existence of frontier in the United States. At his insistence, the Region VII Health Administrator convened a meeting in Kansas City to discuss, "Where does rural end and frontier begin?" Miller thinks of it as a continuum. Gar Elison was elected the first chair of the Frontier Task Force at the 1986 meeting.

As stated in the minutes of the 1986 meeting of the Frontier Task Force "... a new type of health care facility is needed to meet the unique needs of frontier areas. The traditional hospital is too large in scale for most frontier areas. Staffing it according to minimum regulations is technically difficult, if not impossible. The members of the Task Force identified college health stations and military infirmaries as appropriate models for an intermediate facility that would give rural residents who are not sick enough for an acute care hospital but too sick to stay at home a place to go."

In 1997, when the Medicare Hospital Flexibility program passed, Senators Frank Murkowski (AK) and Craig Thomas (WY) immediately introduced a bill to establish a frontier "super-clinic." This later became the extended stay primary care clinic and now is the Frontier Extended Stay Clinic (FESC). Their goal was for Medicare regulations to take into account unique conditions of the smallest clinics and rural hospitals and to have patients remain closer to home, improving quality of care and reducing costs. They thought it was also important for community economics to keep local health care dollars in the local economy.

In order to become a FESC, the Medicare Modernization Act called for the distance to a hospital or a critical access hospital to be 75 miles or not connected by roads.

Many clinics have always provided extended services. It is not unusual - and not specifically a frontier practice - that a patient would be treated for four or more hours for rehydration before the determination is made whether to transport to a hospital. The further a clinic is from a hospital, the more services staff try to provide on site. What makes FESC more frontier than rural is distance.

The National Center for Frontier Communities paper may be completed before the CMS demonstration begins. That demonstration will look at setting a reasonable level of compensation. The demonstration must be budget neutral, which is accomplished in different ways. Medicare typically figures out how much the demonstration will cost and then decides how to make it budget neutral. The purpose of the paper is to describe what

FESC might look like in the lower 48, how places that are interested are similar or different from clinics in Alaska that are participating in the ORHP demonstration. ORHP would like to know who would use this provider type if it was available—both those clinics already providing services without payment and those clinics which might offer these services if reimbursed.

To begin this project, the Center worked with interested State Offices of Rural Health to identify clinics are 75 miles away from a general or critical access hospital. Several factors reduce the number of potential participants. Often Medical Directors are not interested in taking on more medical responsibility. Alaska is close to finalizing FESC licensure. Over half of the Alaska clinics provided FESC type services before the demonstration began. Washington already has licensure laws to allow for innovation, these could include the FESC. Colorado has extensive facility licensure that covers FESC type services. These have been used primarily by the prison system.

Although most patients coming to the current FESC demonstration clinics in Alaska are not Medicare eligible, it will be a Medicare demonstration because this is how programs develop in the federal government. If FESC works as a Medicare provider type then it is likely Medicaid, IHS and private insurers will pick up on this type of provider.

The CMS demonstration will primarily have two types of patients: those who can not be transferred (i.e., due to weather) and those who because of their health or other factors can be cared for on site. The second type of patient may be more common in the lower 48. In Dubois, Wyoming there was concern about elderly patients living alone who were being discharged by the hospital with extensive distances to provide home health care. The Dubois clinic has discussed a FESC demonstration where the home health staff could visit these discharged hospital patients at the clinic. A former hospital in Cuba, New Mexico might be interested in FESC to re-establish services that had been provided there for many years.

Regardless of the reimbursement, there will need to be a fairly high volume of services to make such programs worthwhile.

In the relatively short time that ORHP has been conducting its demonstration diverse scenarios have arisen that impact the type of care a community provides. For example, in two of the clinics that lost physicians, organizers were glad the community had not yet come to expect FESC-type services that the mid-level practitioners could not provide. Even with reimbursement, these small fragile sites will always struggle with provider turnover.

Does being a FESC make it easier or harder to recruit and retain providers? ORHP is hoping to look at the issue of retention in its third year demonstration. Recruitment really depends on the provider. Higher levels of care may appeal to some physicians. With low volume, it may be difficult to maintain skills. Miller has found Medical Directors influence whether or not a clinic will be interested in being a FESC.

Carr wondered about other facilities, such as urgent care centers, in the lower 48 who also may want to be this type of provider. FESC can be an opportunity to talk about health care in a new and creative way.

