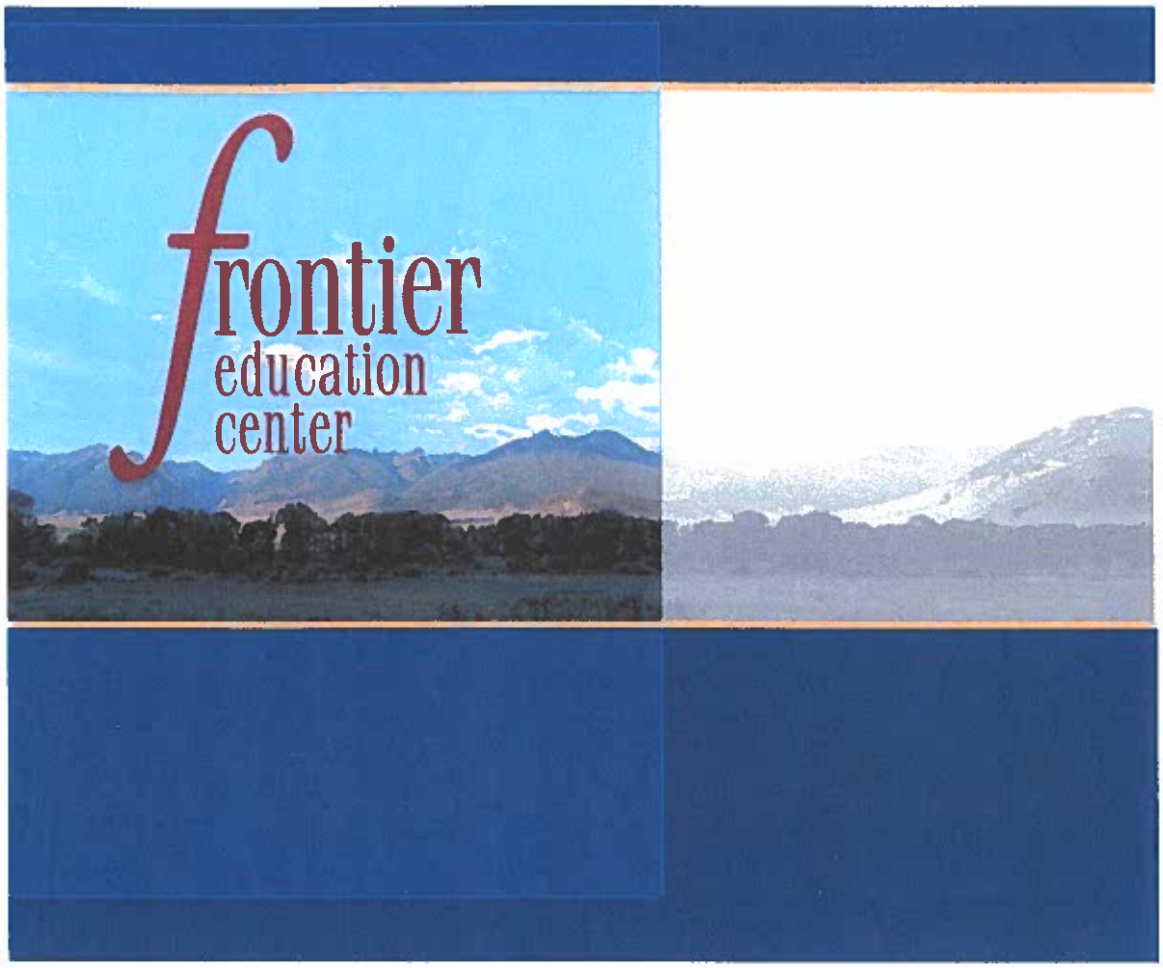

Annual Report
July 1, 2001 – June 30, 2002

frontier education center

The National Clearinghouse for Frontier Communities

723 Don Diego
Santa Fe, New Mexico 87505-1622
(505)820-6732
(505)820-6783 fax
frontierus@frontierus.org

On behalf of the Board of Directors and staff, I am pleased to submit this report on the activities of the Frontier Education Center. The Board members are united in their belief that the Center serves a critical function as a resource and referral center. The geographic and professional diversity of the members assures the center is sensitive to problems across the nation. This pluralism of experiences by the board also assures that issues considered by the Center receive a thorough analysis and information shared is relevant to current conditions and political settings.

