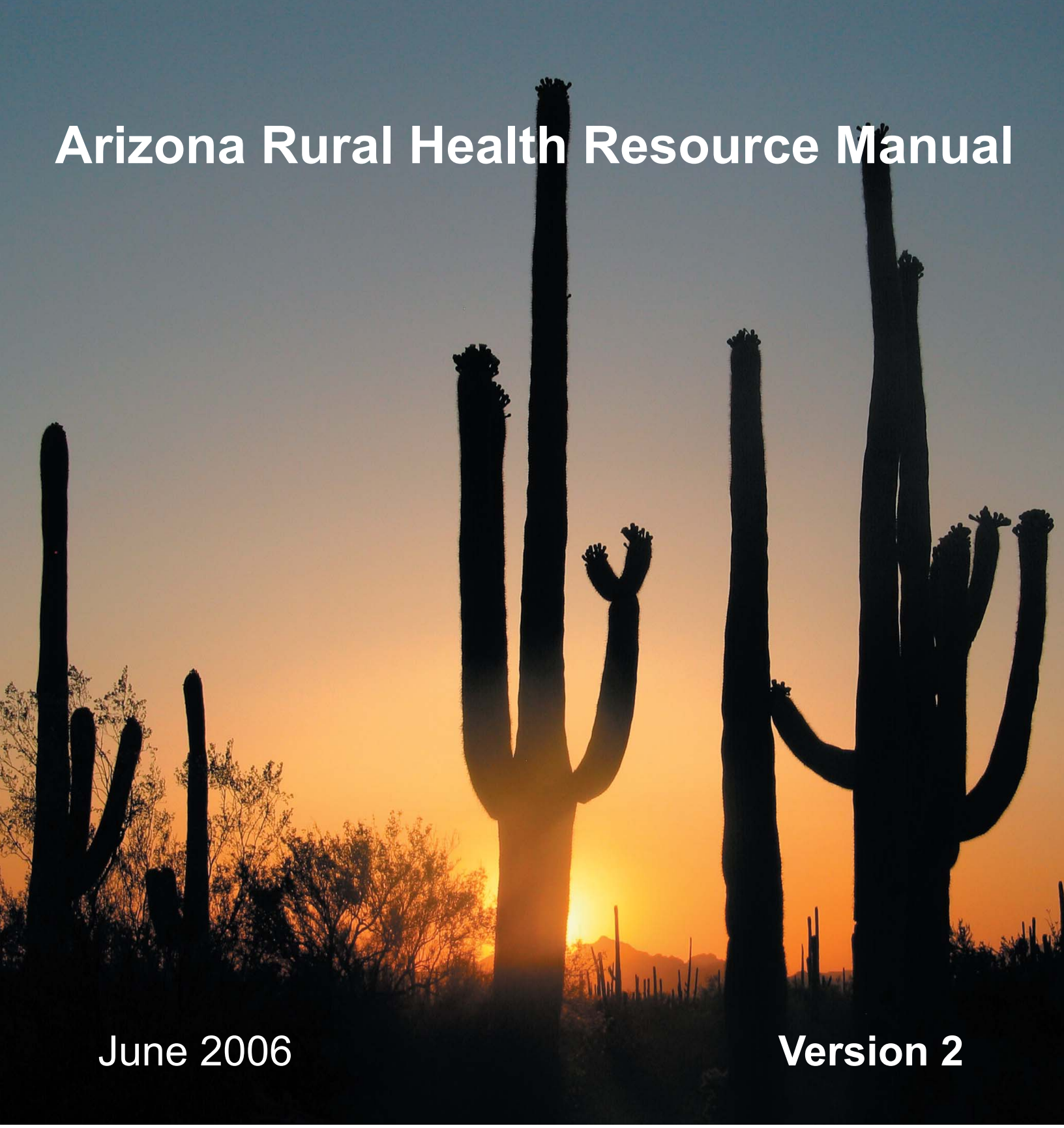
Arizona Rural Health Resource Manual



June 2006

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RURAL HEALTH OFFICE
RHO
ARIZONA'S STATE OFFICE OF RURAL HEALTH

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THE UNIVERSITY OF ARIZONA
Mel and Enid Zuckerman
College of Public Health

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Cover photo taken by Alison Hughes of the Sonoran Desert National Monument.

I. Introduction

The Rural Health Office, located in The University of Arizona Mel and Enid Zuckerman College of Public Health, has worked for over 25 years to extend the University's mission of research, service, and education into rural Arizona.

When Dean Marie Swanson appointed me to head the Rural Health Office (RHO) in 2001 I made a commitment to develop a comprehensive information clearinghouse on rural health that would be accessible to rural health and social service providers, consumers, advocates, and researchers. This Arizona Rural Health Resource Manual is one of the documents produced by the clearinghouse during my four-year tenure as director. The clearinghouse publications contribute to the service commitment of the University, the College, and the Rural Health Office.

The mission of the Rural Health Office is to promote the health of rural and medically underserved individuals, families, and communities. Information is a powerful tool for promoting change and strengthening health care. How information is used can be a potent change agent. It has been said that influencing policy is about providing the right information at the right time to the right person. How to access the right information at the right time is a challenge we all face as we make decisions about the future. As you search the information clearinghouse, please remember that federal and state policies and rules are in a constant state of change. The information provided herein was as accurate as we knew it to be at the time of reporting. It is advisable, therefore, that the user does an "online" check for accuracy before using information that can critically impact a major project you are working on.

Publications available through the online Arizona Rural Health Clearinghouse include:
Rural Health Resource Manual: http://www.rho.arizona.edu
Rural Health Plan: http:www.rho.arizona.edu
Rural Health Clinic Designation Manual: http://www.rho.arizona.edu
Critical Access Hospital Designation Manual: http://azflexprogram.publichealth.arizona.edu
Rural Health Outreach and Network Grants in Arizona: http://www.rho.arizona.edu
Rural Health Briefings, a monthly online newsletter on current national and state rural health issues:
http://azflexprogram.publichealth.arizona.edu

Lynda Bergsma, PhD, assumed the post of Interim Director of the Rural Health Office when I retired from this position in 2005. Dr. Bergsma is carrying our information clearinghouse forward. If you have ideas or comments about any of the clearinghouse documents, feel free to send an email to Jennifer Peters at petersjs@u.arizona.edu.

Finally, I want to acknowledge the work of Leila Barraza, MPH, a member of the Rural Health Office staff, who put this document together. She has worked hard and diligently to research the available information and ensure its accuracy by the time of its printing. Thanks are also extended to the staff at the Federal Office of Rural Health Policy whose ongoing support of our efforts is sincerely appreciated.

Alison Hughes, MPA
Director
Rural Hospital Flexibility Program
Rural Health Office

June 2006

II. What is Rural?

The definition of rural has tremendous fiscal and health service implications for rural residents of our state and country. **Appendix A** of this *Arizona Rural Health Resource Manual* describes a number of methods for defining what is often termed "rurality."

As populations shift and are noted in our official Census records, so does the definition of rural. Twenty years ago Yuma was a rural town. Today only a few zip code areas in the town of Yuma have been federally identified as rural under current definitions. The reason for this shift is population growth.

It is extremely important that health care agencies and institutions remain vigilant over the changing definitions of "rural." For example, modification of a single definition can cause a health care provider to lose its federal Health Professional Shortage Area (HPSA) designation and the financial rewards that accompany the designation.

It is also important for rural providers to make their voices known to policy-makers whenever new rural definitions are proposed. When the federal government proposes to change a definition, a notice seeking public comment is printed in the *Federal Register*. Currently, for example, a definition of "frontier" is being explored by the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services. "Frontier" differs from "rural" in that it may apply to much more sparsely populated areas than those that fit under "rural." Many Navajo Nation members can be identified as living in "frontier" areas of the state where their homes are located in remote areas that are a one-hour drive from the nearest service center. Similarly, the Havasupai Tribe might be identified as "frontier" as there are no roads leading to the homes of the residents that live at the bottom of the Grand Canyon. To date, no formal definition of frontier has been adopted by HRSA. Until then, a few federal programs are funding pilot projects that will strengthen access to health services in areas they consider "frontier."

Defining rural is critical when applying for federal funding that is specifically directed to rural communities. For example, the Federal Office of Rural Health Policy, the U.S. Department of Agriculture, and the Universal Services Corporation all require applicants for funding and/or telecommunications discounts to meet the definition of rural adopted by these agencies. It is highly recommended that before a rural entity applies for federal funding, eligibility based on rurality is determined. **Appendix A** covers most, if not all, definitions of rural adopted by the federal government at this time.

III. Hospital Resources

A. Hospital Financing

The HUD/FHA Section 242 Mortgage Insurance Program

The Department of Housing and Urban Development (HUD), acting through the Federal Housing Administration (FHA) pursuant to Section 242 of the National Housing Act of 1968, provides FHA mortgage insurance to acute care hospital applicants nationwide. FHA Section 242 mortgage insurance securitizes individual hospital loans funded by collateralized direct mortgage loans, as well as municipal bonds, by issuing insurance commitments through HUD licensed FHA mortgage lenders. FHA mortgage insurance is a credit enhancement vehicle that allows below investment-grade hospitals that meet FHA underwriting eligibility criteria to finance the construction of major renovation projects and replacement facilities, as well as equipment purchases and debt refinancing. It is the backing of the U.S. government that supports the FHA mortgage insurance and allows even Critical Access Hospitals to be able to access the capital markets at borrowing rates consistent with AAA rated health systems. The FHA 242 Program is supported on a national basis and is not subject to state funding allocations. Further, as FHA 242 mortgage insurance is only available to hospitals, there is no programmatic competition with other borrowers, or other business sectors.

Program Highlights:

Mortgage loan terms:

- Loan-to-value of 90%.
- Hospital's 10% equity requirement may consist of physical assets and cash.
- HUD's one-time fees total 80 basis points
  - -15 basis points payable at the time of submission of the insurance application,
  - -15 basis points payable upon issuance and acceptance of the insurance commitment,
  - -50 basis points payable at loan closing
- HUD annual Mortgage Insurance Premium is 50 basis points
- Maximum loan term of 25 years, plus construction period.
- No state allocations, loan amounts are set by HUD based upon project feasibility and borrower's creditworthiness.

Financing Methods:

- Tax-exempt bond financing.
- Collateralized mortgage loans.

Eligibility Requirements

Security Requirements:

- The hospital must be able to grant a first mortgage or long-term lease on the entire facility and its contents (Note: Exceptions may include leased equipment, off-site property, capital associated with affiliations, etc.).
- Monthly payments into a mortgage reserve fund that will build to a balance equal to one year's debt service after five years and two year's debt service after ten years.
- Must meet individual financial covenants negotiated by HUD.

Other Requirements:

- Be an acute care hospital with no more than 50% of patient days and revenue attributable to the following services: chronic convalescence and rest, drug and alcoholic,

epileptic, nervous and mental, mental deficiency, and tuberculosis. Critical Access Hospitals (CAHs) are currently exempted from this restriction.

- Over the past 3 years, hospital applicants should have an average Operating Margin equal to or greater than 0.00% and average Debt Service Coverage of 1.25x (for determination of eligibility, CAHs may recast their historic financials utilizing a cost-based reimbursement methodology).
- For hospitals in states with applicable Certificate of Need ("CON") laws, a CON is required, while in non-CON states, HUD will make its own determination of need based upon an independently commissioned feasibility study (The feasibility study can take the form of either a compilation report, or examination).
- The proposed project must utilize Davis Bacon wages, guaranteed maximum price contracts and an open bidding format.

To apply for FHA Section 242 Mortgage Insurance a licensed HUD approved lending institution is required, as the application for mortgage insurance must be in the name of the FHA lender and not the hospital, as technically the applicant is the FHA lender and the borrower is the hospital. For this reason, financial consultants are ineligible to submit FHA mortgage insurance applications. HUD strongly suggests that hospitals seeking FHA mortgage lenders check corporate qualifications and whether they have previously completed an FHA 242 transaction. To assist in this task, a list of eligible FHA mortgage lenders is available from HUD at the Office of Insured Health Facilities.

For more information regarding FHA-insured loans, visit:
http://www.hud.gov/offices/hsg/hosp/hsghospi.cfm.

Source: Alan P. Richman, President & CEO, InnoVative Capital, Springfield, Pennsylvania (610) 543-2490. InnoVative Capital is a HUD Licensed FHA Lender and Hospital Consulting Firm. E-mail: arichman@innovativecapital.com. Web site: http://www.innovativecapital.com.

Rural Healthcare Capital

The following companies provide assistance to hospitals seeking capital.

Pine Creek Healthcare Capital, LLC

Pine Creek is a specialized healthcare lender committed to being the #1 provider of capital to non-profit rural and critical access hospitals. We are an integrated healthcare Asset Manager, which means that we manage all aspects of the credit evaluation, financing and servicing over the life of the loan. Pine Creek has created a $2.5 billion loan program funded through Citigroup Global Markets Inc. for new or replacement hospitals, renovations and expansions, equipment and technology upgrades, refinancing and acquisitions.
http://www.pchcapital.net

Red Capital Group

Red Capital Group is a solutions-oriented capital provider with 7 offices nationwide and 190 employees. The Red hospital team includes Red Mortgage Capital, Inc., an FHA-approved and USDA lender and servicer with expertise in financing hospitals and senior care facilities; and Red Capital Markets, Inc.

Rural Healthcare Capital (con't)

(MEMBER NASD/SIPC) a registered broker-dealer of taxable and tax- tax-exempt securities.
http://www.redcapitalgroup.com

BuildSmart

BuildSmart™ is an integrated process that helps hospitals make capital improvements by coordinating debt-capacity and feasibility analysis, evaluation and presentation of financing structures, government agency representation and complete facility solutions (facilities assessment, planning, design and construction documents and contract administration). This is accomplished through the strategic alliance of three leaders in the delivery of hospital capital solutions: Dixon Hughes PLLC (Certified Public Accountants and Advisors), Batson Architects, Inc. (Health Facilities Design Specialists) and PNC MultiFamily Capital.
http://www.build-smart.org

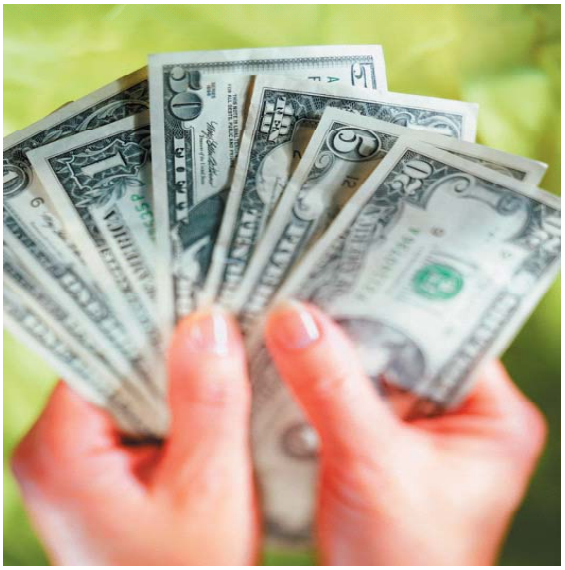


Photo courtesy of Microsoft® Office Online.

Special Tax Districts

Hospital Districts

In the case of hospital districts, a secondary property tax can be used "for the purpose of funding the operation and maintenance of a hospital, urgent care center, combined hospital and ambulance service or combined urgent care center and ambulance service that is owned or operated by the district or to pay costs of an ambulance service contract…." (A.R.S. 48-1907). In addition to the requirements listed in A.R.S. 48-261, "no petition for the formation of a district shall be acted upon unless the area encompassed within the proposed district is first approved by the department of health services as an area needing additional hospital facilities" (A.R.S. 48-1903). Another requirement for the creation of a hospital district is voter approval.

Title 48, Chapter 13 of the Arizona Revised Statutes deals with hospital districts. A.R.S. 48-261 lists the requirements for the formation of a hospital district. This statute, along with all other statutes related to hospital districts, can be obtained online at: http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp.

As of March 29, 2006, there were seventeen hospital districts throughout Arizona. These districts are located in the following areas: St. Johns, Round Valley, Benson, Willcox/Bowie, Page, Graham-Southern, Bonita/Klondyke, Pima, Parker, Chandler, Kingman, Show Low, Chino Valley, Prescott Valley, Prescott, Yavapai-Northeast, and Yuma-West.

The communities of Chandler, Kingman, and Prescott were successful in establishing hospital districts. The hospital district in Chandler was organized by the community in order to construct a hospital. Chandler Regional Hospital was built as a result of the formation of the hospital district and opened on July 17, 1961. The area expanded greatly over the next twenty years, so the hospital district asked the community for approval of additional bonds in order to build a new hospital. In March 1984, the construction of the

new hospital was complete and Chandler Regional Hospital opened in its new location, on the corner of Dobson and Frye roads.

Kingman Regional Medical Center is owned by Hospital District Number One of Mohave County, formed by a voter referendum in 1982. The creation of the hospital district took control of the hospital away from the county and put it under the district's control.
The Central Yavapai Hospital District, formed by a vote of local residents in the early 1960s, owns Yavapai Regional Medical Center in Prescott. The district was created for the purpose of combining the two existing hospitals into one hospital.