Elison stated there needs to be flexibility in looking at rules for clinics in the lower 48. It might be appropriate to include a clinic that is closer than 75 miles to a hospital, but which hospital is barely functioning. Another example is when there is no ground transport to the hospital 71 miles away.

Cook noted that ORHP would be willing to look at good potential FESC sites if there is something to be learned even though the 75 mile distance requirement is not met.

Slifkin pointed out that the problem she has with this model is that there are circumstances where it would be better for the patient and the health care system to remain at the clinic even though it is only two miles from the hospital. The first step should be to find out what these clinics do that goes beyond reimbursed services and the second step should be to look at the subset of those activities that is different from what any provider would do. That subset is what you talk about in the realm of FESC. FESC reimbursement should not divide communities or discourage a systems approach.

The 75 mile limit was to legislate keep eligible FESC's frontier for the purposes of the demonstration. Even with reimbursement, this will not be a moneymaker because FESC usually requires additional staffing, and if a site is not an FQHC, there will be increased liability insurance. Additional facility licensure requirements will be a trade for getting paid for additional services, for example adding sprinklers. Under the life safety code, facilities have to provide a level of safety sufficient to assure the patient safety if they are unable to be moved. Scope of practice licensure varies by state, which may also affect what procedures FESC providers perform.

CMS views FESC as providing hospital services in a clinic setting. The challenge has been to help them understand it is not feasible for clinics to operate like a hospital even though they provide extended stay services. Facility requirements need to make sense for what clinics actually do.

Physicians salaried by hospitals must meet a different set of facility licensure laws (a combination of Medicare and state). The salaried physician is then paid for a higher level of services. Federal requirements stand in for state requirements until state requirements are put in place. At that point both federal and state requirements must be met. For example, for rural clinics Federal rules say a physician only has to visit mid-level providers every two weeks, but states often enact stricter requirements.

New Mexico has strict licensure rules for ambulatory care clinics. It may be interesting to look at what facility licensure rules already exist in states where FESC clinics may become part of the demonstration. Ford suggested looking at HIT issues for FESC clinics.

Some critical access hospitals 75 miles from potential FESC clinics are not going to have to provide definitive care. Some critical access hospitals would be appropriate as FESCs and there is interest by some of these hospitals in watching how the FESC program develops. In other communities, concern about downsizing from a hospital to a clinic would preclude becoming a FESC.

An FQHC which provided extended care would be both an FQHC and a FESC. In Alaska, there are about a dozen sites doing extended stay, but they may decide not to become licensed as FESC sites. Many of these clinics have built new facilities with Denali Commission funds.

Medicare Part D and Frontier Pharmacies

Last year, before Medicare Part D went into effect, the National Center for Frontier Communities communicated with five frontier pharmacies that are sole pharmacies in their community and provided a report to ORHP. This summer the Center will revisit the same pharmacies after Part D implementation. The Center will be studying how pharmacists' expectations compare with the reality to date. Many of these pharmacies provide a very low level of prescriptions and stay in business because they sell other merchandise.

These pharmacies may provide the information over time to serve as case studies of what is happening to sole community pharmacies. Big Piney, Wyoming was the most isolated pharmacy in the study. The pharmacist couldn't go to any training because it was six hours one way to Cheyenne. Two sites in Maine, one in New Mexico and one on an island in Washington are in the study.

Slifkin discussed the Sheps Center study of rural pharmacies. There may be differences in how revenue is generated between really remote pharmacies and the pharmacies in slightly bigger rural areas. Nationally, rural pharmacies are much more likely to be independent and they tend to have most of their revenues come from prescriptions. Slifkin is expecting a greater impact from Medicare Part D than the five community pharmacies in the National Center for Frontier Communities study were expecting.

Medicaid is cutting back on what pharmacists and pharmacies are getting paid. A lot of private plans are working with pharmacy benefit managers to put pressure on people to switch their prescriptions to mail order because it is cheaper for the health plan. Pharmacies are being pressured from three directions— Medicare, Medicaid and the big plans—and a pharmacist who receives most of his or her revenue from prescription reimbursements may be in trouble.

There are tiers between acute and chronic pharmacy needs because the acute need is not amenable to mail order. The Center's study will look at the demographics of the communities of the five pharmacies being studied to see if certain demographics create a greater need for acute pharmacy services.