We believe the Center is fulfilling a primary goal of educating policy makers so the legislative and regulatory environment is flexible and responsive to the needs and conditions of Frontier America. Requests for information sharing have increased markedly this year. As the Center has become more widely known its importance has also increased. We are especially pleased that the interaction has been across a wide array of interests, ranging from healthcare, to education and economic development.

The frontier regions of America often provide relaxation and rejuvenation for many Americans. The Center will continue to address many issues and to advocate on behalf of the concerns and needs of the frontier regions. In doing so, the Center will also serve the needs of both residents and visitors in frontier communities. We look forward to continuing this role of information sharing, referral and serving as the National Clearinghouse for Frontier Communities.

Gar Elison
President, Board of Directors

Frontier Education Center
2001-2002 Annual Report

Table of Contents

"In the United States there is more space where nobody is than where anybody is." – Gertrude Stein

Executive Director's Report

What a great year it has been! In 2001, the Frontier Education Center began to develop the National Clearinghouse for Frontier Communities - a resource and focal point for frontier issues.

We want to thank the federal Office of Rural Health Policy for its recognition of the unique needs of frontier communities and the importance of supporting the only organization dedicated to improving the health and human services available to the ten million residents of the enduring American frontier. While all of the staff at the federal office have been generous with their ideas, assistance, and support, I want to especially recognize Marcia Brand, Director, and Steve Hirsch, our Project Officer, for helping to build the partnership between the Frontier Education Center and the Office of Rural Health Policy. We are very appreciative of the support and look forward to continuing our work together to strengthen the nation's most fragile communities.

Although the Center was incorporated in 1997, our Board of Directors held its first face-to-face meeting in May 2002. After five years of meeting by conference call, it was great to finally meet each other. We are very lucky to have a Board made up of diverse professions, from different parts of the United States, but united in both their knowledge of frontier issues and their strong commitment to the Center and our shared mission.

The more we have studied frontier healthcare, the more we have learned that in the smallest and most isolated communities, it is not effective to look at one service or one sector in isolation. The smaller the community, the more important it is to look at it wholistically. We are using the Healthy Communities model to include physical, emotional, economic, cultural, spiritual and environmental health as all necessary to the health of a community.

The Frontier Education Center also works on state and local projects in New Mexico. This is important to us because we are able to combine national research and policy work with hands-on help to frontier communities. We have developed an 'incubator' for new organizations to provide technical assistance and to serve as fiscal agent. Currently we act as fiscal agent for the Picuris Pueblo Bison Project, the Pueblo is a federally recognized tribe. We are also the fiscal agent for private foundation grants and New Mexico Department of Health contracts with the Picuris-Peñasco Community Coalition (PPCC). The PPCC has brought together more than 30 health, social services, and economic development agencies, schools, churches, and individuals to collaborate and increase the services available to this frontier community of 2,000 people.

We are happy to be working closely with other health organizations as we also develop allies in many new areas - from business and economic development leaders to geographers. We are building a comprehensive network to improve the lives of the people who live in, visit, or travel through the vast lands of the frontier. We would love to hear from you so that your ideas, hopes, and dreams can become a part of our work,

Carol Miller

Meet the Board of Directors

Gar Elison, Utah, President, is currently Executive Director of the Utah Medical Education Council and has served in different capacities in health agencies for over thirty years. He also teaches continuing education courses at the University of Utah and Westminster College. Elison served on the Executive Board of the National Academy for State Health Policy, chaired the Primary Care and Prevention Steering Committee, and was a member of the Access for the Uninsured Steering Committee. He has a bachelor in political science from Brigham-Young University and a masters in library science with a minor in public administration from the University of Oklahoma.