Sources: Arizona Revised Statutes. Title 48, Chapter 13. Hospital Districts; Arizona Department of Health Services, Office of Health Systems Development. Arizona Underserved Areas (HPSA, FedMUA, AzMUA) & Special Tax Districts by County- 2006. Available: http://www.azdhs.gov/hsd/profiles/undersvc.pdf; Chandler Regional Hospital. The History of Chandler Regional Hospital Available: http://www.crhaz.com/index.asp?catID=au&pg=au_history&supnav=off. Accessed June 18, 2004; Kingman Regional Medical Center. Who owns Kingman Regional Medical Center? Available: http://www.azkrmc.com/about/whoowns.htm; Yavapai Regional Medical Center. Who Owns YRMC? Available: http://www.yrmc.org/about/whoowns.aspx.

Health Service Districts

According to state law, a health service district may be formed "for the purpose of purchasing, leasing, lease-purchasing, constructing, establishing, equipping, operating or maintaining an ambulance service, a medical clinic or clinics or a combined medical clinic and ambulance service" (A.R.S. 48-2202). The health service district must be in an area designated by the Arizona Department of Health Services as medically underserved. A health service district can only be established if the area of the district is greater than six hundred forty acres and three hundred qualified electors reside within the district. In addition, the formation of a health service district is contingent on voter approval. The health service districts receive monies by issuing bonds and from taxes on property (A.R.S. 48-2214; A.R.S. 48-2220; A.R.S. 48-2223).

Title 48, Chapter 16 of the Arizona Revised Statutes deals with health service districts. A.R.S. 48-2203 lists the requirements for the formation of a health service district. This statute, along with all other statutes related to health service districts, can be obtained online at: http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp.

As of March 29, 2006, there was only one health service district in Arizona, located in Ajo. The Ajo-Lukeville Health Service District owns the Desert Senita Community Health Center.

Sources: Arizona Revised Statutes. Title 48, Chapter 16. Health Service Districts; Arizona Department of Health Services, Office of Health Systems Development. Arizona Underserved Areas (HPSA, FedMUA, AzMUA) & Special Tax Districts by County- 2006. Available: http://www.azdhs.gov/hsd/profiles/undersvc.pdf; Desert Senita Community Health Center. Community Links. Available: http://www.ajochc.org/commlink.html.

Special Health Care Districts

Special health care districts can receive funding through secondary property taxes. The voters in the area must approve the creation of a special health care district.

In 1995, when Samaritan Health System cancelled its management agreement with White Mountain Regional Medical Center, the residents of the town were concerned that the hospital would not survive; therefore, with assistance from their legislators, a new law was created that would enable the formation of a special health care district. After it passed voter approval, two special health care districts were created, one in

Special Tax Districts (con't)

Northern Apache County and one in Southern Apache County. The special health care districts are authorized to operate and/or manage multiple health care centers. The two special health care districts receive money from a secondary property tax that is collected by the county. The district pays a small fee to the county in exchange for the collection of the taxes. Currently, the special health care district in Southern Apache County pays the salary for some EMTs, supports a primary care center, and contributes money to White Mountain Regional Medical Center. The Northern Apache County special health care district owns two clinics, one in St. Michaels and the other in Sanders, and provides funds for these clinics. In addition, the special health care district gave grant funding to the clinic in Chilchinbito, Arizona.

The 46th Legislature passed HB 2530 in 2003 in order to allow Maricopa County to establish a special health district conditioned by its approval of the voters. Proposition 414, on the ballot in November 2003, allowed a special health care district to be created and take over control of the Maricopa Integrated Health System from the Maricopa County Board of Supervisors. If the health district was not approved, the proposition authorized the closure of the county hospital, trauma, emergency, and burn center services. The proposition passed, with 58.42% of voters voting for the proposition and 41.58% voting against it.

Sources: State of Arizona. Forty-second Legislature. First Regular Session. 1995. House Bill 2522. Senate Engrossed Version; State of Arizona. Forty-sixth Legislature. First Regular Session. 2003. House Engrossed Version; KAET: Horizon. Proposition 414. Available: http://www.kaet.asu.edu/horizon/prop414.html; Maricopa County Recorder. Maricopa County Election Results. Special Election, November 4, 2003. Proposition 414. Available: http://recorder.maricopa.gov/electionresults/defaults.asp.

USDA Community Facilities Program

The United States Department of Agriculture's Rural Development Community Programs offers a program to enlarge, construct, or improve community facilities with three options: the Community Facilities Guaranteed Loan Program, the Community Facilities Direct Loan Program, and the Community Facilities Grant Program.

The Community Facilities Direct Loan Program and the Community Facilities Guaranteed Loan Program are available in order to enlarge, construct, or improve community facilities for health care, public safety, and public services. The loan money can be used to pay professional fees, purchase equipment, or purchase land for a health care facility. Loans can be made and guaranteed to establish vital community facilities in rural areas and towns with a maximum of 20,000 persons. Public entities, such as municipalities, special-purpose districts, non-profit corporations, tribal governments, and counties are all eligible for the loans and guarantees.

Grants are available to help develop community facilities in rural areas and towns with a maximum of 20,000 persons. Since the grants are given on a graduated scale, a higher percentage of grants will be provided to applicants from small communities with low populations and low incomes. Public entities, such as municipalities, special-purpose districts, non-profit corporations, tribal governments, and counties are all eligible for the grants.

For more information about the Community Facilities Programs, visit the following Web site: http://www.rurdev.usda.gov/rhs/cf/cp.htm.

Source: United States Department of Agriculture. Housing Program. Available: http://www.rurdev.usda.gov/rhs/cf/cp.htm.

Small Business Administration Loan Program

This program offers various loans to small businesses. The four programs are: Basic 7(a) Loan Guaranty; Certified Development Company (CDC), a 504 Loan Program; Microloan, a 7(m) Loan Program; and Loan Prequalification. A small business, as defined by the Small Business Administration is "one that is independently owned and operated and not dominant in its field."

For more information, visit the United States Small Business Administration at: http://www.sba.gov/index.html.

Source: United States Small Business Administration. SBA Loan Program. Available: http://www.sba.gov/financing/sbaloan/snapshot.html.

Arizona Health Facilities Authority

The Arizona Health Facilities Authority provides tax-exempt financing to nonprofit health care institutions and providers in Arizona. The types of facilities that may receive tax-exempt financing from the Authority include: hospitals, nursing homes, health clinics, assisted living facilities, therapy facilities, extended care facilities, outpatient clinics, living facilities for the elderly or disabled, rehabilitation centers, and blood banks. In addition, the Authority has a small loan program that provides direct loans ranging from $50,000 to $150,000. The term for the loans is up to five years and the interest rate is 7%. The loans are available for various capital components, including equipment (both medical and computer).

The Authority has provided loans to the following rural health care institutions in Arizona: Southeast Arizona Medical Center in Douglas; Copper Queen Community Hospital in Bisbee; White Mountain Regional Medical Center in Springerville; and Canyonlands Community Health Care in Page. The Authority provided financing through bonds to Northern Arizona Health Care. It has also provided planning grants to American Indian communities.

For more information or to apply, please visit: http://www.azhfa.com.

Source: Arizona Health Facilities Authority. Available: http://www.azhfa.com.

Medicare Modernization Act of 2003

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

Effective December 8, 2003, Medicare must "pay hospitals, physicians, and ambulance providers (including IHS and Tribal) for their otherwise un-reimbursed costs of providing services required by Sec. 1867 of the Social Security Act (EMTALA) and related hospital inpatient, outpatient and ambulance services, as defined by the Secretary [of Health and Human Services], furnished to undocumented aliens, aliens paroled into the U.S. at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S. with a laser visa."

The Emergency Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 so that the public would be assured access to emergency services regardless of their ability to pay. EMTALA (42 U.S.C. 1395dd) requires that if a request is made for an examination or treatment of an emergency medical condition, including active labor, Medicare-participating hospitals, that provide emergency services, must provide the service, regardless of the patient's ability to pay. The hospital must then deliver stabilizing treatment. If it is not possible for the hospital to provide such stabilizing treatment, or at the patient's request, a transfer to another hospital should be made.

Medicare Modernization Act of 2003 (con't)

Rural Ambulance and Outpatient Lab Reimbursement

Small rural hospitals with less than 50 beds, located in the zip codes listed below, are eligible to receive the rural ambulance bonus. The rural ambulance bonus is the Medicare "Super Rural Bonus" of 22.6% for ambulance trips originating in low population density counties and census tracts. The ambulance reimbursement is effective as of July 1, 2004, and is available through 2009. In addition, the small rural hospitals that are eligible for the rural ambulance bonus are also eligible to receive cost-based reimbursement for outpatient labs. The lab reimbursement is effective as of July 1, 2004.

Pictured: Hu Hu Kam Memorial Hospital in Sacaton, Arizona.
Critical Access Hospital, desginated 11/21/2002.

The zip codes in Arizona that are eligible to receive rural ambulance and outpatient lab reimbursement from Medicare are listed in **Appendix G**.

Medicare Incentive Payment Program Improvements for Physician Scarcity

Physicians who provide services in a Health Professional Shortage Area (HPSA) are eligible to receive a 10% increase over the amount that would normally be paid under the physician fee schedule. In the past, physicians were responsible for identifying that services were provided in a full county primary care geographic area HPSA. The new law requires that the Secretary of Health and Human Services automatically pay the 10% bonus for services provided in full county primary care geographic area HPSAs. This provision is effective as of January 1, 2005. Refer to **Appendix G** for a list of eligible zip codes in Arizona.

In addition, a new incentive payment program has been established, which gives primary care and specialist care physicians, who provide services in physician scarcity areas, a 5% bonus. The 5% incentive payment program applies to services provided after January 1, 2005, and before January 1, 2008. Eligible counties must be identified based on the ratio of primary care physicians to Medicare eligible individuals residing in the county and the ratio of specialist care physicians to Medicare eligible individuals residing in the county. For the 5% bonus, as with the HPSA bonus program, payment is added after deductions for beneficiary cost sharing have been made. Eligible physicians, for the Primary Care Physician Scarcity Area bonus payments, include: family practice, general practice, internal medicine, and obstetrics/gynecology. For the Specialist Care Physician Scarcity Area bonus payments, eligible physicians include: all physicians other than family practice, general practice, internal medicine, and obstetrics/gynecology. Refer to **Appendix G** for a list of eligible zip codes in Arizona.

For more information regarding the HPSA and PSA bonus payments, please visit: http://www.cms.hhs.gov/providers/bonuspayment.

Sources: CMS Legislative Summary. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. Available: http://www.cms.hhs.gov/mmu/hr1/PL108-173summary.asp; Rural Assistance Center. Information Guide: Emergency Medical Services. Available: http://www.raconline.org/info_guides/ems; Centers for Medicare and Medicaid Services. Medicare Information for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs). Available: http://www.cms.hhs.gov/providers/bonuspayment; Source: Centers for Medicare and Medicaid Services. Emergency Medical Treatment and Labor Act (EMTALA) Resource.
Available: http://www.cms.hhs.gov/providers/emtala/default.asp#gen.

340B Discount Drug Program

The 340B Discount Drug Program was enacted through passage of the 1992 Veterans Health Care Act. The 340B program allows certain Federal facilities to obtain dramatic discounts on outpatient drugs. On average, 340B drugs cost 20 to 40 percent of the Average Wholesale Price (AWP). Drugs purchased through the 340B program can only be used by the covered entities' patients, and covered entities cannot "double-bill" by including those drugs in the state Medicaid rebate program. A variety of entities are eligible, such as Federally Qualified Health Centers (FQHCs), Urban Indian Health Centers, and Family Planning Clinics. Non-profit, publicly owned Disproportionate Share Hospitals (DSH), with a DSH adjustment percentage of greater than 11.75, are also eligible to participate. Private non-profit DSH hospitals may participate if they contract with a State or local government to provide uncompensated care. Critical Access Hospitals are not eligible to participate in the 340B Discount Drug Program.
For more information, visit: http://www.hrsa.gov/opa.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. SHIP Grantee hospitals may be eligible for the 340B Discount Drug Program. Available: http://ruralhealth.hrsa.gov/news/340B.htm.

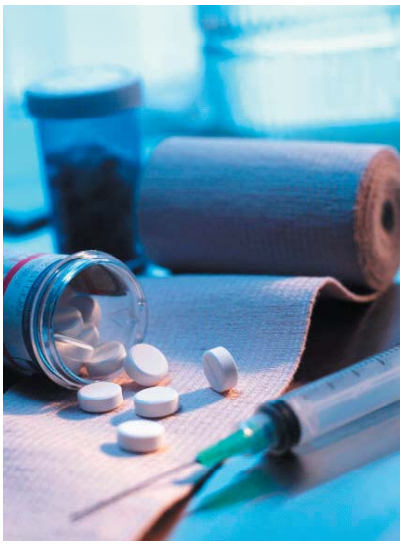


Photo courtesy of Microsoft® Office Online.

B. Hospital Designations

Refer to **Appendix C** for a list of rural hospitals in Arizona.

Critical Access Hospitals

Background

The Medicare Rural Hospital Flexibility [Flex] Program was created by Congress [authorized under section 4201 of the Balanced Budget Act of 1997 (BBA), Public Law 105-33, and its amendment, the Balanced Budget Refinement Act of 1999] to improve the financial viability and stability of health care in rural areas across the nation. A key aspect of the Flex program was the creation of a new designation for rural hospitals called Critical Access Hospitals (CAHs), as well as provisions for promoting quality initiatives and strengthening EMS systems. The Medicare Modernization Act of 2003 (MMA) modified some of the regulations governing CAHs.

CAHs are eligible for reimbursement of 101% of costs of services provided to Medicare beneficiaries. In some states, including Arizona, extra reimbursement is provided to CAHs for service to Medicaid patients. The Arizona state legislature has supported its Critical Access Hospitals by creating a pool of money, administered by AHCCCS, that draws 3 to 1 federal matching dollars. The pool is distributed through quarterly payments to eligible CAHs, based on their Medicaid volume.

Pictured: Ft. Yuma IHS Hospital.
Critical Access Hospital, designated 4/1/2003.

Hospitals eligible for Critical Access Hospital designation must meet the following criteria:

- Be a located in a rural area.
- Be a current Medicare provider.
- Be located 35 miles from another hospital [15 miles in a mountainous area with secondary roads].
- Maintain no more than 25 beds, which includes acute care and swing beds.
- Maintain an annual average length of stay of 96 hours or less.

CAH Designation

Specific steps are required for an Arizona hospital to apply for conversion to Critical Access Hospital designation:

- Conduct a financial feasibility study.
- Solicit support from the hospital's board, medical staff, and employees, and the community to seek CAH designation.
- Complete CAH application
    - CAH application information available at: http://azflexprogram.publichealth.arizona.edu/publications_app.html.
- Verify compliance with quality assurance standards and availability of suitable medical personnel.
- Identify EMS provider and tertiary care referral center supporting the rural health network.

Critical Access Hospitals (con't)

The Conditions of Participation for Critical Access Hospitals are listed in Appendix B.

For more information regarding Critical Access Hospitals, visit the following website: http://azflexprogram.publichealth.arizona.edu or www.raconline.org.

Sole Community Hospital (SCH)

The intent of the Sole Community Hospital (SCH) program, which was started in 1983, is to maintain access to needed health services for Medicare beneficiaries by providing financial assistance to hospitals that are geographically isolated.

According to the Centers for Medicare and Medicaid, in order to be eligible to be classified as a Sole Community Hospital, a hospital must be located more than 35 miles from other like hospitals or must be located in a rural area AND meet at least ONE of the following three conditions:

1) The hospital is located between 25 and 35 miles from other like hospitals AND meets ONE of the following criteria:
    - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area;
    - The hospital has fewer than 50 beds and would meet the 25 percent criterion above were it not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital; or
    - Other like hospitals are inaccessible for at least 30 days in each of two out of three years because of local topography or prolonged severe weather conditions.
2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years.
3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest hospital is at least 45 minutes.

Payments to Sole Community Hospitals are based on the highest of:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on fiscal year (FY) 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge;
- For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 are based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate; or
- For discharges beginning in FY 2004, the hospital-specific rate is 100 percent of the FY 1996 hospital-specific rate.

For more information, contact the Centers for Medicare and Medicaid Services (http://www.cms.hhs.gov).

Sources: Medpac. Summary of Medicare's special payment provisions for rural providers and criteria for qualification, Appendix B. Available: http://www.medpac.gov/publications/congressional_reports/Jun01%20AppB.pdf; Centers for Medicare and

Sole Community Hospital (SCH) (con't)

Medicaid Services. Medicare Learning Network. Sole Community Hospital Fact Sheet. February 2006. Available: http://www.cms.hhs.gov/MLNGenInfo.

Rural Hospital

According to Arizona Revised Statutes 36-2905.02, a "rural hospital" means either:

1) A health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds and that is located in a county with a population of less than five hundred thousand persons.

2) A health care institution that is licensed as a critical access hospital.

Source: Arizona Revised Statutes. 36-2905.02. Available http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp.

Pictured: Wickenburg Community Hospital.
Critical Access Hospital, designated 11/1/2001.