Many clinics are talking about adding pharmacies to make sure acute needs are met. Pharmacy conscience laws passed by states are having an impact on access to services. In some states if the pharmacy won't fill a prescription, the prescribing provider will be able to fill it.

The Medicare drug benefit law says pharmacies can not routinely fill out of network prescriptions. There are fairly loose requirements for emergencies and the mileage criteria. For example, for some people it makes sense to mail order some drugs and get others locally. Even if there is no in-network pharmacy available, patients are not allowed to routinely get their prescriptions from the closest provider. Regardless of distance, they are required to go to the in-network provider. Although this coverage is voluntary, it sets up an unfair condition.

Update on National Center for Frontier Communities

Miller requested feedback on the best process for communicating with Panel members about works in progress. The web site has intranet capability, which can be accessed by password and used to review and comment on draft papers. The web site gets about 12,000 hits a month.

Slifkin suggested email attachments and others agreed. She also suggested giving deadlines for comments. Carr suggested that the subject line include notice of a deadline to encourage a quick response. Ford suggested linking other studies, which mention frontier to the National Center for Frontier Communities web site.

Jill Sherman, a researcher under contract with the National Center for Frontier Communities, continues to work on seasonal fluctuation impacts. The original study included Skagway, Alaska; Hinsdale, Colorado and Quartzsite, Arizona. Sherman looked at the economics of each community and how that impacts their ability to expand and contract their health care system for a paper presented at the annual meeting of the American Association of Geographers. Even though the communities share seasonal population fluctuations, they are completely different. This study proves the saying that, "When you've seen one rural community, you've seen one rural community."

This probably also will be true for the FESC study. The uniqueness of frontier communities often makes it difficult to report findings that can apply to other communities. Often the important findings are anecdotal.

Bernstein asked about Center operations. The Center is funded through a combination of grants and contracts. For many years, everyone was a volunteer. Currently the Center is funded by a contract with the Office of Rural Health Policy and a subcontract with the National Rural Health Association. There are two salaried employees and a lot of contracted services. There is also an active Board of Directors. The Center has changed

its name and plans to build an endowment over the next year. Staying small and partnering with other people always has been the vision for the center.

Site Visits *Ambos Nogales*, US and Mexico

Field Trip

On March 9, 2006, panel members visited Nogales, Arizona and Nogales, Sonora. Robert Guerrero, Chief, Arizona Office of Border Health, narrated the field trip. Guerrero educated panel members on border health issues for several hours while the group traveled together in a van.

The first stop was Holy Cross Hospital with a presentation by Richard Polheber, CEO, on the transition to electronic medical records currently underway. He explained there is some resistance but the system is committed to phasing in the new technology.

The second stop was the Southeast Arizona Area Health Education Center with a presentation by Karen Halverson, Director of SEAHEC and Jesus Kataura, Program Coordinator. The group watched a film on the Mexican health care system and health a question and answer session with the AHEC staff.

The group then walked across the border for a lunch meeting in Nogales, Sonora, Mexico with Juan Manuel Hurtado Monreal, Administrator for the Nogales, Sonora General Hospital. Mr. Hurtado answered questions about the Mexican public health system.

The group returned to Tucson by van and the meeting was adjourned.

Attachment A
FRONTIER AND RURAL EXPERT PANEL

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Attachment B
Frontier and Rural Expert Panel Meeting
Public Health on the U.S.-Mexico Border and the Use of Health Information
Technology
March 8, 2006, Tucson, Arizona

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Field Trip Guide

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Cc: <carol@frontierus.org>, <karen@frontierus.org>

Dear Panel Members:

Thank you for your timely responses to our Conference Call Availability Calendar.

Please save the following date and time on you calendars for the conference call:

TUESDAY, AUGUST 30, 2005 AT 2:00 P.M.
MOUNTAIN DAYLIGHT TIME

A reminder and a meeting agenda will be sent to each member shortly before the meeting. Please take a few minutes to browse the website's Intranet beforehand.

****Conference Call Instructions****

Each participant follows these steps:

- ☛ Please calculate your local time to call in (Mountain Daylight Time)
- ☛ Call 1-800-860-2442
- ☛ Ask for the Frontier Education Center/Miller call
- ☛ Each participant will be announced as they join the call.

Thank you again for being available to take part!

Tess