Caroline Ford, Nevada, Vice President, is currently Assistant Dean/Director of the Center for Education and Health Services Outreach at the University of Nevada School of Medicine, Office of Rural Health. She has held this position since 1983. Ford served on the first Department of Health and Human Services Secretary-appointed National Advisory Committee on Rural Health and has been active in the National Rural Health Care Association since 1983 serving in several offices and on several committees. Ford holds a board of director position on the National Organization of State Offices of Rural Health, and also has been active in the American Public Health Association since 1978. She has a bachelors and masters in community health education.

Betty F. King, Arizona, Secretary and Treasurer, received a bachelors and masters in public health from the University of North Carolina at Chapel Hill. She has worked for over twenty years on diverse public health and rural health issues and held positions such as the Deputy Director of the National Rural Health Association and Director of a rural county health department. King is on sabbatical until her son begins school.

Harriet Brandstetter, New Mexico, is Executive Director of La Clinica de Familia in Las Cruces. The organization's programs include migrant and community health centers, an Adolescent Family Life Program, Promotora Program, Early Head Start Program and a Healthy Start Program. Harriet serves on numerous committees and boards including the NM Primary Care Association and the Southwest Primary Care Association. Harriet attended the University of New Mexico, Trinity University and is a graduate of New Mexico State University.

Louis LaRose, Nebraska, is an enrolled member of the Winnebago Tribe of Nebraska. Currently, LaRose is the Bison Caretaker for the Winnebago Bison Project whose mission is to restore bison to the Winnebago Indian Reservation in a manner that promotes cultural enhancement, spiritual revitalization and personal health, ecological restoration and economic development. He also served five years as Chairman of the Winnebago Tribe of Nebraska. In additional to his position as Bison Caretaker, he is currently employed as a Fellow in the New Voices Program and works as a mediator for the Nebraska Justice Center.

Frank J. Popper, New Jersey, teaches in the Bloustein School of Planning and Public Policy at Rutgers University, where he also participates in the Geography and American Studies Departments. He is author of many books, including The Buffalo Commons and the Future of the Great Plains (Liveoak Editions: forthcoming). He now serves on the boards of the American

Land Publishing Project, the American Planning Association, Ecocity Builders, and the Great Plains Restoration Council. His article "The Great Plains: From Dust to Dust" (Planning, December 1987), written with his wife, Deborah Popper, put forward the controversial Buffalo Commons thesis that has stimulated an ongoing national debate about the future of the Great Plains region. He has a masters degree in public administration and a doctorate in political science, both from Harvard University.

Meet the Frontier Education Center Staff

> "... democratic institutions and the American character have been largely shaped by the experience of successive frontiers ..."
> Wallace Stegner, *Where the Bluebird Sings to the Lemonade Springs*

Carol Miller, MPH, Executive Director
Carol Miller is the founder of the Frontier Education Center, served as President from 1997–2001, and is currently the Executive Director. Miller has lived in a frontier mountain village in northern New Mexico since 1976. She has held Presidential appointments in both the Reagan and Clinton Administrations, serving, as a Commissioned Officer in the US Public Health Service in the 1980's and in 1993 was a Presidential Appointee to the White House Health Care Task Force. Miller served as President of the New Mexico Public Health Association, represented the Frontier Constituency Group on the board of the National Rural Health Association, and served as a Governing Councilor of the American Public Health Association for 14 years.

Lisa Adler, Ph.D., Researcher/Technical Writer
Lisa Adler completed her Ph.D. in Political Science from Rutgers University in 2000. She has published articles in the areas of political economy, economic development and feminist studies. Adler has experience working on legislative issues, having worked in the New Mexico Legislature analyzing new legislation and composing summaries for publication in a layperson's newsletter. She has also taught courses at Rutgers University, Haverford College and the College of Santa Fe. She grew up in a frontier town, Hayfork, California.

Daran Moon, Administrative/Research Assistant
Daran Moon has more than 17 years in the non-profit world. Most recently, she was Director of Administration at The Nature Conservancy in both New Mexico and Texas. She has also worked in the academic and architectural/construction fields and has a long history of community service and volunteer efforts.

Gerald Pitzl, Ph.D., Researcher
Jerry Pitzl is a retired professor of geography at Macalester College in St. Paul, Minnesota where he taught a wide variety of courses in the field of geography. He is also the editor of the *Dushkin Annual Edition - Geography*, now in its 17th edition, and is working on the 18th edition. Pitzl assists the Center with both research and the development of reports.