Rural Referral Center (RRC)

The Rural Referral Center (RRC) Program was created to support rural hospitals with high-volumes that treat a large number of complicated cases. The criteria for Rural Referral Centers are described in the Code of Federal Regulations under 42 CFR 412.96 (the Code of Federal Regulations can be accessed online at: http://www.gpoaccess.gov/cfr/index.html). According to the Centers for Medicare and Medicaid, in general, a hospital may be classified as a Rural Referral Center if the hospital is a Medicare participating acute care hospital and meets ONE of the following criteria:

1) The hospital is located in a rural area AND has the following number of beds available for use:
   - Has 275 or more beds during its most recently completed cost reporting period. If the hospital's bed count has changed, written documentation may be submitted with the application regarding one or more of the following:
   - The merger of two or more hospitals;
   - Acute care beds are reopened that were previously closed for renovation;
   - Acute care beds are transferred to the Prospective Payment Systems that were previously classified as part of an excluded unit; or
   - The hospital expands the number of acute care beds for use and these beds are permanently maintained for inpatients. Such expansion does not include beds in corridors or other temporary beds.

2) The hospital shows the following three elements:
   - At least 50 percent of the hospital's Medicare patients are referred from other hospitals or from physicians who are not on the staff of the hospital;
   - At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital; and

Rural Referral Center (RRC) (Con't)

- At least 60 percent of all services the hospital furnishes to Medicare patients are furnished to patients who live more than 25 miles from the hospital.

If a hospital does not meet the above mentioned criteria, the hospital can alternatively be classified as a Rural Referral Center if it is located in a rural area and it meets the criteria listed below in paragraphs 1) and 2) AND at least ONE of the criterion described in paragraphs 3), 4), or 5).

1) Its case mix index for discharges during the most recent fiscal year ending at least one year prior to the beginning of the cost reporting period for which the hospital is seeking RRC status is at least equal to one of two case mix figures calculated by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Code of Federal Regulations under 42 CFR 412.96(c)(1)(ii).

2) The number of discharges is at least equal to 5,000 (3,000 for an osteopathic hospital) or a threshold amount set by CMS, in accordance with the Code of Federal Regulations under 42 CFR 412.96(c)(2). CMS uses data from the latest available cost report data.

3) More than 50 percent of the hospital's active medical staff are specialists who meet the conditions specified in the Code of FederalRegulations under 42 CFR 412.96(c)(3).

4) At least 60 percent of all discharges are for inpatients who reside more than 25 miles from the hospital.

5) At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

Source: Centers for Medicare and Medicaid Services. Medicare Learning Network. Rural Referral Center Fact Sheet. February 2006. Available: http://www.cms.hhs.gov/MLNProducts.

Pictured: Page Hospital.
Critical Access Hospital, designated 3/1/2002.

IV. Health Clinic Resources

This section explains the differences among Rural Health Clinics, Community Health Centers, Federally Qualified Health Centers, Federally Qualified Health Center Look-Alikes, Migrant Health Centers, and Free Clinics and the procedures for designation applications. Refer to **Appendix D: Health Clinics in Arizona** for a list of Rural Health Clinics, Federally Qualified Health Centers, and Free Clinics in Arizona.

History of Community Health Centers

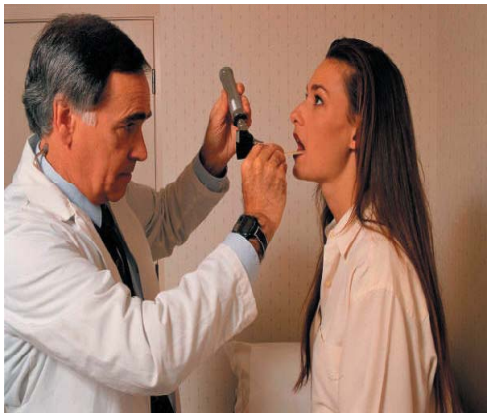


Photo courtesy of Microsoft® Office Online.

In the year 1965, grant funding was provided for the development of the first two community health centers in the United States, one located in a Boston housing project, called Columbia Point, and the other located in Mount Bayou, Mississippi. The Economic Opportunity Act of 1964 established the Community Action Program, which provided the funding for the first community health centers. At the time, these first community health centers were referred to as neighborhood health centers. The development of the neighborhood health center was part of President Johnson's War on Poverty, an attempt to provide job training, basic education, and other services to low-income individuals. The goal of the establishment of the neighborhood health center was to provide quality health care to low-income individuals who lived in medically underserved areas of the United States. Six more neighborhood health centers were granted funding during the fiscal year 1966. In 1975, neighborhood health centers evolved into community health centers as a result of Congress' Community Health Center program.

Federally Qualified Health Centers (FQHCs) were created through legislation, in the late 1980s, to provide cost reimbursement to community health centers serving Medicare and Medicaid recipients. Community health centers often did not receive enough reimbursement from Medicare or Medicaid to pay for the actual cost of the health care provided. With the initiation of FQHCs, community health centers received greater reimbursement for the health care services rendered to Medicare and Medicaid beneficiaries.

The Health Centers Consolidation Act was passed by Congress in 1996 in order to bring the authority for community health centers (CHCs), migrant health centers (MCHs), health care for the homeless (HCH), and the public housing primary care program (PHPC) all under section 330 of the Public Health Service Act. In 1997, under the Balanced Budget Act, the payment for FQHCs was supposed to be phased out. However, in 1999, under the Balanced Budget Refinement Act, the phase-out was delayed, and a study of how community health centers should be paid in the future was ordered.

In 2005, it is estimated that 14 million people will have received health care at a community health center. The federal budget for the Community Health Center Program, for FY 2005, was $ 1.734 billion, an increase of approximately $ 116 million from FY 2004.

Sources: Sardell A. *The U.S. Experiment in Social Medicine.* Pittsburg, Pa: University of Pittsburg Press, 1988; U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. *Experts With Experience: Community & Migrant Health Centers Highlighting a Decade of Service (1990-2000).* Available: http://bphc.hrsa.gov/CHC/CHCDocuments/pdf/tenyear_report.pdf; Dailard C. Community Health Centers and Family Planning: What We Know. *The Guttmacher Report on Public Policy.* 2001;4(5):6-9; U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. President's Health Center Initiative. Available: http://bphc.hrsa.gov/chc/pi.htm.

Community Health Centers

Community Health Centers (CHCs) provide care to low-income individuals in medically underserved areas. CHCs are public or private non-profit organizations that are intended to provide primary and preventive health care services. They receive federal grant funding under section 330 of the Public Health Service Act. CHCs are required to provide a sliding-fee-scale for their services and must provide care to everyone, regardless of their ability to pay. CHCs must be governed by a volunteer board of directors and a majority of the board members must also be patients of the health center.

Source: Health Resources and Service Administration, Bureau of Primary Health Care. Health Center Program. Available: http://bphc.hrsa.gov/chc.

Federally Qualified Health Centers

As mentioned earlier, the Federally Qualified Health Center (FQHC) is a reimbursement status available to community health centers that enable them to receive enhanced reimbursement for services provided to Medicare and Medicaid beneficiaries. In addition, FQHCs receive access to the resources of the National Health Service Corps; are eligible to purchase reduced cost prescription and non-prescription medications as a result of the 340B Drug Pricing Program; receive access to the Vaccines for Children Program; and receive medical malpractice coverage through the Federal Tort Claims Act (FTCA).

FHQCs are required to provide primary health care services to all persons, regardless of their ability to pay. They are also required to provide, either on site or through an arrangement with another provider, preventive health services, mental health and substance abuse services, dental services, transportation services, hospital care, and specialty care.

Source: Rural Assistance Center. FQHC Frequently Asked Questions. Available: http://www.raconline.org/info_guides/clinics/fqhc.php.

Migrant Health Centers

Migrant Health Centers provide health care to migrant and seasonal farmworkers and their families. Migrant Health Centers also receive funds under section 330 of the Public Health Service Act. They must meet the same requirements as the other community health centers receiving PHS section 330 grant funding. However, they do not have to be located in a designated medically underserved area (MUA) or medically underserved population (MUP).

Source: Rural Assistance Center. FQHC Frequently Asked Questions. Available: http://www.raconline.org/info_guides/clinics/fqhc.php.

Certification of FQHCs

Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Programs, and Urban Indian and Tribal Health Centers are automatically certified as FQHCs if they receive PHS section 330 grant funding. According to the Centers for Medicare and Medicaid Services, a site may qualify as an FQHC if it is:

- Receiving a grant under Section 330 of the Public Health Service (PHS) Act;
- Receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;

Certification of FQHCs (con't)

- Determined by the Secretary of the Department of Health and Human Services to meet the requirements for receiving such a grant (look-alike) based on the recommendation of the Health Resources and Services Administration; or
- An outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Source: Centers for Medicare and Medicaid Services. *Medicare Guide to Rural Health Services Information for Providers, Suppliers and Physicians*. September 2005.

Grant Application

In order to apply for the Community Health Center 330 Grant, a site must determine whether or not it is located in a medically underserved area or if the site serves a medically underserved population (see **Appendix A: Definitions of Rural**). It is also important to know whether or not the site has the support of the community. This support may be determined by holding a meeting in order to identify interested community members who would be willing to offer assistance. The Community Health Center must be able to meet all of the PHS section 330 requirements within 90 days of receiving the grant award. The application process for the grant is the same for tribal and non-tribal health centers. The National Association of Community Health Centers developed a manual, *So You Want to Start a Health Center: A Practical Guide for Starting a Federally Qualified Health Center*, to guide applicants through the application process. This manual is available online at: http://www.nachc.com/about/files/Start(final).pdf.

For more information regarding the PHS section 330 Grant, visit the Bureau of Primary Health Care's Health Center Program Web site at: http://bphc.hrsa.gov/chc.

Source: Rural Assistance Center. FQHC Frequently Asked Questions. Available: http://www.raconline.org/info_guides/clinics/fqhc.php.

FQHC Look-Alike

Community Health Center/Federally Qualified Health Center Look-Alikes meet all of the eligibility requirements for grant funding under PHS section 330. However, Look-Alike centers do not receive any PHS section 330 grant funding. Look-Alike centers are eligible to purchase reduced cost prescription and non-prescription medications for outpatients through the 340B Drug Pricing Program. They also receive enhanced reimbursement from Medicare and Medicaid. There are currently no FQHC Look-Alikes in Arizona.

Source: Rural Assistance Center. FQHC Frequently Asked Questions. Available: http://www.raconline.org/info_guides/clinics/fqhc.php.

Becoming an FQHC Look-Alike

In order to apply to become a FQHC Look-Alike, clinics must be fully operational at the time of the application. Sites must already have Medicare and Medicaid billing numbers before they apply or they must show proof that they have applied for them. For information regarding Medicare provider enrollment, visit the Centers for Medicare and Medicaid Services' Provider-Supplier Enrollment Web site, available at: http://www.cms.hhs.gov/MedicareProviderSupEnroll. FQHC Look-Alikes must meet all of the require

Becoming an FQHC Look-Alike (con't)

ments for the PHS section 330 grant funding, must serve a medically underserved area (MUA) or medically underserved population (MUP), must be a public or private non-profit organization, and may not be controlled, operated, or owned by another organization. Since FQHC Look-Alikes do not compete for funding, applications can be submitted at any time. The Bureau of Primary Health Care's (BPHC) estimated time of review for new FQHC Look-Alike applications is 90-120 days. For more information, or to download the guidelines and application package, visit the Bureau of Primary Care's FQHC Look-Alike Program website, available at: http://bphc.hrsa.gov/chc/lookalikes.htm.

Source: U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Primary Health Care. FQHC Look-Alike Program. Available: http://bphc.hrsa.gov/chc/lookalikes.htm.

Rural Health Clinics

Rural Health Clinics (RHCs) must be located in a non-urbanized area and in an area that is designated as either a health professional shortage area (HPSA) or a medically underserved area (MUA). Rural Health Clinics do not receive section 330 grant funding like CHCs, but they are eligible for various federal grants, such as the Rural Health Outreach Grant Program. RHCs are not required to provide services on a sliding-fee-scale, nor are they required to be run by a volunteer board of directors. RHCs are required to provide outpatient primary medical care services and basic laboratory services; employ at least one midlevel practitioner (Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant) at least 50 percent of the time the clinic is open; meet health and safety requirements imposed by Medicare and Medicaid; and must have a physician on staff who provides medical supervision, direction, and consultation. The physician must be present on-site at least every two weeks and available by telecommunication for assistance at all times. Like FQHCs, RHCs receive an enhanced reimbursement from Medicare and Medicaid.

Becoming an RHC

The steps involved in becoming a certified Rural Health Clinic, taken from the *Arizona Rural Health Clinic Designation Manual* (available online at: http://www.rho.arizona.edu/resources/manuals.htm), include:

Step 1: Determine Eligibility for Certification. The interpretive guidelines for Rural Health Clinics can be found on the National Rural Health Clinic Association's Web site (http://www.narhc.org/resources_and_links/rhc_rules_and_guidelines.php).

Step 2: Financial Feasibility Assessment. A financial study should assess the actual (for existing clinics) or estimated (for new clinics) data on payor mix (Medicare, Medicaid, and other). Experts say that a good rule of thumb to follow is if at least thirty-five to forty percent of your patients are combined Medicare and Medicaid patients, then becoming a certified RHC could be financially beneficial. Additionally, if an existing practice does not currently employ an NP, PA, or CNM, the practice must decide whether the cost of hiring one would be offset by increased revenue.

Step 3: File an RHC Application. If the site is already licensed as an Outpatient Treatment Center by the state of Arizona, the site must send a letter to the Arizona Department of Health Services, Division of Licensing Services, Office of Medical Facilities Licensing (http://www.azdhs.gov/als/medical) stating that the site would like to be certified as a Rural Health Clinic. The letter should also include a request for an RHC application packet. It is important that the site contact their Medicare fiscal intermediary before completing the CMS 855A provider/supplier enrollment application form. If the site does not know who their fiscal intermediary is, they may check the Centers for Medicare and Medicaid Service's Intermediary

Becoming an RHC (con't)

Carrier Directory website (http://www.cms.hhs.gov/contacts/incardir.asp) or they may contact the Arizona Department of Health Services, Division of Licensing Services, Office of Medical Facilities Licensing.

If the site is not already licensed as an outpatient treatment center by the state of Arizona, the site must send a letter to the Arizona Department of Health Services, Division of Licensing Services, Office of Medical Facilities Licensing (http://www.azdhs.gov/als/medical) stating that the site would like to be licensed as an Outpatient Treatment Center and certified as a Rural Health Clinic. In the letter, the site should request both a licensing packet and an RHC application packet. It is important that the site contact their Medicare fiscal intermediary before completing the CMS 855A provider/supplier enrollment application form (this form can be obtained from the following website: http://www.cms.hhs.gov/forms/). If the site does not know who their fiscal intermediary is, they may check the Centers for Medicare and Medicaid Service's Intermediary Carrier Directory website (http://www.cms.hhs.gov/contacts/incardir.asp).

Please note: Facilities located on an Indian Reservation do NOT have to be licensed as an Outpatient Treatment Center in order to apply for Rural Health Clinic certification. In addition, private practice cinics not providing urgent care services may not be required to be licensed as an Outpatient Treatment Center in order to apply for Rural Health Clinic certification. Contact the Arizona Department of Health Services, Division of Licensing Services, Office of Medical Facilities Licensing for more information.

Step 4: RHC Certification Inspection. Once the site is ready for inspection and in compliance with RHC requirements, the site should contact the Arizona Department of Health Services, Division of Licensing Services, Office of Medical Facilities Licensing, in writing, and request an inspection. The state agency will then conduct a survey.

Step 5: Rural Health Clinic Cost Report. Once a clinic has received its Medicare Provider Letter from the Centers for Medicare and Medicaid Services, the clinic then files a projected cost report in order to have its Medicare Rate determined. Independent Rural Health Clinics complete the CMS-222 Form and Provider-based Rural Health Clinics complete Worksheet M of the CMS-2552-96 Form. These forms are available from the CMS Web site (http://www.cms.hhs.gov/CMSForms).

Free Clinics

Free Clinics are private, non-profit corporations, with an independent governing body, that provide medical health care services at little or no charge to the uninsured and/or underinsured. Free Clinics deliver health care services through the utilization of volunteer health care providers and community volunteers. Funding for Free Clinics is usually raised at the local level and health care services are made possible through donations of goods and services, volunteers, and community donations. There is currently only one free clinic located in rural Arizona, which is the Stanfield Free Clinic in Stanfield, Arizona. The Prescott Free Clinic, Inc. existed as a Free Clinic in Prescott, Arizona until November 2002, when it converted to an FQHC.

For more information regarding Free Clinics, visit the National Association of Free Clinics' Web site at: http://www.freeclinics.us.

Source: National Association of Free Clinics. Available: http://www.freeclinics.us.