Developing the National Clearinghouse for Frontier Communities

There are four primary ways that the Frontier Education Center (the Center) is developing the National Clearinghouse for Frontier Communities: networking, outreach, referrals, and Internet.

Networking

Board and staff participation in other associations and organizations is at the core of networking. Members of the Center's Board are officers and active members in a number of national organizations, including the National Organization of State Offices of Rural Health (NOSORH), the National Association of Area Health Education Centers Directors, the Inter-Tribal Bison Cooperative, the Great Plains Restoration Council, the National Rural Health Association, and the American Planning Association.

National Rural Health Association (NRHA) – The Center is an organizational member of NRHA. Executive Director, Carol Miller, is the Frontier Constituency Group member of the Government Affairs Committee. Miller is also an NRHA representative to the NRHA/National Association of Community Health Centers Joint Task Force. Miller was a presenter at both the NRHA Rural Minority Health Conference and the Annual Conference this year. The Center was an exhibitor at the NRHA Annual Conference in Kansas City. Several hundred people visited the booth and more than 100 signed up for the mailing list. Fifty packets containing additional information were sent as follow-up to visitors to the booth at the Annual Conference.

National Organization of State Offices of Rural Health – The Center is a supporter of NOSORH and works closely with the State Offices of Rural Health. We had more than 300 contacts with state offices this year in developing the Census 2000 Frontier County Update, the list of frontier counties with no health services, and Extended Stay Primary Care (ESPCC) work. In addition, the Center exhibited at the NOSORH 10th Anniversary Conference in January.

National Association of Rural Mental Health (NARMH) – The Center is an organizational member of NARMH. Executive Director Miller served on the NARMH National Conference Planning Committee in 2001 and 2002 helping to organize the conference, which was held in Santa Fe, New Mexico in August 2002. Because this meeting was held in our home community, Center staff helped NARMH with registration and other needs and was an exhibitor at the conference.

New Mexico Department of Health E-EMS Task Force – Executive Director Miller was invited by the New Mexico Department of Health to serve on the E-EMS Task Force to adapt the nationally recognized Red River Project to become a statewide program. The Red River Project was originally developed with the support of a federal Rural Health Outreach Grant and is both a training program and an innovative use of EMS personnel as community health specialists. Miller, a veteran, 14-year frontier EMT and former CHC-owned ambulance service director, had been the Planner-Evaluator of the original Rural Health Outreach Grant.

"The frontier is America's great hidden region. The nation will be better off - more knowledgeable about itself, better able to deal with its future - when it rediscovers the place."
-Frank Popper
FEC Board Member and Professor, Rutgers University

Outreach

Outreach consists of several types of activities. For example, one activity is developing relationships with new organizations, others are advertising, public relations and media outreach.

Developing Organizational Relationships:
National Rural Women's Health Conference – This conference, sponsored by Pennsylvania State University, will be held in Washington, DC in September 2002. The Center submitted an abstract on behavioral health and local economies in frontier communities. The abstract was accepted and will be a Poster Session at the conference. The Center will also be an exhibitor at the conference, which will provide the opportunity to expand our network further.

Western Governors Association – In the Summer of 2001, the Center was asked to be part of a small group writing a rural health policy paper for the consideration of the governors. This paper was adopted on August 14, 2001 as WGA Policy Resolution 01-06, Rural Health Improvements.

Rural Women's Studies Association (RWSA) – The Center has been a member of the Rural Women Studies Association for several years. The Association is primarily a network of faculty and students in academic programs of Rural Women's Studies. The Center submitted an abstract, which was accepted for presentation at their Conference in Las Cruces, New Mexico in February of 2003.

American Association of Geographers (AAG) – The Center has submitted a proposal to sponsor a theme session at their annual conference to be held in New Orleans in March 2003. Several co-presenters have been identified and invited. The professional geographers, who have been contacted by the Center, are excited about the way we are bringing geography to life by linking real programs and communities with their defining geographical information.

Advertising:
In an effort to increase knowledge of the Center, ads have been purchased in the NRHA 2002 Member Directory and the Conference Program of the International Rural Nurses Congress.

Media:
New Mexico's Senior Senator Pete Domenici made the announcement of HHS funding for the Center in July 2001. The news release from the Senator's office was reported widely in the New Mexico media.

Referrals:
As the Center becomes better known, it is beginning to be recognized as a resource for people with questions about frontier issues or those wanting to share information with the Center. State Offices of Rural Health are currently the source of most referrals.

Internet:
After a slow start, the Center's website is nearing completion of its re-design and will contain much more information than it has in the past. The company which is managing the re-design is also providing a service to make it easier for people to be directed to our website by the major search engines. They are also helping to place our site as a hot-link from a number of related sites. This is very helpful as we realize that Internet professionals are able to provide these services much more quickly than we could on our own. The web address is still www.frontierus.org.

Research and Policy

The Frontier Education Center has successfully developed the National Clearinghouse for Frontier Communities to advance its mission to conduct research, provide education, and lead policy analysis to support frontier communities throughout the United States. The special needs of frontier communities are too often left out of policy discussions due to a lack of basic information on the specific conditions in these areas. While some frontier issues overlap with rural issues, in many cases the needs of frontier communities are unique due to their isolation and the structure of their economies. The Frontier Education Center has documented that the difficulties in accessing health care and social services in rural areas are even more extreme in frontier areas. The Frontier Education Center has been at the forefront of identifying these needs and informing policy makers.

Research

Frontier County Inventory - Census 2000 Update

A basic function of the Frontier Education Center has been to maintain an inventory of frontier counties in the United States. Based on figures from the 2000 US Census, and after consultation with State Offices of Rural Health,the Frontier Education Center determined that around ten million people live in frontier counties. There are a total of 816 frontier counties located in 39 states. Although the percentage of people who live in frontier is small, only about 4% of the US population, the area on which they live is large. Frontier counties comprise about 56% of the land area and contain 49% of the water area in the United States, a total of 2,125,413 square miles. For a complete list of frontier counties and background on the methodology, please visit www.frontierus.org.

In 1997, the Frontier Education Center convened a group of frontier providers and policy experts to develop a consensus definition of "frontier." Early on, it became clear that defining frontier

solely by population density was not an adequate approach. For example, in some large counties, the presence of a city in one corner skews population density and overshadows the existence of many large frontier areas. At the same time, small counties that are clustered close together may have low population densities, but exist within or adjacent to metropolitan areas. Furthermore, a key component to frontier life is distance. Areas with population density as high as 20 people per square mile could be considered frontier if the community were located at a great distance or travel time from the closest significant service center or market. The Frontier Education Center adopted a consensus definition of frontier, which is based on a matrix that includes population density and distance in miles and travel time in minutes from a market-service area. This consensus definition has been formally adopted by both the National Rural Health Association and the Western Governors Association.

The Center believes that states and communities should be involved in frontier designation. Local involvement is necessary because local people understand best the actual conditions of the areas in their state. By consulting with local experts, a list of frontier counties that more accurately reflects the conditions in each county is developed. This process is unique in that is has follows a "bottom-up" approach which acknowledges the diversity among frontier counties.

Following the development of the consensus definition, the Frontier Education Center began compiling a list of Frontier counties using data from the 1990 decennial census. As the release of 2000 data has become available, the Frontier Education Center has been in the process of updating the consensus list of frontier counties. Once again, we have achieved 100% response rate from the State Offices of Rural Health.

Counties With No Services

In 2002, the Frontier Education Center conducted a needs assessment with State Offices of Rural Health to identify counties that have no health services. In a sample analysis of ten states, 57 counties were identified which do not have any health services available to their populations. This means that in these 57 counties, 124,757 people do not have access to even the most basic health care that most Americans take for granted. Our needs assessment included Rural Health Clinics, Community Health Centers, Indian Health Services, Hospitals, and Private Physicians. The assessment did not look at dental, mental health, or specialty clinics. Had these and other additional services been considered, the numbers of underserved counties would have soared. The 10 states with frontier counties that have no health services are located predominantly in the west and south. They include: Georgia, Idaho, Mississippi, Montana, Nebraska, Nevada, North Dakota, South Dakota, Texas, and Utah.