Clinic Comparison Chart

RHCs	FQHCs	FQHC Look-Alikes
Do not receive PHS Section 330 grant funding	Receive grant funding under PHS Section 330	Do not receive PHS Section 330 grant funding
Do not have to be governed by a board of directors	Must be governed by volunteer board of directors	Must be governed by volunteer board of directors
Receive enhanced reimbursement from Medicare/Medicaid	Receive enhanced reimbursement from Medicare/Medicaid	Receive enhanced reimbursement from Medicare/Medicaid
Ownership can be public, private, or non-profit	Must be public entity or private non-profit organization	Must be public entity or private non-profit organization
No sliding-fee-scale required	Sliding fee-scale required	Sliding-fee-scale required
Must provide outpatient primary care services and basic laboratory services	Must provide primary and preventive health care services	Must provide primary and preventive health care services
Not eligible for 340B Drug Pricing Program	Eligible for 340B Drug Pricing Program	Eligible for 340B Drug Pricing Program
Not eligible to receive coverage under FTCA	Eligible to receive malpractice coverage under Federal Tort Claims Act	Not eligible to receive coverage under FTCA
Must employ at least one midlevel provider at least 50% of the time the clinic is open	No specific staffing requirements	No specific staffing requirements
Must be located in a non-urbanized area	Can be located in a rural or urban setting	Can be located in a rural or urban setting
Must be located in a HPSA or MUA	Must be located in a MUA/MUP	Must be located in a MUA/MUP
Do not have to provide services to everyone, regardless of their ability to pay	Must provide services to everyone, regardless of their ability to pay	Must provide services to everyone, regardless of their ability to pay
Eligible to receive Rural Health Grants from HRSA's Office of Rural Health Policy	May be eligible to receive Rural Health Grants from HRSA's Office of Rural Health Policy, depending on location	May be eligible to receive Rural Health Grants from HRSA's Office of Rural Health Policy, depending on location
No required minimum hours per week	Must be open at least 32 hours per week	Must be open at least 32 hours per week

Source: Rural Assistance Center. Clinics. Available: http://www.raconline.org/info_guides/clinics

V. Tribal Resources

History

The responsibility for Indian health care was given to the U.S. War Department in 1803. In 1824, the Bureau of Indian Affairs was created in the War Department and then transferred to the Department of the Interior in 1849. By the end of the nineteenth century, the Bureau of Indian Affairs operated a small number of hospitals.

In 1921, the Snyder Act was passed, which stated that the Bureau of Indian Affairs "shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes: . . .For relief of distress and conservation of health" (25 USC 13). Although the act gave authorization for health care, the act failed to outline specific rights and responsibilities.

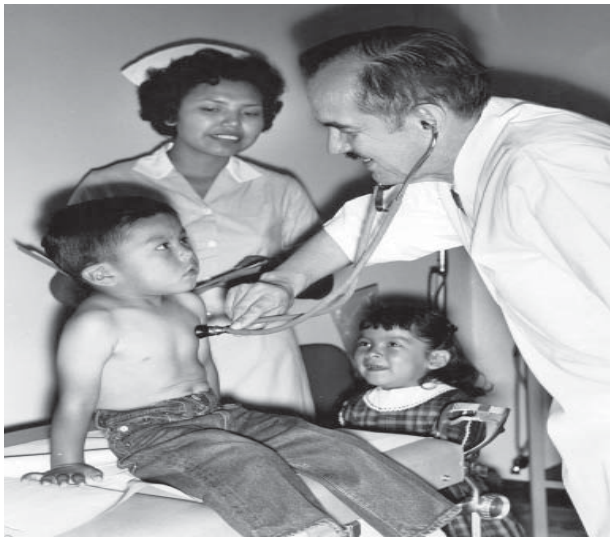


Photo Courtesy of the Indian Health Service/U.S. Department of Health and Human Services.

The responsibility for Indian health care was transferred from the Bureau of Indian Affairs to the Public Health Service, a division of the Department of Health, Education, and Welfare, on July 1, 1955, according to the Transfer Act of 1954. Within the Public Health Service, responsibility was granted to the Division of Indian Health, Bureau of Medical Services. After the Bureau of Medical Services was abolished as a result of a reorganization of the Department of Health, Education, and Welfare, the Division of Indian Health was transferred to the newly established Bureau of Health Services in 1966. In 1968, the Division of Indian Health was renamed the Indian Health Service. The Indian Health Service (IHS) became a separate agency within the Public Health Service in 1988.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEA) (P.L. 93-638) allowed programs administered by the Indian Health Service and Bureau of Indian Affairs to be transferred to the tribal governments. This Act enabled tribes to assume responsibility for managing and delivering their own health care.

The Indian Health Care Improvement Act of 1976 (IHCIA) (P.L. 94-437) authorized specific funds to remove deficiencies in Indian health care. It is declared in the Act that, "A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services" (25 USC 1601 et seq.).

Where the Snyder Act provided a global authority, the IHCA provided specific service areas, and several important innovations were made possible by this legislation. The Act authorized the establishment of a personnel-development program built around scholarship support for preparatory and graduate education in several health disciplines. It authorized appropriations (Indian Health Care Improvement Fund, IHCIF) designed to bring the level of health services of Indian people up to that of the rest of the country, and dollars were appropriated to address level of unmet needs/deficiencies in Indian health care.

History (con't)

One of the most important provisions allowed that the I.H.S. could be reimbursed through the Medicare and Medicaid programs for care rendered to Indians eligible for services under these programs. Funds generated under these Medicare and Medicaid collections were to be placed in a special account and used for acquiring and maintaining accreditation of hospitals. For the first time, authority to support urban Indian health needs was provided.

Amendments to the Indian Health Care Improvement Act, over the years, have extended and added other provisions to enhance the capability of the Agency, the Tribes, Tribal Organizations and Urban Indian Programs to support the national goal of "elevating the health status of Indians to the highest possible level and encourage the maximum participation of Indians in the planning and management of those services."

In May 2005, S.1057, was introduced in the U.S. Senate. This bill amends the IHCIA with some new provisions and extends others established with the original Act and/or its subsequent amendments. Some major provisions include:

- Continuation of a number of programs, such as the scholarship program, IHCIF, Catastrophic Health Emergency Fund, Diabetes prevention, treatment, and control, Epidemiology centers, sanitation facilities, contracts & grants to Urban Indian Organizations, etc.
- Directs the Secretary, acting through the Indian Health Service and Indian tribes and tribal organizations, to consolidate certain existing programs into a new program of comprehensive behavioral health, prevention, treatment and aftercare for Indian tribes.
- Establishes a National Bi-Partisan Indian Health Care Commission to: 1) establish a Study Committee to study the extent of Indian health services needs; 2) review and analyze the Study Committee's report, and 3) make recommendations to Congress regarding the delivery of Federal health care services to Indians.
- Reauthorizes the IHCIA through FY 2015
- Amends SSA title XIX (Medicaid) and XXI (SCHIP) to conform with this Act

In May 2006, a related bill, H.R.5312, was introduced in the U.S. House of Representatives. This bill amends the Indian Health Care Improvement Act to revise requirements for health care programs and services for Indians, Indian tribes, tribal organizations, and urban Indian organizations.

Sources: Pfefferbaum R, Pfefferbaum B, Rhoades E, Strickland R. Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices. American Indian Law Review. 1997;21;211-258; Infoplease: Encyclopedia. Bureau of Indian Affairs. Available: http://www.infoplease.com/ce6/history/A0825102.html; United States Code. Title 25, Chapter 1, Sec. 13. Available: http://www.gpoaccess.gov/uscode; United States Code. Title 25, Chapter 14, Subchapter II, Sec. 450 et seq. Available: http://www.gpoaccess.gov/uscode; United State Code. Title 25, Chapter 18, Sec. 1601 et seq. Available: http://www.gpoaccess.gov/uscode; U.S. National Archives & Records Administration. Records of the Indian Health Service. Available: http://www.archives.gov/research/guide-fed-records/index.html; U.S. National Library of Medicine. Images from the History of Public Health Service. Available: http://www.nlm.nih.gov/exhibition/phs_history/148.html.

Indian Health Service Budget

The Indian Health Service (Agency, Area, and Service Unit) Budget is a combination of congressional appropriation and third party collections. The historical base amount may be adjusted for program increases/decreases, new programs, cost of living/inflation allowance, projected revenue (collections), special initiatives, and assessments. Significant increases may be realized if new facility construction monies (for a specific site) are appropriated.

Indian Health Service Budget (con't)

Tribes have an opportunity to influence the priority and level of funding during the annual Indian Health Service budget formulation process. Area, Regional, and National Budget Formulation Tribal Consultations are conducted by the U.S. Department of Health and Human Services through and with the twelve I.H.S. Area Offices. The federal budget process begins with the President's budget request and includes three year projections: the 1st, the 2nd, and 3rd year beyond the existing fiscal year.

Under the Indian Self-Determination and Education Assistance Act, tribes may contract or compact for programs, services, functions, and activities (PFSAs) currently administered on their behalf by the I.H.S. The amount of funds available to tribes is the "Secretarial Amount" or § 106 (a) (1) amount (in reference to the particular section of P.L. 93-638) that establishes a tribe's "entitlement" to the amount the Secretary would have otherwise expended in the administration of that particular PFSA, or severable portion thereof. Contract funding is negotiated at the Service Unit and Area level and determined by actual appropriations. Compact funding is negotiated at the headquarter level.

Health Services for Tribes

The tribes have three options regarding the control of their health services. The three options include: leaving all control to the I.H.S., choosing to let the I.H.S. control some services and taking over responsibility for the other services (known as 638 contract), or taking over control of all services from the I.H.S. (known as 638 compact). To date, in Arizona, tribes have largely left control with the I.H.S.

The tribes in Arizona that have chosen to take over responsibility for services from the I.H.S. are the Gila River Indian Community and the Ak-Chin Indian Community. The tribes that have chosen to take over control of some services and leave other services under the I.H.S.' control include: Cocopah Tribe, Colorado River Indian Tribes, Fort McDowell Yavapai Nation, Fort Mojave Indian Tribe, Fort Yuma-Quechan Tribe, Havasupai Tribe, Hopi Tribe, Hualapai Tribe, Kaibab-Paiute Tribe, Navajo Nation, Pascua Yaqui Tribe, Salt River Pima-Maricopa Indian Community, San Carlos Apache Tribe, Tohono O'odham Nation, Tonto Apache Tribe, White Mountain Apache Tribe, Yavapai-Apache Nation, and Yavapai-Prescott Indian Tribe.

In regards to the construction of new health care facilities, tribes have two options. Tribes can either use their own money or be placed, following the I.H.S. planning process, on the I.H.S. Health Facilities Construction Priority List.

Source: Phoenix Area Indian Health Service; Navajo Nation.

638 Contracts

As a result of the Indian Self-Determination and Education Assistance Act (PL-93-638), tribes are given the option to receive the money that the I.H.S. would have used to provide health care services to tribal members. Tribes can then use this money to either provide health care services directly or through another entity. This option is commonly known as 638 contracts.

As of June 2006, there are two 638 Tribal hospitals and four 638 Tribal clinics located in Arizona. The two hospitals are the Tuba City Regional Health Care Corporation and Hu Hu Kam Memorial Hospital and the clinics are the Winslow Health Care Center, Gila Crossing Health Center, Ak Chin Health Clinic, and Wassaja Memorial Health Center. In addition, Sage Memorial Hospital currently has partial-638 status.

Tribal Resources List

Arizona Department of Health Services
Native American Liaison
Michael Allison
150 N. 18th Avenue, Room 595
Phoenix, AZ 85007
Phone: (602) 364-1041
Fax: (602) 364-3445
Web site: http://www.azdhs.gov/phs/tribal

Phoenix Area Indian Health Service
Two Renaissance Square
40 North Central Avenue
Phoenix, AZ 85004
Phone: (602) 364-5039
Fax: (602) 364-5042
Web site: http://www.ihs.gov

Tucson Area Indian Health Service
7900 S. J. Stock Road
Tucson, AZ 85746
Phone: (520) 295-2405
Fax: (520) 295-2602
Web site: http://www.ihs.gov

Navajo Area Indian Health Service
P.O. Box 9020
Window Rock, AZ 86515
Hwy 264 & St. Michael Road
St. Michael, AZ 86511
Phone: (928) 871-5811
Fax: (928) 871-5872
Web site: http://www.ihs.gov

Bureau of Indian Affairs
Phoenix Area Office
400 N. 5th Street
Phoenix, AZ 85004
Phone: (602) 379-6600
Fax: (602) 379-4413
Web site: http://www.doi.gov/bureau-indian-affairs.html

Arizona Commission of Indian Affairs
1400 W. Washington, Suite 300
Phoenix, AZ 85007
Phone: (602) 542-3123
Fax: (602) 542-3223
Web site: http://www.indianaffairs.state.az.us/

Inter Tribal Council of Arizona, Inc.
2214 North Central Avenue, Suite 100
Phoenix, AZ 85004
Phone: (602) 258-4822
Fax: (602) 258-4825
Web site: http://www.itcaonline.com

National Indian Health Board
101 Constitution Ave. N.W., Suite 8-B02
Washington, DC 20001
Phone: (202) 742-4262
Fax: (202) 742-4285
Web site: http://www.nihb.org/

Tribal Regional Behavioral Health Authorities (TRBHAs):

Colorado River Indian Tribe Behavioral Health Services
12033 Agency Rd.
Parker, AZ 85344
Phone: (928) 669-3256

Gila River Regional Behavioral Health Authority
P.O. Box 38
Sacaton, AZ 85247
Phone: (602) 528-1206

Navajo Nation Regional Behavioral Health Authority
P.O. Box Drawer 709
Window Rock, AZ 86515
Phone: (928) 871-6239

Pascua Yaqui Regional Behavioral Health Authority
7490 South Camino De Oeste
Tucson, AZ 85746
Phone: (520) 883-5185

VI. Health Information Technology Resources

Introduction

The purpose of this section of the *Arizona Rural Health Resource Manual* is to provide a brief review of national and state initiatives that are underway to implement health information technology systems nationally and in Arizona.

The movement toward a national health information system was given a boost in April 2004 when the President of the United States signed an Executive Order that generated incentives for the use of health information technology, and established the position of the National Health Information Technology (NHIT) Coordinator.

By July 2004, the Department of Health and Human Services (HHS) released the Framework for Strategic Action, *The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care*. The Strategic Framework outlined four major goals to realize the President's vision of health care that utilizes information technology to avoid dangerous medical mistakes, reduce costs, and improve care:

- Inform clinical practice with use of electronic health records (EHRs).
- Interconnect clinicians so that they can exchange health information.
- Personalize care with consumer-based health records and better information for consumers.
- Improve population health through advanced biosurveillance methods

Source: Summary of Nationwide Health Information Network (NHIN) Request for Information (Responses), June 2005, US Department of Health and Human Services, Office of the National Coordinator for Health Information Technology.

Photo courtesy of Microsoft® Office Online.

Acronyms used in Health Information Technology

AHIC	American Health Information Community
AHIMA	American Health Information Management Association
BROADBAND	Telecommunication in which a wide band of frequencies is available to transmit information
CCR	Continuity of care record
CDR	Central data repository
CISSP	Certified Information Systems Security Professional
EHR	Electronic health record
EMR	Electronic medical record
HIE	Health Information Exchange (infrastructure to enable data sharing among organizations)
HIPAA	Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191
HIT	Health information technology

Acronyms used in Health Information Technology (con't)

MPI	Master Patient Index
MTA	Medical Trading Area
NHII	National Health Information Infrastructure
NHIN	National Health Information Network
ONC	Office of the National Coordinator for Health Information Technology
PHS	Patient health summary
RHIO	Regional Health Information Organization
SIREN	Security in regional networks
VISTA	Veterans Health Information Systems and Technology Architecture
WIFI	Wireless Fidelity

Federal Resources

The White House

The purpose of the Executive Order of April 2004 was to develop and implement a nationwide, interoperable health information technology infrastructure that will improve the quality and efficiency of health care, reduce medical errors, and reduce the costs associated with health care delivery. The Executive Order defines specific tasks for the NHIT coordinator to accomplish. These include the following:

1. Ensure that appropriate information to guide medical decisions is available at the time and place of care;
2. Improve health care quality, reduce medical errors, and advance the delivery of appropriate, evidence-based care;
3. Reduce health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;
4. Promote a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes;
5. Improve the coordination of care and information among hospitals, laboratories, physician offices, and other ambulatory care providers through an effective infrastructure for the secure and authorized exchange of health care information; and
6. Ensure that patients' individually identifiable health information is secure and protected.

Furthermore, the Executive Order calls for the completion and adoption of national standards, collaboratively developed with the private sector, that will allow medical information to be stored and shared electronically while assuring privacy and security.

By November 2005, $18.6 million in grants were awarded by the Department of Health and Human Services (HHS) to four groups of health care and health information technology organizations to develop prototypes for a Nationwide Health Information Network (NHIN) architecture. These grants built upon previous HHS grants to create processes to harmonize health information standards, to develop criteria to certify and evaluate health IT products, and to develop 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.

Federal Resources (con't)

U.S. Congress

Over 50 bills on health information technology have been introduced in the current (109th) Congress. It is anticipated that some of the bills will become law, and bring with them appropriations aimed at supporting the implementation of electronic health record systems throughout the country. The Government Health IT website cites most of the bills (http://www.govhealthit.com/resources/bills.asp). Bill tracking can be done by inserting the bill number in the appropriate box in the Library of Congress' Thomas Web site (http://thomas.loc.gov).