Among the counties lacking access to services, there are differences. Some of the counties identified have care available part-time at clinics staffed with mid-level practitioners. In some of the counties, acute and/or episodic care is also available through the EMS system. A majority of the counties with EMS have volunteer services that transport patients to the nearest health facility in a neighboring county. However, because frontier EMS is usually minimally funded by local resources and depends on volunteerism, there are often longer response times or gaps in available services. Furthermore, extreme weather conditions may prevent transportation at all. It is important to remember that in some frontier counties weather conditions can change rapidly

during any month. For example, sunny mornings changing rapidly to afternoon snowstorms are not unusual in the Rocky Mountains – even in the middle of the summer. Some counties have no safety net services at all. In those cases, people are forced to rely on their neighbors in times of crisis and to drive long distances to reach care.

Seasonal fluctuations in population due to tourism can put an increased strain on the services available in frontier areas. When seasonal impacts hit, frontier populations draw from their already overtaxed health delivery systems to provide for people who probably have better services back home. For example, in Billings County, North Dakota, there are no health services. In the summer, when tourists stream through to visit the Badlands, the population drastically increases, putting a tremendous strain on the fragile EMS system. A similar trend happens in the Chama Valley of northern New Mexico. A Community Health Center in the Chama Valley did a study that looked at the zip codes of all patients billed for emergency services. During the summer, the majority of emergencies are out-of-state visitors. When possible, the EMS system doubles their staffing during peak months to accommodate the increased need even though it creates financial problems for this economically fragile system. Seasonal fluctuations that strain health resources and other county infrastructure are common in the western United States. More research is needed in this area. A more complete needs assessment that includes access to substance abuse; behavioral health and oral health services should be conducted. A more comprehensive analysis of seasonal impacts on the infrastructure of frontier communities must also be completed.

Structural Barriers Faced by Frontier Communities

In 2002, the Frontier Education Center began a study to identify structural barriers to federal programs faced by frontier communities. While this study is still in its initial stages, important patterns of structural disadvantage have already been identified, and some initial recommendations have been developed. These patterns fall into four major categories: 1) Inappropriate Floor, 2) Match and Partial Funding, 3) Eligibility Methodologies, and 4) Capitation.

Federal programs that set expectations too high for frontier communities may establish an inappropriate floor that creates a structural barrier. For example, in order to apply for Welfare to Work funds, an organization has to demonstrate that it can create a minimum of 25 jobs. In the smallest communities, 25 jobs are unattainable. Even three good jobs with benefits can have an important multiplier effect in a very small community. The Frontier Education Center recommends that agencies conduct a Frontier Community Impact Statement to make appropriate adjustments to eligibility requirements so that all communities may access funding.

Programs that require matching funds create another structural barrier for America's smallest and most isolated communities. For example one community of 500 people surrounded by federal lands, with a very small tax base, was unable to raise matching funds for a Community Development Block Grant to build a wastewater treatment facility. Even though they had been approved for the grant, they had to reject the funding because they had no ability to raise the balance. The Frontier Education Center recommends a process whereby communities below a certain size can apply for a waiver of matching fund requirements.

Many federal programs establish eligibility methodologies that discriminate against frontier communities. For example, many communities in the Great Plains have had difficulty accessing Community Health Center expansion funds due to the methodologies used. The Frontier Education Center recommends that agencies conduct a Frontier Community Impact Statement to make appropriate adjustments to eligibility requirements so that all communities in need of programs or services may access funding.

Capitation, by definition, will not work in our smallest communities. There are just not enough people receiving services to cover the costs of providing services. Frontier communities do not have a critical mass of program users to aggregate enough payments to cover costs. The Frontier Education Center continues to advocate for reasonable cost based reimbursement for frontier health care and human services.