U.S. Department of Health and Human Services (HHS)

HHS is guiding the development of standards for Health IT systems that will improve patient care and increase efficiency across the health care system. HHS, through several of its agencies, also provides funding to organizations engaged in building and testing Health IT systems, standards and projects.
http://www.hhs.gov

- American Health Information Community (AHIC) - The AHIC is a federal advisory body, chartered to make recommendations to the Secretary of HHS on how to accelerate the development and adoption of Health IT. The AHIC pursues breakthroughs that will produce tangible value to the health care consumer in the near-term, while building toward long-term goals for a broad and robust system.
  http://www.hhs.gov/healthit/ahic.html

- The Office of the National Coordinator for Health Information Technology (ONC) - The ONC advises the Secretary of HHS on health IT policies and initiatives, and coordinates the Department's efforts to meet the President's goal of making an electronic medical record available for most Americans by 2014. The ONC provides leadership for the development and implementation of a nationwide health IT infrastructure allowing secure and seamless exchange of data and records.
  http://www.hhs.gov/healthit

- Agency for Healthcare Research and Quality (AHRQ) - The AHRQ funds health information technology research and development with $166 million in grants and contracts. This money is awarded to programs across the country to support and stimulate investment in health IT, especially in rural and underserved areas. The AHRQ also created the National Resource Center for Health Information Technology, which provides technical assistance and shares knowledge and findings that have the potential to transform every day clinical practice.
  http://www.ahrq.gov

- Indian Health Services (IHS) - The IHS provides care for nearly two million American Indians and Alaska Natives across the United States. For three decades, the IHS has been at the forefront of health IT utilization. The IHS captures clinical and public health data using the Resource and Patient Management System (RPMS). The RPMS Electronic Health Record (EHR) allows providers to manage all aspects of patient care electronically, starting before the patient is ever seen and continuing through follow-up care. The RPMS is based on the VA's VistA (Veterans Health Information Systems and Technology Architecture) system.
  http://www.ihs.gov

Federal Resources (con't)

- National Institutes of Health (NIH) - The NIH, through the Nation Library of Medicine (NLM), hosts an online medical database that provides up-to-date information to consumers and health care professionals. Called MedlinePlus, the database is free to use, provides extensive information about drugs, an illustrated medical encyclopedia, interactive patient tutorials, and the latest health news.
  http://medlineplus.gov

Department of Defense (DoD)

Currently, thousands of military medical providers use the DoD's electronic health record system, AHLTA, and nearly 300,000 outpatient visits are captured digitally every week. AHLTA is not an acronym. It is the name of the system. Launched in 2005, AHLTA moves information globally. DoD's vision is to provide each patient with a continuously updated digital medical record from the point of injury or care on the battlefield to discharge from military clinics and hospitals in the United States. These records would be completely transferable electronically to the Veterans Health Administration as part of the Joint Patient Electronic Health Record (JPEHR).
http://www.defenselink.mil

Department of Veterans Affairs

Veterans Health Administration (VHA) - The VHA is a division of the U.S. Department of Veteran's Affairs, and provides care for over five million veterans of the United States Armed Services. The VHA's electronic health record system is called VistA (Veterans Health Information Systems and Technology Architecture). Introduced in 1996, VistA is a rich, automated environment that supports day-to-day operations at hundreds of VA hospitals, clinics, and nursing homes throughout the country. VistA software is in the public domain and is available through the VA website. Detailed information about VistA may be found in this VA monograph: http://www.va.gov/vista_monograph/docs/vista_monograph2005_06.pdf

VistA has been refined over the years, and currently offers the following benefits:

- A Real-Time Order Checking System that alerts clinicians during the ordering session that a possible problem could exist if the order is processed;
- A Notification System that immediately alerts clinicians about clinically significant events;
- A Patient Posting System, "MyHealtheVet," displayed on every Computerized Patient Record System (CPRS) screen that alerts clinicians to issues related specifically to the patient, including crisis notes, warning, adverse reactions, and advance directives. My HealtheVet allows patients to refill prescriptions online and provides access to health information, links to Federal and VA benefits and resources, and the patient's Personal Health Journal. The VHA continues to add capabilities to My HealtheVet, to empower consumers to take a more active role in managing their health and health care.
  http://www.myhealth.va.gov
- The Clinical Reminder System that allows caregivers to track and improve preventive health care for patients and ensure timely clinical interventions are initiated.
- Remote Data View functionality that allows clinicians to view a patient's medical history from other VA facilities to ensure the clinician has access to all clinically relevant data available at VA facilities.

Federal Resources (con't)

The National Health Information Infrastructure (NHII)

The widespread adoption of health IT will depend on the availability of a common set of standards for technology and nomenclature. Several HHS agencies are supporting the NHII Initiative to develop these standards. Learn more about these agencies and their work at: http://www.aspe.hhs.gov/sp/nhii/hhsrole.html

For more information regarding these projects, please visit HealthIT, a U.S. Government Health Information Technology Web site, at: http://www.hhs.gov/healthinformationtechnology.

Sources: The White House. Promoting Innovation and Competitiveness: President Bush's Technology Agenda. Executive Summary. Available: http://www.whitehouse.gov/infocus/technology/economic_policy200404/chap1.html; Health IT. Federal Efforts. Available: http://www.hhs.gov/healthinformationtechnology.

State Resources

Arizona Health-e Connection Roadmap

On August 30, 2005, Governor Janet Napolitano issued Executive Order 2005-25 establishing the Arizona Health-e Connection Steering Committee. Their charge was to develop a roadmap for statewide interoperability for electronic health records to reduce costs and enhance the quality of health care. Dozens of Arizonans representing diverse interests and geographies contributed to the process, serving on the Steering Committee or on one of the various task groups convened to address specific issues.
The Steering Committee delivered the Roadmap to Governor Napolitano on April 4, 2006. Major components of the Roadmap include:

- Encouraging health information technology adoption among health care providers;
- Identifying key infrastructure components that enable providers to securely exchange health information;
- Implementing both regional and centralized initiatives;
- Developing a not-for-profit, public-private governance organization with representation from all major stakeholders groups to provide leadership implementing the Roadmap; and,
- Creating a funding structure that is value-driven and self-sustaining with many costs borne by those receiving benefit.

Transition to a permanent governance organization will require approximately one year. During this time additional project milestones are to be reached. The first year milestones include:

1. Organize a transition team;
2. Obtain start-up funding;
3. Establish the governance organization;
4. Implement several statewide infrastructure projects that provide immediate value;
5. Establish one or two regional health information exchanges; and,
6. Develop a marketing and education plan to encourage stakeholder participation.

For more information or to download a complete copy of the Health-e Connection Roadmap, visit: http://gita.state.az.us/tech_news/2005/ehealth/E_Health.htm.

Source: Arizona Health-e Connection Roadmap. Available: http://gita.state.az.us/tech_news/2005/ehealth/E_Health.htm.

State Resources (con't)

Arizona's Governor was successful in obtaining support from the state legislature to appropriate $1.5 million to help rural health care providers to implement electronic health record systems. These funds were in the budget bill that passed the state legislature in Spring 2006. By July 2006, the policies and procedures for distributing the funds were in the process of being adopted through the Government Information Technology Agency (GITA).

In June 2006, the Arizona Rural Hospital Flexibility Program at the University of Arizona's Mel and Enid Zuckerman College of Public Health Rural Health Office funded four critical access hospitals to plan for implementing electronic health record systems, and in one case, to expand an existing E.H.R. into the hospital pharmacy. The projects were seeded with an appropriation of $104,000. http://azflexprogram.publichealth.arizona.edu.

Development of a RHIO

Dr. David Brailer, the immediate past national coordinator for health IT at the Department of Health and Human Services, has called RHIOs an essential element in the formation of a National Health Information Network. RHIOs support state and other regional projects that help harmonize the privacy and business rules for health information exchange. According to the ONC website, there over 100 RHIO's have or are in the process of forming throughout the country. No official definition of RHIO has yet been adopted, since the concept is still new. Nevertheless a framework for RHIO models and functions is beginning to be shaped.

Health information exchange provides the capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged.

In Arizona, a RHIO was officially launched in June 2006 to cover the southern geographic area of the state. This RHIO recently received news that federal funding support for its operations is anticipated.

Resources for Implementation

Federal Funding Resources

All federal funding sources: http://www.grants.gov
Selected sources for possible H.I.T. related funding:

Office for the Advancement of Telehealth: http://telehealth.hrsa.gov
Office of Rural Health Policy Outreach Grants, Network Planning Grants, Network Grants: http://ruralhealth.hrsa.gov
Agency for Health Research and Quality: http://www.ahrq.gov
National Library of Medicine: http://www.nlm.nih.gov
U.S. Department of Agriculture Rural Utilities Grants: http://www.ed.gov/pubs/AchGoal4/doa.html
U.S. Department of Commerce, Economic Development Administration: http://www.commerce.gov/grants.html
Grants and Funding Resource Guide by Polycom: http://www.polycom.com/pw_files/GrantandFundingResourceGuide_4-05.pdf

Resources for Implementation (con't)

Arizona Funding Resources

Government Information Technology Administration (GITA):
http://gita.state.az.us
Arizona Department of Health Services (ADHS): http://www.azdhs.gov

Vendor Certification

The Certification Commission for Healthcare Information Technology (CCHIT) is the recognized certification authority for electronic health records and their networks, and an independent, voluntary, private-sector initiative. The mission of the CCHIT is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable product certification program. CCHIT is developing certification criteria and an inspection process for health information technology in three areas: ambulatory EHRs, inpatient EHRs, and the networks through which they interoperate. The certification of EHR products for physician offices has been completed. A list of CCHIT Certified products and their developers is expected to be released in July 2006. To access this list, visit the CCHIT's Web site at: http://www.cchit.org.

The eHealth Initiative's Connecting Communities Toolkit

The eHealth Initiative and the Foundation for eHealth Initiative are independent, non-profit affiliated organizations whose missions are the same: to drive improvement in the quality, safety, and efficiency of healthcare through information and information technology.

The eHealth Initiative is offering the Connecting Communities Toolkit, which includes a cost model for health information exchange and a market assessment tool. These interactive tools support learning among diverse stakeholders including regional and community-based organizations. The Toolkit is a distillation of the knowledge accumulated through work with many communities. Stakeholders from every sector of healthcare, pioneers who are mobilizing information at the state, regional and community levels, and leading experts have helped develop a set of common principles and guides in seven modules, each including online documents and tools. Each module includes an introduction and overview, a roadmap, key principles, sample community experiences, and a set of resources and links specific to the module. They are available free of charge.

The toolkit can be accessed through the eHealth Initiative's Web site at:
http://toolkit.ehealthinitiative.org.

Sources: Certification Commission for Healthcare Information Technology. Available: http://www.cchit.org; eHealth Initiative. Available: http://www.ehealthinitiative.org.

HIT Planning Grid

SUGGESTIONS FOR PLANNING HEALTH INFORMATION TECHNOLOGY SYSTEMS IN RURAL HOSPITALS AND CLINICS*

Prepared by the Arizona Rural Hospital Flexibility Program, Rural Health Office, University of Arizona Mel and Enid Zuckerman College of Public Health

STRATEGIC PLANNING *Note:* *Electronic Health Record vs. Electronic Medical Record*	**STEPS** *Note:* *E.H.R. is the whole system* *E.M.R. is the medical chart*
Perform a Readiness Assessment	
ENGAGE BOARD, MEDICAL STAFF, AND ADMINISTRATION IN HIT STRATEGIC PLANNING	$ Discuss need for HIT & provide resource information $ Gain commitment of Board/Medical Staff, and Administration for expansion of HIT $ Define desired outcomes for HIT expansion
FORM HIT PLANNING COMMITTEE	Include representation from Board, Administrative Staff, Medical Staff, Department Heads, Community
Conduct An Analysis of the Existing Information Technology Infrastructure, and a Work Flow Analysis	
CURRENT IT INFRASTRUCTURE VS. DESIRED (GAP ANALYSIS)	Identify the telecommunications system in place in all facilities to be included in the proposed Electronic Health Record system $ Broadband $ T-1 $ L.A.N. (local area network) $ W.A.N. (wide area network) $ Satellite Existing Software Existing Hardware, etc.

Resources for Implementation (con't)

STAFF TO SUPPORT NEW E.H.R. SYSTEM	EXISTING $ Full-time/Part-time IT $ Resources $ Desired $ Full time/Part-time $ Payroll resources STAFF TRAINING NEEDS FOR EHR $ IT staff capacity and needs $ Other staff training needs once E.H.R. system is installed
INTERNAL DEPART-MENTAL WORKFLOW REVIEW	$ Current facility/physical space in relation to workflow $ Admissions/Discharge flow by department $ Coding/Billing/Collections flow $ Pharmacy records $ Laboratory $ Radiology $ Therapy services $ Clinical services in all facilities $ Skilled nursing facility $ Home health care $ Others
EXTERNAL WORK-FLOW REVIEW	$ Ambulance records $ Emergency Room records $ Clinic(s) records $ Private Physician practice records $ Pharmacy records $ Long term care facility records $ Public health reports/records $ Others
FINANCIAL REVIEW AND PLANNING	$ Review cost report trends $ Identify available resources to invest in HIT initiative (e.g., staffing, telecommunications access, staff training, cost of extra staff learning time, facility modification, hardware, software systems, etc.) $ Identify potential grant and other funding sources to support H.I.T. system (Federal: RUS, Commerce, HHS/ ORHP Outreach Grants, Network Development Grants, Network Grants, Office of the Advancement of Tele-health)

Hiring a Consultant to Help Plan Your Electronic Health Record System	
BENEFITS	$ Experience with planning & implementing HIT design $ Expertise with multiple systems $ Knows the vendors, and is experienced in negotiating contracts that produce cost saving
CAUTIONS	$ Costs $ Check reputation and experience (reference checks) $ Need to confirm knowledge of and understanding of the "whole" E.H.R. system and not a component $ Perform reference checks
Vendor Selection	
SMART QUESTIONS TO ASK POTENTIAL VENDORS *Note: Be sure your vendor contract stipulates that final payment will be made after the whole system is installed and tested, and NOT upon equipment delivery*	$ Is the vendor certified by (or plans to be) CCHIT (Certification Commission for Healthcare Information) $ Does the vendor's system meet HIPAA criteria? $ How long has vendor been in business? $ Can the vendor name other rural health facilities in which they have installed E.H.R. systems? $ Is a system they created available for review/visit? $ Can the E.H.R. be exported to other systems? $ How much staff training will the vendor provide for using the new system? $ Does the vendor manufacture both the E.H.R. hardware and software? (If not, how will hardware/software systems be aligned?)

Resources for Implementation (con't)

QUESTIONS VENDORS MAY ASK (Continued)	USAGE AND VOLUME $ Number of HIT system users $ Total FTE's $ Number of beds $ Average daily census $ Annual admissions $ Total medical staff $ Total employed physicians $ Total employed staff that will use system $ Annual outpatient visits $ Annual E.D. visits DESCRIBE FINANCIAL SYSTEM $ Current system $ Admissions-discharge transfer system $ Type of billing systems $ Medical record number inpatient/outpatient CURRENT EMR/CPOE SYSTEM $ Physician order entry $ Nursing documentation system $ Physician documentation system $ Scanned documents $ Dictation system $ Coding system $ Pharmacy management system $ Medication admin record system $ Med. cabinet system (e.g., Pyxis) $ Pharmacy staffing FTEs CURRENT IT INFRASTRUCTURE $ See above CURRENT CLINIC SYSTEM $ Practice management $ Electronic medical record $ Consumer portal HOSPITAL PROFILE $ Current revenue (most recent cost report) $ Current operating expenses (as above) $ Annual capital budget $ Annual IT budget $ Top 10 DRG's $ Top 10 outpatient visits $ Top 10 clinic visits

* We wish to acknowledge the Colorado Rural Health Center, PrivaPlan Associates, Inc., and the Cerner Corporation for providing some of the above ideas in planning and implementing an EHR initiative.

Introduction to Telemedicine

Telemedicine benefits both the patient and the provider. Often it takes months to get an appointment with a specialist. In some of the more remote areas of Arizona, patients must drive hundreds of miles to Phoenix or Tucson to see a specialist. Telemedicine provides access to health care, and prevents a lot of travel to get care.

This section briefly explains the telemedicine system in the state, and answers questions regarding access to telemedicine technology and the costs of this service.

The Arizona State Legislature adopted a definition of telemedicine in 1997. By state law, telemedicine is "the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation" (A.R.S. 36-3601).

Pictured: Dr. Ronald Weinstein (left) and Alison Hughes during the Rural Health Roundtable on West Nile Virus, held on August 27, 2004.

Arizona's extensive telemedicine network has gained national renown in recent years. Both the Arizona Telemedicine Program (ATP) and the Northern Arizona Behavioral Health Authority's telemedicine system have been honored with national awards for excellence.

Arizona's two major telemedicine networks are now linked together, along with two new, large telemedicine networks – the Navajo Nation and the Phoenix Area Indian Health Service Telecommunications Networks. The Arizona Telemedicine Program's network serves as a hub site for linking all the telemedicine networks, including the state prisons' telemedicine network. While each network functions separately from the other, and strict firewalls exist that prevent access to information being transmitted within the networks, the linkage allows for all sites within each network to connect with each other. Network engineers control the switching devices that link network sites to each other. This is done with prior agreement and approval. In addition, other private and public providers are linked to the Arizona Telemedicine Program's network, including the Banner Health System, Carondelet Health Network, and St. Luke's Arizona Foundation for the Eye. A fee is assessed to network members for connectivity to the Arizona Telemedicine Program network. The assessments are used to pay for recurring costs of maintaining the network and ensuring its technological efficiency.

Arizona's telemedicine network (also referred to as the telehealth network) allows for four functions: (1) health care delivery, (2) education and training, (3) videoconference administrative meetings, and (4) research in telemedicine utilization and capacity.

Health Care Delivery

Care is delivered to rural and urban telemedicine sites by both "Store and Forward" and "Real Time" technology, and reimbursement for the care is possible within adopted federal rules and regulations.

"Store and forward" technology involves the use of a camera and a desktop or laptop computer. The patient is not required to see a physician "live" with this technology. Store and Forward technology is popular for diagnoses in specialty fields such as dermatology, pathology, and ophthalmology, and radiology. In dermatology, a digital camera and laptop or desktop have proven to work well as photographs can be stored in the computer and transmitted through the network or regular telephone lines to a specialist who can diagnose and recommend treatment quickly using email. In pathology, photographs are transmitted to a specialist who has access to an electronic microscope that is used for diagnosis. In ophthalmology, a non-mydriatic camera is used to photograph the patient's eyes. The image is stored in the computer and then transmitted to the specialist for diagnosis.

Radiology is the most popular store and forward technology used in Arizona. Digital radiology systems are now the preferred method of gaining access to specialists. While regular telephone lines can be used to transmit X-rays, it takes a long time for the images to be transmitted as the files are very large. Increasingly, digitized radiology equipment is being installed to allow for rapid transmission of X-rays.

"Real time" technology occurs when the patient is in a different physical location from the doctor and communications are occurring between them by video transmission. This is done by appointment. In a "full service" telemedicine site that offers live patient-specialist consultations, peripheral devices are often used to monitor the heart (as in cardiology), or ear nose and throat. Before a hospital or a clinic invests in the expense of gaining access to real time telemedicine technology, a survey should be conducted to identify the specialty fields that can benefit the most patients, and also the extent to which physicians will actually use the system if it is made accessible to them. Real time technology is popular in the psychiatry field. In Arizona, the second highest utilization of telemedicine technology is for psychiatry, with radiology being the highest.

The question most often asked regarding telemedicine is how do you pay for it? There are a number of federal grant programs available that fund telemedicine equipment. These are described in the section on **Rural Health Funding Resources** in this Resource Manual. Also the Universal Service Administrative Company (USAC) provides discounted services for T-1 connectivity (and for Internet service access in rural health facilities).

Education and Training

The Arizona Telemedicine Program offers a comprehensive training program in telemedicine planning and utilization for individuals interested in implementing telemedicine programs. Training is open to interested individuals and groups from inside and outside of the state of Arizona. Information may be obtained at the ATP web site at http://www.telemedicine.arizona.edu/Training/index.html or by contacting Janae Cooley at (520) 626-4785 or janae@u.arizona.edu.

ATP also offers educational opportunities to any of its members who are connected to the telemedicine network. Trainings are often conducted in collaboration with the Northern Arizona Behavioral Health System telemedicine network, and the Indian Health Service telemedicine network, along with the Arizona Department of Health Services and the Health Services Advisory Group. These have included live multi-site opportunities in current topics such as the management of health and human services during the Rodeo Chediski Fire: Lessons Learned, Eye Care and the Diabetic, West Nile Virus prevention planning; and Influenza prevention and treatment during a vaccine shortage. In addition, the telemedicine network

regularly broadcasts Grand Rounds to medical providers throughout the state for which they can obtain continuing education credits. For more information about the educational opportunities available through the telemedicine network, go to the Distance Education link on the Arizona Telemedicine Program web site at: http://www.telemedicine.arizona.edu/distanceEd/index.html.

Videoconference Administrative Meetings

The Arizona Telemedicine Program network is also used to conduct administrative meetings among its members. The network makes possible connections between any two points in the network, regardless of location. Appointments are necessary for the use of the network for this purpose, and available through the Arizona Telemedicine Program staff. For more information, contact: Tracy Skinner at (520) 626-6103 or tskinner@email.arizona.edu.

Research in Telemedicine Utilization and Capacity

The Arizona Telemedicine Program, housed in the University of Arizona's College of Medicine, researches the efficacy of telemedicine technology applications. Staff members test and document the use of different types of telemedicine equipment, and identify that which offers the best quality in areas such as picture resolution, speed, and magnifying capacity. They also analyze the utilization trends among telemedicine network members throughout the state, and document the impact of telemedicine applications on patient care. The results of their research are published frequently in national journals, books, and magazine.

For more information about connecting rural health provider sites to ATP, contact Sandy Beinar, ATP Associate Director for Administration, at: (520) 626-2493 or beinars@u.arizona.edu.

Frequently Asked Questions Regarding Telemedicine in Arizona

1. What is Telemedicine?

Telemedicine is the practice of medicine using a telecommunications system to provide clinical services at a geographically separate site. Service can be delivered in "real time" using interactive video conferencing, or through "store and forward" which relies on the transmission of images and data for review immediately or at later time.

2. What is the Arizona Telemedicine Program?

The Arizona Telemedicine Program is a statewide program intended to increase access to healthcare to all residents in Arizona using telemedicine technologies. The Program's telecommunications network spans the entire state and is linked to other telecommunications networks in Arizona. The Arizona Telemedicine Program also delivers continuing educational programming to healthcare providers on a regular basis, and provides the telecommunications link for administrative meetings. More information is available on the Arizona Telemedicine Web site at: http://www.telemedicine.arizona.edu.

3. How can I join the Arizona Telemedicine Program, and what are the benefits?

The Arizona Telemedicine Program is open to all healthcare-related organizations in Arizona. There is a

modest membership fee that is based on services desired. The Arizona Telemedicine Program can assist healthcare enterprises in assessing their needs and determine what services would most benefit the organization. The benefits of the program are numerous. For a complete overview of benefits see the Arizona Telemedicine Program Network Services section of the ATP Web site. Briefly, they include:

- Assistance to interested organizations in conducting a needs assessment for their site.
- The option to contract for a full range of services from consulting only, to a turnkey solution; charges are only for those services desired. Cost estimates and a workplan are provided to every interested organization.
- Members of the Arizona Telemedicine Program receive access to a variety of continuing education programming and associated credits for healthcare providers.
- Arizona Telemedicine Program network staff continuously monitor network operations and troubleshoot and resolve any network problems.
- Members of the Arizona Telemedicine Program receive a free 2-day formal training at its training center. The training covers a broad range of telemedicine topics including, but not limited to, business and reimbursement, clinical protocols, technical operations, and legal/regulatory issues. In addition, there is follow up on-site training.
- Rural members receive assistance with filing federal Universal Service Program forms to reduce telecommunications costs to those areas.

4. Are there financial benefits of joining the Arizona Telemedicine Program?

There are potentially a number of financial benefits in joining the Arizona Telemedicine Program. These include:

- Critical Access Hospitals can amortize the costs of startup and continuing telemedicine on their cost report for reimbursement.
- Telecommunications costs can be reduced because the Arizona Telemedicine Program is a volume dealer and rural healthcare organizations can benefit from the federal Universal Service Fund program, which reduces telecommunications costs further.
- For virtually all third party payers in Arizona, healthcare providers can bill for almost all telemedicine services at the same rate as for in-person services. Medicare is the most restrictive payer, but does reimburse for a limited number of real time telemedicine services. Healthcare facilities can also bill a modest facility fee.
- Valuable transport and travel time can be saved if patients or providers do not have to travel to receive or provide healthcare services.
- There is an opportunity for an organization, with excess capacity, to increase their market share.
- ATP staff can recommend which types of telemedicine equipment and peripheral devices used in the delivery of telemedicine have been shown to be more effective than others, and which are compatible with that used in the Arizona Telemedicine Program.

5. What are my responsibilities as an Arizona Telemedicine Program member?

Members of the Arizona Telemedicine Program are responsible for providing a technical coordinator, who will attend the free training session. This individual should understand how to work the telemedicine equipment, assist participants in their use of the equipment, and distribute broadcast program notifications

to members of their organization. Members are also responsible for signing their contract, and abiding by the contract provisions, including paying membership dues on a timely basis. In addition, member sites are also expected to designate a medical director for telemedicine as one of their responsibilities for network membership.

6. Can I implement telemedicine without an affiliation with the Arizona Telemedicine Program?

Yes. It is possible for any health care facility to assume its own responsibility for arranging for the installation of telecommunication lines and telemedicine equipment without affiliation with the Arizona Telemedicine Program. Negotiations between medical providers can occur among collaborating sites for the provision of telemedical care without being connected to the Arizona Telemedicine network.

7. A frequently asked question from rural sites- how can we get teleradiology?

The fastest and most efficient means of transmitting radiology data is with digitalized equipment. This requires high-speed telecommunication lines and digitized radiology equipment systems. Start-up costs covering telecommunications lines and digital teleradiology equipment can be $ 70,000 to $ 100,000. Regular phone lines can also be used to transmit radiology data, but this process is extremely slow and would require an inordinate amount of staff time to transmit the data. Interested rural sites need to contact their telecommunications company to arrange for the installation of high-speed lines, a process that can take 6 months to 1 year, depending on location and the telecommunications company. Online searches can be conducted for information on potential teleradiology equipment vendors.

VII. EMS Resources

Federal Emergency Medical Services Resources

National Highway Traffic Safety Administration, Office of EMS

In February 2006, the National Highway Traffic Safety Administration announced the creation of the Office of Emergency Medical Services. The mission of the Office of EMS is to reduce death and disability by providing leadership and coordination to the EMS community in assessing, planning, developing and promoting comprehensive, evidence-based emergency medical services and 9-1-1 systems. This national EMS office, in close coordination with its Federal partners, will serve its constituents with a coordinated, consensus-based process to reinforce the vital role of the EMS community in shaping and realizing its own future. Numerous programs and products, including the *EMS Agenda for the Future*, the Next Generation 9-1-1 Initiative, the *National EMS Education Agenda for the Future: A Systems Approach*, the National Research Agenda, and the National EMS Information System (NEMSIS) demonstrate NHTSA's ongoing commitment to EMS. For more information, visit: http://www.nhtsa.gov/portal/site/nhtsa/menuitem.2a0771e91315babbbf30811060008a0c

National EMS Information System (NEMSIS)

The NEMSIS Project is an effort to create a National EMS Database. The database will contain data from local and state agencies from across the nation. This effort will define EMS and pre-hospital care in a way never before imagined, improving patient care and EMS curriculum and defining a standard on with to measure care. For more information, visit: http://www.nemsis.org.

Sources: National Highway Traffic Safety Administration. EMS Update. March 2006. Available: http://www.nhtsa.dot.gov/people/injury/ems/EMSUpdate/index.htm; National EMS Information System (NEMSIS). Available: http://www.nemsis.org.

There are two EMS systems in the state of Arizona. The Arizona Department of Health Services administers one system and the second system is administered by the Tribal Governments. This chapter describes both systems.

State Emergency Medical Services System

Pictured: Action Medical Service, Inc. in Winslow, Arizona.

The state agency for the administration, development, and coordination of a statewide system of emergency medical services (EMS) is the Arizona Department of Health Services. Within the Department of Health Services, the Director of the Division of Public Health Services leads the Bureau of Emergency Medical Services in the overall administration and coordination of emergency medical services. The mission of the Bureau of Emergency Medical Services is "To protect the health and safety of people requiring emergency medical services; promote improvements in Arizona's EMS and trauma system through research and education of the public and EMS providers; and prevent illness and injury to Arizona's residents and visitors."

The funding for the statewide EMS system comes from the EMS operating fund. However, certain EMS programs may receive funding through federal grants.

State Emergency Medical Services System (con't)

Source: Arizona Department of Health Services, Division of Public Health Services, Bureau of Emergency Medical Services. http://www.azdhs.gov/bems/.

EMT Certification

The Bureau of Emergency Medical Services, Arizona Department of Health Services, certifies Emergency Medical Technicians (all levels) in Arizona. To become certified as an EMT at any level in Arizona you must successfully complete a Department approved training course, submit required certification application and necessary forms, and successfully pass the National Registry written examination within three attempts with a score of at least 70% within one year of the official course ending date. In addition, Intermediate and Paramedic applicants must pass the National Registry practical examination.

Arizona does not have reciprocal agreements with any other state or jurisdiction for certification. However, applicants who hold current and valid EMT-Basic certification in another state or jurisdiction may become eligible for Arizona certification. Go to the Bureau's Web page at http://www.azdhs.gov/bems/faq.htm for additional assistance.

For further information on EMT certification issues, you may contact these offices for information:

PHOENIX
Certification Services
Bureau of EMS
150 N. 18th Ave., Suite 540
Phoenix, AZ 85007-3248
(602) 364-3186

TUCSON
Certification Services
Bureau of EMS
400 W. Congress, Suite 100
Tucson, AZ 85701-1353
(520) 628-6985

FLAGSTAFF
Certification Services
Bureau of EMS
1500 E. Cedar Ave., Suite 22
Flagstaff, AZ 86004-1642
(928) 774-2218

Statewide Toll Free: 1-800-200-8523

The Bureau of Emergency Medical Services Certification offices listed above are open Monday – Friday, 8:00 a.m. to 5:00 p.m. excluding state holidays. Any of our Customer Service Representatives can be contacted if you require assistance, as they are trained to answer your certification questions. It is recommended that if the regional Customer Service Representative is not available or out of the office, you may use the toll free number to contact the Phoenix office for assistance.

State Emergency Medical Services System (con't)

Source: Arizona Department of Health Services, Bureau of Emergency Medical Services. EMT Certification. Available http://www.azdhs.gov/bems/emtcert.htm

Certificate of Necessity (CON)

An application process must be completed before a ground ambulance service can operate in Arizona. The application is submitted to the Arizona Department of Health Services, Bureau of Emergency Medical Services. The Director grants a Certificate of Necessity (CON). The service area, level of service, hours of operation, effective date, response times, expiration date, type of service, legal name and address of the ambulance service, and any limiting or special provisions as prescribed by the Director will be included in the Certificate of Necessity.

To apply for a CON, visit the Certificate of Necessity program Web site at: http://www.azdhs.gov/bems/conpage.htm

Source: Arizona Department of Health Services, Bureau of Emergency Medical Services. Ground Ambulance Certificate of Necessity (CON) Program. Available: http://www.azdhs.gov/bems/ambulance.htm

Tribal Emergency Medical Services System

The funding for Tribal Emergency Medical Services programs comes from four sources:
1) IHS funds through PL 93-638 contracting or self-governance compacting;
2) Contributions from Tribal General Funds;
3) IHS-GSA Shared Cost Ambulance Program; and
4) Collections from Third Party Billings.

Pictured: Tony Huma, Director, Hopi EMS.

In Arizona, tribal EMS programs are not required to meet state standards for ambulance vehicles, the equipment within the ambulance, or the number of staff. However, tribal EMS programs can voluntarily comply with all of the state standards and ambulance service licensure requirements and many tribes use the state's requirements as a minimum standard. Tribes do have to follow state rules and regulations in order to get base hospitals established. The state health department does not inspect the ambulances operating on tribal lands, but they carry the same equipment as state regulated ambulances. As of July 1, 2005, there were 79 tribal EMS programs throughout the 48 contiguous United States, 10 of which operate in Arizona. The tribal EMS systems operating in Arizona include: Navajo Nation EMS, Ak-Chin Fire Department, Gila River EMS, Hopi EMS, Peach Springs Ambulance Service, Fort McDowell Fire Department, Salt River Fire Department, San Carlos EMS, White Mountain Apache Tribe EMS, and Pascua Pueblo Fire Department. On the Tohono O'odham Reservation, the Indian Health Service at Sells PHS Indian Hospital operates an EMS ambulance program and the Tohono O'odham Tribal Fire Department provides EMS First Responder services.

The structure of tribal EMS systems varies among tribes; however, most have the standard structure of a director or fire chief, a manager, and line personnel.

Source: U.S. Department of Health and Human Services, Public Health Service, Indian Health Services. Quantifying the Unmet Need in IHS/Tribal EMS. Available: http://www.heds.org/1999-2001%20Unmet%20Needs%20Report.pdf; The Mountain Plains Health Consortium. Tribal EMS/Ambulance Program Directory. Available: http://www.heds.org/ambpro10.html.

Rural EMS Agenda for the Future

In 2004, the National Rural Health Association published the *Rural/Frontier Agenda for the Future*. *The Rural/Frontier EMS Agenda for the Future* is built on the foundation of NHTSA's 1996 *EMS Agenda for the Future*. With one minor change, the *Rural/Frontier EMS Agenda for the Future* also proposes continued development of the following 14 EMS attributes:

- Integration of Health Services
- EMS Research
- Legislation and Regulation
- System Finance
- Human Resources
- Medical Oversight
- Education Systems
- Public Education
- Prevention
- Public Access
- Communication Systems
- Clinical Care and Transportation Decisions/Resources
- Information Systems
- Evaluation

The Rural/Frontier Agenda for the Future can be downloaded online from: http://www.nrharural.org/groups/sub/EMS.html.

In addition, the Arizona Rural Hospital Flexibility Program's EMS Working Group adopted the *Arizona Rural EMS Agenda for Future* on July 26, 2005. This document will continually be used and updated to help guide and report on rural EMS initiatives in Arizona. A copy of this document can be downloaded from: http://azflexprogram.publichealth.arizona.edu/initiatives_ems.html.

EMS Training for Critical Access Hospital Geographic Areas

EMS personnel training is available through the Arizona Rural Hospital Flexibility Program (Flex) for Critical Access Hospital geographic areas. For more information, visit the Flex Web site at: http://azflex-program.publichealth.arizona.edu.

Medicare Rural Ambulance Reimbursement

Small rural hospitals with less than 50 beds, located in certain ZIP codes, are eligible to receive the rural ambulance bonus. The rural ambulance bonus is the Medicare "Super Rural Bonus" of 22.6% for ambulance trips originating in low population density counties and census tracts. The ambulance reimbursement is effective as of July 1, 2004 and is available through 2009.