> "The journey through the Great Frontier was a mental adventure of the first magnitude. Many splendid vistas opened, and many things that were familiar took on new meaning."
> -Walter Prescott Webb,
> 1958 Presidential Address to the American Historical Association

Geographical Research and Outreach to Geographers

The Frontier Education Center has been working with Jerry Pitzl, a retired professor of geography, to look broadly at the historic and current relationship between geography and the frontier. One of the products of this collaboration is the development of the *Introduction to the Enduring American Frontier: An Annotated Bibliography* (available at www.frontierus.org). By developing a better understanding of national frontier policy development from the early and recent history of the United States, it is possible to develop better policy now and in the future.

Policy

Another structural barrier faced by frontier communities is the ability to impact policy. People who live in frontier America have small numbers spread over great distances. As such, it is difficult for them to organize together to represent their interests to policymakers. Another important role for the Frontier Education Center has been to provide information to frontier community members and frontier advocates.

HHS Rural Initiative

In the Summer of 2001, the Center learned that Secretary Tommy Thompson, the newly confirmed Secretary of Health and Human Services, had grown up in rural Wisconsin and wanted to make serious improvements in the way that services are provided in rural, frontier, and tribal communities. The Secretary announced the Initiative on Rural Communities and asked the public for comments and assistance.

The Frontier Education Center provided public comment on the Department of Health and Human Services' Initiative on Rural Communities in order to highlight the particular needs of frontier communities. On September 27, 2001, the Center submitted recommendations to Secretary Thompson and called his attention to the fact that harsh climates and geography, combined with remoteness and limited economies create access barriers to even minimal levels of health care and social services in frontier areas.

The Center recommended that the Secretary of Health and Human Services adopt a matrix definition of frontier that considers population density and distance in miles and travel time in minutes to services. The recent policy adopted by the Western Governors Association (WGA Policy Recommendation 01-01, Rural Health Improvements) would be an appropriate model on which to base HHS regulations.

The Center recommended the development of financing mechanisms for frontier health facilities and providers that will work in the frontier context. A capitated system will not work in frontier. Because frontier areas, by definition, have a limited population, they never accrue enough capitations in a prepaid system to cover true costs. Either frontier-specific capitation adjustments or reasonable cost based reimbursement must be required for all payers.

The Frontier Education Center made several recommendations to encourage the recruitment and retention of health care providers in frontier:

- Encourage the development of incentives (e.g. enhanced signing and retention bonuses, supplemental loan repayment amounts) to National Health Service Corp providers who select "hardship" sites, most of which are in frontier communities.
- Change the resource allocation methodology to ensure that frontier sites are filled early in each placement cycle.
- Assure that the new formula for determining Health Professions Shortage Areas considers the specific needs of frontier communities and allows for full eligibility.
- Encourage and incentivize frontier states to allow mid-level providers the fullest possible scopes of practice, prescriptive and dispensing authority to best serve frontier communities.
- Recognize that since many frontier communities rely solely on EMS for medical care, provide federal grant support for the maintenance of high quality EMS systems, and tax credits and free local training for volunteer EMT's.
- Expand federal support for mental health services, education and outreach in frontier communities in order to strengthen frontier families.

Families in the frontier often face a multitude of additional stresses caused by long travel distances to work and school, and higher levels of poverty and persistent poverty. The Center supports creative solutions to resource shortages and other services delivery challenges including the multi-purpose use of public buildings and collaboration between programs.

The Frontier Education Center made several recommendations regarding economic development in frontier areas, including:

- Full funding of Payments In Lieu of Taxes (PILT's) to compensate counties with high percentages of federal land for the loss of tax revenues.

- Encourage federal capital grant and loan programs to extend their reach to small frontier communities by implementing a waiver of matching funds and fully funding proposals for qualifying frontier communities.
- Increase support for small business incubators and micro-lending practices, which might provide significant economic development in frontier areas.

The Center also recognizes that supporting health and human services in frontier communities provides a link to economic development as these programs create jobs.

The Frontier Education Center recommended that HHS identify and eliminate barriers to collaboration between State, local and Tribal governments. Most Indian reservations and trust lands are located in the frontier. The quality of tribal relationships with state and local government varies from state to state. The Center suggested that the HHS Rural Initiative do a meta-analysis of solutions already in place in order to disseminate best practices and fund these models in the most needed areas.

Finally, the Frontier Education Center advocated incorporating frontier residents into policy-making and offered our expertise in identifying frontier people to provide the knowledge and/or consumer representation on Commissions, Boards, Working Groups, and Task Forces involved in policy development and implementation.

In January of 2002, Center staff attended a meeting where leaders from the Secretary's office gave a briefing and update on the progress in finalizing the Initiative. Executive Director Miller raised the work of the Center in identifying 'structural barriers' in federal programs and was asked to provide a briefing paper on these structural barriers – within 24 hours. A two-page paper was developed and forwarded to staff in the Secretary's office. It is gratifying to read the final report of the Secretary's initiative and see how many ideas submitted by the Center were included, among them the important concept of structural barriers which Miller raised.

The concept of structural barriers has become an important theme and component of the work of the Center.

Extended Stay Primary Care Clinics

The Frontier Education Center has worked with the federal Office of Rural Health Policy, the National Rural Health Association, and a number of states to develop a new type of health facility, designed specifically to meet the needs of frontier communities, the Extended Stay Primary Care Clinic (ESPCC). This work grew out of the passage of the Balanced Budget Act of 1997 that established several rural initiatives including the Medicare Rural Hospital Flexibility Program which allowed for reasonable cost-based reimbursement from the Center for Medicare and Medicaid Services (CMS, previously HCFA). While this program serves an important need, it became clear that it did not serve the specific needs of many frontier communities. The basic problem was that the Flex program is a hospital model and many frontier communities do not have and cannot afford to operate a hospital.

Yet there is often a need for extended stay primary care. For example, weather conditions frequently make it impossible to transport a patient to another facility. Sometimes allowing a patient to be close to home and family provides better quality of care and is more cost effective.

For example, re-hydration therapy is a frequent procedure for some older persons. Often they are transported and admitted to a hospital for treatment. Some primary care clinics are able to administer IV solutions on site, saving the patient (and payer) both a transport and hospital admission as well as allowing them to return home more quickly. As ESPC clinics develop, they must be eligible for reasonable cost-based reimbursement.

The Frontier Education Center has convened an ESPCC Working Group. In order to develop an ESPCC program, the Working Group has addressed issues including facility requirements, costs of service delivery, appropriate provider types and quality assurance. In order to promote implementation, the Working Group has investigated the removal of statutory and regulatory barriers to the provision of ESPCC services. The Center recommends that Congress direct CMS and HRSA to work together to facilitate the reimbursement of ESPCC clinics in frontier communities.

Congressional Testimony

The Frontier Education Center Executive Director, Carol Miller, was invited to testify on June 18, 2002 before the U.S. House of Representatives, Subcommittee on Employer-Employee Relations at a hearing on the Rising Cost of Health Care. Although Miller was speaking as the consumer representative at the hearing, and not representing the Center, we are proud that she was invited.

Miller's testimony noted that three of the occupations least likely to provide insurance (agriculture, forestry and fisheries) are primarily located in rural areas, contributing to the high rates of rural uninsurance. Furthermore, these occupations tend to be seasonal, doubling a worker's risk of being uninsured during at least part of the year. One way people in these communities have responded to this crisis is by organizing local fundraisers like pancake breakfasts, enchilada dinners and car washes to pay for life-and-death health services for sick children or family members with cancer, an unacceptable way to pay for health services in this great nation.

Research by the Commonwealth Fund documented that most uninsured people are employed. This study found that 19 million full-time workers (16.4% of all full-time workers) are uninsured and 5.2 million part-time workers (22.4% of all part-time workers) are uninsured. Miller's testimony stressed the need for systemic improvements to guarantee access to health coverage by working people.

The lack of health insurance and underinsurance weakens our economy and our people. Nearly half of all personal bankruptcies (more than 500,000 a year) are caused by health problems or a large medical debt, even though 79% of the families filing for bankruptcy had some health insurance coverage. This staggering statistic demonstrates the high failure rate of the current insurance system to cover a catastrophic illness. The Institute of Medicine released a report in May 2002 that documented that people without health insurance are sicker and die earlier than people with insurance.