The ZIP codes in Arizona that are eligible to receive rural ambulance reimbursement from Medicare are listed in **Appendix G. Eligible Zip Codes for Special Medicare Reimbursements**.

Source: Rural Assistance Center. Information Guide: Emergency Medical Services. Available: http://www.raconline.org/info_guides/ems; CMS Legislative Summary. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. Available: http://www.cms.hhs.gov/mmu/hr1/PL108-173summary.asp.

EMS Resource Agencies

Arizona Department of Health Services
Division of Public Health Services
Bureau of Emergency Medical Services

The mission of the Bureau of Emergency Medical Services is to protect the health and safety of people requiring emergency medical services; promote improvements in Arizona's EMS and trauma system through research and education of the public and EMS providers; and provide courteous, professional and responsible service to the public and EMS providers.
150 N. 18th Avenue, Suite 540
Phoenix, AZ 85007
Phone: (602) 364-3150
EMT Questions: (602) 364-3186
Toll Free: (800) 200-8523
Fax: (602) 364-3568
Email: bemswebmaster@azdhs.gov
Web site: http://www.azdhs.gov/bems

Arizona Emergency Medical Systems, Inc. (AEMS)

Arizona Emergency Medical Systems, Inc. (AEMS), a 501(c)(3) non-profit, is a community-based, volunteer organization dedicated to improving emergency medical services (EMS) for the Central Region of Arizona.
P.O. Box 33116
Phoenix, AZ 85067-3116
Phone: (623) 847-4100
Fax: (623) 847-3773
Email: info@aems.org
Web site: http://www.aems.org/index.html

Arizona Rural Hospital Flexibility Program

The Arizona Rural Hospital Flexibility Program (Flex) offers training for EMS personnel in Critical Access Hospital geographic regions.
Mel and Enid Zuckerman Arizona College of Public Health
Rural Health Office
P.O. Box 245210
Tucson, Arizona 85724
Express Mail (FedEx, UPS, etc.):
1295 N. Martin Avenue, Bldg. 202A
Room # A 245
Tucson, Arizona 85719
Phone: (520) 626-6253
Fax: (520) 626-3101
Web site: http://azflexprogram.publichealth.arizona.edu

National Native American EMS Association

The National Native American EMS Association serves the nation's Native American EMS professionals.
P.O. Box 80
Maricopa, AZ 85239
Phone: (602) 361-2099
Fax: (520) 568-0023
E-mail: nnaemsaassist@earthlink.net
Web site: http://www.heds.org/nnaemsa.htm

Northern Arizona Emergency Medical Services (NAEMS)

The Regional Council for Northern Arizona is the Northern Arizona Emergency Medical Services (NAEMS).
P.O. Box 2127
Flagstaff, AZ 86003
Phone: (928) 284-2689
Fax: (928) 284-2640
E-mail: admin@naems.org
Web site: http://www.naems.org

Southeastern Arizona EMS Council (SAEMS)

The Southeastern Arizona EMS Council focuses it's attention upon the emergency medical services of the population in southeastern Arizona.
PMB 321 / 6890 East Sunrise
Tucson, AZ 85750
Phone: (520) 529-1450
Fax: (520) 529-2369
E-mail: tpayson@saems.net
Web site: http://www.saems.net

The National Association of EMS Educators

The mission of The National Association of EMS Educators is to promote EMS Education, develop and deliver educational resources, and advocate research and life long learning.
Foster Plaza 6, 681 Andersen Drive
Pittsburgh, PA 15220
Phone: (412) 920-4775
Fax: (412) 920-4780
E-mail: naemse@naemse.org
Web site: http://www.naemse.org

Western Arizona Council of EMS (WACEMS)

The Regional Council for western Arizona is the Western Arizona Council of EMS.
3463 West 13th Place
Yuma, AZ 85364
Phone: (928) 782-4554
Fax: (928) 782-5563
E-mail: rod.reed@wacems.org
Web site: http://www.wacems.org

VIII. Emergency Preparedness Resources

Federal Resources

U.S. Department of Homeland Security

The Department of Homeland Security (DHS) has three primary missions: Prevent terrorist attacks within the United States, reduce America's vulnerability to terrorism, and minimize the damage from potential attacks and natural disasters.

The U.S. Department of Homeland Security promotes preparedness through the Ready campaign. Ready.gov is a common sense framework designed to launch a process of learning about citizen preparedness. One of the primary mandates of the Department of Homeland Security is to educate the public, on a continuing basis, about how to be prepared in case of a national emergency -- including a possible terrorist attack. Information is provided on how to prepare a kit of emergency supplies, create emergency plans, and be informed on what might happen. For more information, visit: http://www.ready.gov or http://www.dhs.gov/dhspublic.

FEMA

On March 1, 2003, the Federal Emergency Management Agency (FEMA) became part of the U.S. Department of Homeland Security (DHS). FEMA's continuing mission within the new department is to lead the effort to prepare the nation for all hazards and effectively manage federal response and recovery efforts following any national incident. FEMA also initiates proactive mitigation activities, trains first responders, and manages the National Flood Insurance Program. For more information, visit FEMA's website at: http://www.fema.gov/index.shtm.

U.S. Department of Health and Human Services

On November 2, 2005, the U.S. Department of Health and Human Services (HHS) released the *HHS Pandemic Influenza Plan*. This plan is a blueprint for pandemic influenza preparation and response. It provides guidance to national, state, and local policy makers and health departments.

The HHS Plan includes an overview of the threat of pandemic influenza, a description of the relationship of this document to other Federal plans and an outline of key roles and responsibilities during a pandemic. In addition, it specifies needs and opportunities to build robust preparedness for and response to pandemic influenza.

The HHS Plan has three parts. Part 1, the HHS Strategic Plan, outlines federal plans and preparation for public health and medical support in the event of a pandemic. It identifies key roles of HHS and its agencies in a pandemic and provides planning assumptions for federal, state and local governments and public health operations plans. Part 2, Public Health Guidance for State and Local Partners, provides detailed guidance to state and local health departments in 11 key areas. Part 3, which is currently under development, will consist of HHS Agencies' Operational Plans. Each HHS component will prepare, maintain, update and exercise an operational plan that itemizes their specific roles and responsibilities in the event of a pandemic.

A copy of the *HHS Pandemic Influenza Plan* can be downloaded from the following Web site: http://www.hhs.gov/pandemicflu/plan.

Federal Resources (con't)

To view the U.S. Department of Health and Humans Services' list of Disaster and Emergencies resources, visit: http://www.hhs.gov/emergency.

PandemicFlu.gov

PandemicFlu.gov, managed by the U.S. Department of Health Services, is intended to provide comprehensive government-wide information on pandemic influenza and avian influenza. In the event of a pandemic, this will be the authoritative site for U.S. government information on the pandemic. For more information, visit: http://pandemicflu.gov.

The National Strategy for Pandemic Influenza

The *National Strategy for Pandemic Influenza*, announced by President Bush on November 1, 2005, guides our Nation's preparedness and response to an influenza pandemic, with the intent of (1) stopping, slowing or otherwise limiting the spread of a pandemic to the United States; (2) limiting the domestic spread of a pandemic, and mitigating disease, suffering and death; and (3) sustaining infrastructure and mitigating impact to the economy and the functioning of society.

On May 3, 2006, the Bush Administration announced the *Implementation Plan for the National Strategy for Pandemic Influenza*. The Plan translates the *National Strategy for Pandemic Influenza* into more than 300 actions for Federal departments and agencies and sets clear expectations for State and local governments and other non-Federal entities. It also provides guidance for all Federal departments and agencies on the development of their own plans.

Copies of the *National Strategy for Pandemic Influenza* and the *Implementation Plan for the National Strategy for Pandemic Influenza* can be downloaded from the following Web site: http://www.whitehouse.gov/infocus/pandemicflu.

The Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention's (CDC) *Public Health Emergency Response Guide for State, Local, and Tribal Public Health Directors* is intended to assist state, local, and tribal public health professionals in the initiation of response activities during the first 24 hours of an emergency or disaster. It should be used in conjunction with existing emergency operations plans, procedures, guidelines, resources, assets, and incident management systems. It is not a substitute for public health emergency preparedness and planning activities. The response to any emergency or disaster must be a coordinated community effort. This guide is can be downloaded from: http://www.bt.cdc.gov/planning/responseguide.asp.

The CDC also maintains a list of resources on preparedness for specific types of emergencies; personal preparedness; preparedness for businesses; preparedness for healthcare facilities; state and local preparedness; national preparedness; and legal preparedness. This list is available online at: http://www.bt.cdc.gov/planning.

In addition, the CDC and the American Red Cross joined together to answer common questions & provide guidance on disaster preparedness. This information is available online at: http://www.redcross.org/preparedness/cdc_english/CDC.asp.

Federal Resources (con't)

Sources: U.S. Department of Homeland Security. Available: http://www.dhs.gov/dhspublic; Federal Emergency Management Agency. About Us. Available: http://www.fema.gov/about/index.shtm; U.S. Department of Health and Human Services. HHS Pandemic Influenza Plan. Available: http://www.hhs.gov/pandemicflu/plan; Pandemicflu.gov. Available: http://pandemicflu.gov; The White House. National Strategy for Pandemic Influenza. Available: http://www.whitehouse.gov/infocus/pandemicflu; The Centers for Disease Control and Prevention. Emergency Preparedness and Response. Available: http://www.bt.cdc.gov.

State Resources

AZ 2-1-1

Arizona 2-1-1 Online is the official site for alerts and bulletins on emergencies and disasters in Arizona, including public health and safety advisories, homeland security alerts and disaster relief bulletins. Visit the AZ 2-1-1 online at: http://www.az211.gov.

Arizona Division of Emergency Management

The Arizona Division of Emergency Management (ADEM), part of the Arizona Department of Emergency and Military Affairs, is the lead state agency that provides direction and control of state emergency response operations during natural and technological disasters. For more information, visit: http://www.dem.state.az.us.

Arizona Office of Homeland Security

The Arizona Office of Homeland Security was created in March 2003 by Governor Janet Napolitano to coordinate homeland security efforts among state, federal, local, tribal and border community agencies and entities. Securing the homeland involves many elements including intelligence gathering, analysis and dissemination to detect and deter a terrorist event and emergency planning and preparedness to build capacity to respond to and recover from a large-scale Weapons of Mass Destruction (WMD) event. For more information, visit: http://www.homelandsecurity.az.gov.

Arizona Department of Health Services, Office of Public Health Emergency Preparedness and Response

The Office of Public Health Emergency Preparedness and Response, at the Arizona Department of Health Services, was created to detect and respond to natural or intentional disease events. Funded by the Centers for Disease Control and Prevention, it is the program mission to ensure that the public health system of Arizona is prepared for public health emergencies.

The Office of Public Health Emergency Preparedness and Response is comprised of five program areas:

1) Preparedness and Planning
The Emergency Preparedness and Planning Office works with numerous internal, governmental and community partners such as county health departments, hospitals, and the Arizona tribes to enable public health to respond to an emergency. Specifically, these agencies have plans to receive and dispense antibiotics and medical supplies to the community during a bioterrorism event or disease outbreak. Some of the areas of planning include: Overt and covert bioterrorism; emerging infectious disease outbreaks
SARS; pandemic influenza; flooding; and power outage.

State Resources (con't)

Since 2000, the Arizona Department of Health Services, Office of Public Health Emergency Preparedness and Response, has coordinated or participated in dozens of emergency exercises. These exercises are of three varieties:

- Table Top Exercises – designed to bring emergency response partners together in a room to work through scenarios and identify gaps in planning
- Functional Exercises – designed to field test systems and portions of plans to further determine gaps in response systems
- Full Scale Exercises – field exercises the fully testing plans, personnel, equipment, and systems

2) Electronic Disease Surveillance Program

The goal of the Electronic Disease Surveillance Program is to enhance public health's ability to detect and respond to suspect bioterrorism events, outbreaks of infectious diseases, and other public health emergencies.

The program objectives are to work with local health departments, other office areas, the Office of Infectious Disease Services, and the Office of Hospital and Community Emergency Preparedness and Response to:

- Develop and implement an electronic disease surveillance system
- Increase epidemiology capacity statewide
- Ensure the ability to receive, triage and appropriately respond to urgent public health reports 24 hours a day, seven days a week
- Plan and begin development of prediagnostic or syndromic surveillance systems for early detection of outbreaks and bioterrorism events
- Coordinate the planning and development of an Early Warning Infectious Disease Surveillance System in conjunction with the Office of Border Health, and our Mexican public health partners

3) Arizona Health Alert Network

The Arizona Health Alert Network was established as part of the efforts to enhance the public health response capabilities for the State of Arizona. This Program was created to address the communications needs associated with both public health response and daily operational sharing of information for planning and disease surveillance. AZHAN serves as a communications network between State and local public health agencies, healthcare providers, hospitals, and emergency management organizations. The Health Alert Network was designed around six major objectives:

- Redundant Communications
  Developing systems that add redundancy as well as daily use, without duplication of existing response systems.
- Integrated Development
  No stand alone systems. All development is integrated within public health and with other response partners.
- Secure Communications
  Recognizing the need for secure communications within the public health community.
- Outreach
  Recognizing and aiding communications with public audiences for response efforts and risk communication.
- Collaboration
  Facilitating statewide collaboration for public health preparedness in areas of planning and information sharing.

- Response Needs
  Prepare for varied levels of scaled public health response with the development of tracking systems and alternative communication mechanisms.

These six objectives have led to the development of many projects to address response communications and information sharing. Among them, include:

- Satellite Downlink Network - For the receipt of public health broadcasts for distance learning and response activities
- SIREN Development - Secure web-based collaboration and alerting network to support response and disease surveillance applications.
- Satellite-Based Response Equipment - Portable response equipment for remote clinic operations and remote emergency operations center.
- Satellite Internet Communications - Coordinated redundant satellite Internet connections for local public health and hospitals.
- Strategic National Stockpile Inventory Tracking - Response application to address the management of inventory and tracking of patients.
- Telehealth – Video Conferencing Network - Coordinate with local public health to utilize telehealth for statewide trainings, planning, and emergency communications.

4) Risk Communication and Public Information

Public information regarding the potential risks of biological agents and other public health emergencies is a critical component of public health emergency preparedness. Crisis and Emergency Risk Communication is defined by the Centers for Disease Control as "the attempt by science or public health professionals to provide information that assists people in making the best possible decisions during an emergency about their well-being." Often, this communication must be accomplished within nearly impossible time constraints, with incomplete information and under highly stressful and emotional conditions.

The Risk Communication and Public Information Program aims to enhance overall emergency preparedness efforts by accomplishing four main goals:

- To enhance the capacity for local and statewide public health communications.
- To provide needed health/risk information to the public and key partners during a bioterrorism event or public health emergency.
- To establish critical baseline information about the current communication needs and barriers within individual communities.
- To identify effective channels of communication for reaching the general public and special needs populations during any public health emergency.

5) Education and Preparedness Training

The goal of this program is to ensure the delivery of appropriate education and training to public health and healthcare professionals in preparation for and response to bioterrorism and other public health threats and emergencies either directly or through the use of existing curricula.

Three major activities are the focus of this program:

- Statewide Coordination - Statewide coordination and collaboration on bioterrorism and preparedness activities including developing and maintaining education and training materials.
- Public Health Training - Education and training of public health professionals at both the state

and local level. This includes providing technical expertise and an emphasis on increasing epide miology skills through a staff member dedicated to epidemiology training.

- Health Care Training - Education and training of key healthcare professionals. The two infectious disease physicians and nurse with the program provide education and training to the medical community through direct face-to-face presentations, developing resources, working with academic medical institutions to integrate information into existing curricula and providing medical expertise.

The core curricula topic areas provided or facilitated by this program include:

- Top bioterrorism agents and emerging infectious diseases
- Public Health Incident Management System
- Smallpox preparedness, response and mass vaccination clinics
- Medical experts for rapid response teams
- Epidemiology and surveillance including forensic epidemiology
- Risk communication

For more information, visit: http://www.azdhs.gov/phs/edc/edrp.

The Arizona Influenza Pandemic Response Plan

On February 6, 2006, the State of Arizona released an updated Influenza Pandemic Response Plan. This Plan was created to promote an effective response throughout the pandemic. The plan was first crafted in 2000, through a coordinated effort of the Arizona Department of Health Services (ADHS), Arizona Division of Emergency Management (ADEM), local health departments and other partners and stakeholders. It is also an annex to the Arizona State Emergency Response and Recovery Plan (SERRP). To download a copy of the Influenza Pandemic Response Plan, please visit: http://www.azdhs.gov/pandemicflu/pandemic_flu_plan.htm.

Arizona Center for Public Health Preparedness

The Arizona Center for Public Health Preparedness (AzCPHP) was established in August 2005 as the newest academic center of The University of Arizona Mel and Enid Zuckerman College of Public Health.

AzCPHP is part of a national network of training centers designed to strengthen the public health workforce readiness to respond to terrorism and other public health threats. Funded by the Centers for Disease Control and Prevention, the AzCPHP aims to improve the capacity of the public health workforce to respond to an all-hazard type of public health emergency in Arizona and the Southwest by providing comprehensive competency-based education and training in emergency preparedness.

Mission

The mission of Arizona Center for Public Health Preparedness (AzCPHP) is to fortify the public health infrastructure by providing training opportunities to augment emergency preparedness, response, and disaster recovery.

The fundamental components of the AzCPHP program are to:

- Assess the competencies of the public health workforce

State Resources (con't)

- Communicate and collaborate with our partners
- Strategically plan to provide comprehensive all-hazards training
- Evaluate preparedness capabilities

For more information, visit AzCPHP's Web site at: http://azcphp.publichealth.arizona.edu/.

Critical Response and Emergency Systems Training

The Arizona Emergency Medicine Research Center at the University of Arizona, the UNM Center for Disaster Medicine within the Department of Emergency Medicine at the University of New Mexico, and the Border Epidemiology and Environmental Health Center at New Mexico State University have created the *Critical Response and Emergency Systems Training* (CREST) program through a cooperative agreement with the U.S. Health Resources and Services Administration. The goals of CREST are to equip the healthcare professional workforce in the States of Arizona and New Mexico to:

- Recognize indications of a terrorist event
- Identify acute care needs of patients in a safe & appropriate manner
- Participate in a coordinated multidisciplinary response to manage public health emergencies
- Assess & effectively alert the public health system of such an event

CREST will deliver courses and activities that have been selected to incorporate the goals. The courses are presented by qualified health professionals with special training and knowledge regarding emergency preparedness and response. Courses can vary in length and can be adapted to meetings, conferences and other venues. Certain courses are also available on CDs and through telemedicine networks.

CREST Training Opportunities

- Answering the Call : introduction to emergency response and preparedness needs of Arizona
- National Disaster Life Support : basic & advanced training in the recognition and management of all hazards
- Advanced Hazmat Life Support : training to rapidly assess and manage patients with chemical exposures
- Conference: 2-day annual conference on topics related to domestic preparedness
- Speakers Bureau: short lectures on various emergency preparedness and response topics

For more information, visit the CREST Web site at: http://www.crest.arizona.edu.

Sources: Arizona Division of Emergency Management. Director's Office. Available: http://www.dem.state.az.us; Arizona Office of Homeland Security. Available: http://www.homelandsecurity.az.gov; Arizona Department of Health Services, Bureau of Emergency Preparedness and Response. About the Office. Available: http://www.azdhs.gov/phs/edc/edrp/es/abouttheoffice.htm; The Arizona Influenza Pandemic Response Plan. Available: http://www.azdhs.gov/pandemicflu/pandemic_flu_plan.htm; Arizona Center for Public Health Preparedness. Available: http://azcphp.publichealth.arizona.edu; Critical Response and Emergency Systems Training. Available: http://www.crest.arizona.edu.

IX. Rural Health Funding Resources

In order to obtain any Federal Grant or Contract, a DUNS Number is required. The following section explains how to obtain a DUNS number.

Request a DUNS Number

In order to register with the Central Contractor Registry, a requirement for registering with Grants.gov, your organization will need a Data Universal Number System (DUNS) Number. A DUNS number is a unique nine-character identification number provided by the commercial company Dun & Bradstreet (D&B).

Most large organizations, independent libraries, colleges and research universities already have DUNS numbers. Prior to requesting a DUNS number, you should investigate if your organization already has a DUNS number. You should ask your organization's chief financial officer, grant administrator, or authorizing official to provide your organization's DUNS number. Alternatively, you can determine if your organization has a DUNS number by calling D&B at 1-866-705-5711.

If your organization does not have a DUNS number, you can apply by web registration or by phone. To apply via web registration, visit the following web site: https://eupdate.dnb.com/requestoptions/government/ccrreg/. If you apply through the web registration, D&B will contact you via e-mail within 48 hours with your DUNS number. To apply by phone, call (866) 705-5711. The process to request a DUNS Number by telephone takes between five and ten minutes. There is no charge for applicants and recipients of federal grants.

You will need to provide the following data elements when applying for a DUNS number:

- Legal Name
- Tradestyle, Doing Business As (DBA), or other name by which your organization is commonly recognized
- Physical Address, City, State and Zip Code
- Mailing Address (if separate)
- Telephone Number
- Contact Name
- SIC Code (Line of Business)
- Number of Employees at your location
- Headquarters name and address (if there is a reporting relationship to a parent corporate entity)

As a result of obtaining a DUNS number, you have the option to be included on D&B's marketing list that is sold to other companies. If you do not wish to have your name/organization included on this list, request to be de-listed from D&B's marketing file.

For more information, please visit the following Web sites: http://www.grants.gov/RequestaDUNS or https://eupdate.dnb.com/requestoptions/government/ccrreg/

HHS/HRSA Office of Rural Health Policy Funding Opportunities

These grants are aimed at expanding access to, coordinating, restraining cost of, and improving the quality of essential health care in rural areas. All counties that are not part of a Metropolitan Area are eligible for the Rural Health Grants. In Metropolitan counties, Rural-Urban Commuting Areas (RUCAs) are used to determine eligibility. For more information regarding these grants or to determine geographic eligibility for these grants, please visit: http://ruralhealth.hrsa.gov/funding.

- Rural Health Care Services Outreach Grant Program
  The emphasis of this grant program is on service delivery through creative strategies requiring the grantee to form a network with at least two additional partners.
  http://ruralhealth.hrsa.gov/funding/outreach.htm

- Rural Health Network Development Planning Grant Program
  This relatively new grant program provides one-year of funding to rural communities needing assistance in the development of an integrated healthcare network. The planning grants are to be used to develop a formal network with the purpose of improving the coordination of health services in rural communities and strengthening the rural health care system as a whole.
  http://ruralhealth.hrsa.gov/funding/networkplanning.htm

- Rural Health Network Development Grant Program
  These grants are designed to further ongoing collaborative relationships among health care organizations by funding rural health networks that focus on integrating clinical, information, administrative, and financial systems across members.
  http://ruralhealth.hrsa.gov/funding/network.htm

- Rural Access to Emergency Devices (RAED) Grant Program
  The Rural Access to Emergency Devices (RAED) Grant Program provides funding to rural communities to purchase automated external defibrillators (AEDs) and provide training in their use and maintenance.
  http://ruralhealth.hrsa.gov/funding/aed.htm

- Small Rural Hospital Improvement Grant Program (SHIP)
  The Office of Rural Health Policy's Small Rural Hospital Improvement Grant Program provides funding to small rural hospitals under 50 beds to help them pay for costs related to the implementation of PPS, comply with provisions of HIPAA, and/or reduce medical errors and support quality improvement. In Arizona, this grant is administered by the Rural Health Office.
  http://ruralhealth.hrsa.gov/ship.htm

- Small Health Care Provider Quality Improvement Grant
  This grant will assist rural providers with the implementation of quality improvement strategies, while improving patient care and chronic disease outcomes. This program is available to support rural public, rural non-profit, or other health care providers, such as critical access hospital or rural health clinic. Improving the quality of chronic disease management in ambulatory care settings can improve health indicators and decrease emergency room visits and admissions to hospitals. The Small Health Care Provider Quality Improvement Grant will focus on quality improvement for chronic diseases, i.e., diabetes mellitus and cardiovascular disease.
  https://grants.hrsa.gov/

HHS/HRSA Office of Rural Health Policy Funding Opportunities (con't)

- Frontier Extended Stay Clinic (FESC) Cooperative Agreement Program
  The purpose of the Frontier Extended Stay Clinic (FESC) Cooperative Agreement Program is to examine the effectiveness and appropriateness of a new type of provider, the FESC, in providing health care services in certain remote locations. http://ruralhealth.hrsa.gov/funding/fesc.htm

Other Funding Opportunities

- Arizona Commission of Indian Affairs- This regularly updated resource lists possibilities for grants, scholarships (including tribal scholarships), and fellowships.
  http://www.indianaffairs.state.az.us/careered/grants.html

- Distance Learning and Telemedicine Grant Program
  Distance learning and telemedicine grants are specifically designed to provide access to education, training and health care resources for people in rural America. The Distance Learning and Telemedicine (DLT) Program, administered under the USDA Rural Development's Telecommunications Program, provides financial assistance to encourage and improve telemedicine services and distance learning services in rural areas through the use of telecommunications, computer networks, and related advanced technologies by students, teachers, medical professionals, and rural residents. The grants are awarded through a competitive process.
  http://www.usda.gov/rus/telecom/dlt/dlt.htm

- HeartRescue Grant Program
  Through HeartRescue grants, the Medtronic Foundation partners with communities and organizations to initiate or enhance early defibrillation programs to save lives that would otherwise be lost to Sudden Cardiac Arrest (SCA). http://www.medtronic.com/foundation/programs_hr.html

- Local Initiative Funding Partners Program
  Local Initiative Funding Partners is a partnership program between The Robert Wood Johnson Foundation and local grantmakers that supports innovative, community-based projects to improve health and health care for vulnerable populations. Local Initiative Funding Partners provides grants of $100,000 to $500,000 per project, which must be matched dollar for dollar by local grantmakers such as community foundations, family foundations, corporate grantmakers, and others.
  http://www.lifp.org/html/apply/programdetails.html

- Multiplan's Rural Health Outreach Grant Program
  This program seeks to help rural hospitals develop creative community outreach programs that encourage new services or reach new populations. Each recipient of a rural grant will receive $3,000 for the purpose of implementing an outreach program in their community. http://www.multiplan.com/index.cfm?id=provider/provider_ruralhealth

- Office of Advancement of Telehealth's (OAT) Telehealth Network Grant Program
  OAT's Telehealth Network Grant Program is a competitive, merit-based grant program. The program helps increase access to quality health care services for the underserved by promoting the use of advanced telecommunications and information technologies by rural health providers across America.
  http://telehealth.hrsa.gov/grants.htm

Other Funding Opportunities (con't)

- Rural Cooperative Development Grant Program
  Rural Cooperative Development grants are made for establishing and operating centers for cooperative development for the primary purpose of improving the economic condition of rural areas through the development of new cooperatives and improving operations of existing cooperatives.
  http://www.rurdev.usda.gov/rbs/coops/rcdg/rcdg.htm

- Rural Development Community Connect Grant Program
  The Community-Oriented Connectivity Broadband Grant Program is designed to provide financial assistance in the form of grants to eligible applicants that will provide currently un-served areas, on a "community-oriented connectivity" basis, with broadband transmission service that fosters economic growth and delivers enhanced education, health care, and public safety services.
  http://www.usda.gov/rus/telecom/commconnect.htm

- Rural Emergency Responders Initiative
  The Rural Development, through its community facilities program, provides funding for the Rural Emergency Responders Initiative to specifically strengthen the ability of rural communities to respond to local emergencies. The community facilities program funds are used to support rural emergency responder efforts by financing needed equipment and services. These funds are available to public bodies, non-profit organizations, and recognized Indian tribes.
  http://www.rurdev.usda.gov/rhs/cf/Emerg_Responder/rural_emergency_responders_initi.htm

- Rural Fire Assistance (RFA)
  The Rural Fire Assistance Program is designed to increase firefighter safety and enhance the fire protection capabilities of rural fire departments by assisting those departments in meeting or exceeding accepted standards of wildfire qualifications, training and performance. Emphasis is placed on departments that protect rural communities of less than 10,000 and play a substantial role in the protection of federal lands managed by the Department of the Interior (DOI). Funding assistance is limited to advanced/basic wildland fire training and wildland personal protective equipment this year.
  http://www.azstatefire.org

- Rural Mental Health and Drug Abuse Research
  The National Institute of Mental Health (NIMH) and the National Institute on Drug Abuse (NIDA) invite grant applications for research that will ultimately lead to a reduction in the burden of mental illness and drug abuse in rural and frontier populations. The purpose of this program announcement is to stimulate research on mental health and/or drug abuse problems in rural and frontier communities that will: (1) enhance understanding of structural (including community risk and resilience factors), cultural, and individual factors that may limit the provision and utilization of prevention and treatment services in these communities; and (2) generate knowledge to improve the organization, financing, delivery, effectiveness, quality, and outcomes of mental health and drug abuse services for diverse populations in rural and frontier populations. Applications may focus exclusively on mental disorders, drug abuse disorders, or on the co-occurrence of these and related disorders. Comparison of rural and urban populations and/or comparisons between rural populations is encouraged whenever possible, but this is not a requirement.
  http://grants.nih.gov/grants/guide/pa-files/PA-04-061.html

Other Funding Opportunities (con't)

- Substance Abuse and Mental Health Services Administration (SAMHSA) Grants

(1) Knowledge Dissemination Conference Grants Program Announcement (Short Title: SAMHSA Conference Grants)

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), and Center for Substance Abuse Treatment (CSAT) are accepting applications for SAMHSA Knowledge Dissemination Conference Grants (also referred to as SAMHSA Conference Grants). The purpose of the Conference Grant program is to disseminate knowledge about practices within the mental health services and substance abuse prevention and treatment fields and to integrate that knowledge into real-world practice as effectively and efficiently as possible.
http://www.samhsa.gov/grants/2006/RFA/PA_06_001_Conference.aspx

(2) Safe Schools/Healthy Students (SS/HS) Initiative

Since 1999, the U.S. Departments of Education, Health and Human Services, and Justice have collaborated on the Safe Schools/Healthy Students (SS/HS) Initiative. The SS/HS Initiative is a discretionary grant program that provides students, schools, and communities with federal funding to implement an enhanced, coordinated, comprehensive plan of activities, programs, and services that focus on promoting healthy childhood development and preventing violence and alcohol and other drug abuse. Eligible local educational agencies (LEAs) or a consortium of LEAs, in partnership with their community's local public mental health authority, local law enforcement agency, and local juvenile justice entity, are able to submit a single application for federal funds to support a variety of activities, curriculums, programs, and services.
http://www.sshs.samhsa.gov/apply/default.aspx

(3) Strengthening Treatment Access and Retention – State Implementation Cooperative Agreements (STAR-SI)

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) announces the availability of FY 2006 funds for the Strengthening Treatment Access and Retention – State Implementation (STAR-SI) program. STAR-SI is an infrastructure cooperative agreement program that promotes State-level implementation of process improvement methods to improve access to and retention in outpatient treatment. Outpatient treatment facilities account for 80 percent of all substance abuse treatment programs in the United States and serve 89 percent of the 1.1 million clients in care on any day (National Survey of Substance Abuse Treatment Services, SAMHSA, 2002). Outpatient treatment providers face tremendous challenges in their efforts to serve populations in need of treatment. States are in a unique position to effect system change by working together with outpatient substance abuse treatment providers to remove systems barriers, streamline administrative procedures, provide incentives and assist provider networks in their efforts to improve access and retention performance outcomes.
http://www.samhsa.gov/Grants06/RFA/TI_06_006_STAR_SI.aspx

(4) Family Centered Substance Abuse Treatment Grants for Adolescents and their Families

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) announces the availability of FY 2006 funds for Family Centered Substance Abuse Treatment Grants for Adolescents and their Families. Grants under this program are authorized under Section 509 of the Public Health Service Act, as amended. The program addresses the Healthy People 2010 focus area 26-Substance Abuse.
http://www.samhsa.gov/Grants06/RFA/TI_06_007_adolescent.aspx

Other Funding Opportunities (con't)

- The Agency for Healthcare Research and Quality (AHRQ) Grants

(1) Small Grant Program for Conference Support

The Agency for Healthcare Research and Quality (AHRQ), announces its continued interest in supporting conferences through its Small Grant Program for Conference Support. AHRQ seeks to support conferences that help to further its mission to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The types of conferences eligible for support include: 1) Research development - conferences where issues or challenges in the delivery of health services are defined and a research agenda or strategy for studying them is developed; 2) Design and methodology - conferences where methodological and technical issues of major importance in the field of health services research are addressed or new designs and methodologies are developed; 3) Dissemination conferences - where research findings are summarized and communicated broadly to organizations and individuals that have the capability to use the information to improve the outcomes, quality, access to, and cost and utilization of health care services; and/or, 4) Research Training, Infrastructure and Career Development-conferences where research faculty and students are brought together with users of research to develop, share and disseminate research products, experiences, curricula, syllabi, approaches or core competencies required to train individuals from multi- and interdisciplinary backgrounds or prepare developing or emerging research institutions to conduct and translate research related to fostering improvements in health care delivery in the US.

http://grants.nih.gov/grants/guide/pa-files/PA-06-074.html

(2) Large Grant Program for Conference Support

The Agency for Healthcare Research and Quality (AHRQ) announces its continued interest in supporting conferences through its Large Grant Program for Conference Support. AHRQ Large conference grants are those with direct costs of more than $50,000 per year or with a project period of longer than 1 year, but not exceeding 5 years. This Program is intended to complement and promote AHRQ's core research by providing a mechanism for Agency stakeholders and others to (1) develop health services research agendas and identify strategies and mechanisms for studying them; (2) discuss and develop consensus around health services research methodological and technical issues; (3) disseminate health services research information and facilitate adoption of research findings from AHRQ-sponsored research and research training grants in the formulation or evaluation of health policy, management of health care programs, and use or purchase of health services; and (4) develop partnerships with stakeholder organizations and build their capacity to participate in research activities and use the results of health services research.

http://grants.nih.gov/grants/guide/pa-files/PA-03-117.html

(3) Small Research Grant Program

AHRQ announces a program of small research grants designed to provide support for new investigators or researchers new to health care services issues and encourage preliminary, exploratory, or innovative research in new or previously unexamined areas.

http://grants.nih.gov/grants/guide/pa-files/PAR-01-040.html

(4) AHRQ Health Services Research

The mission of the Agency for Healthcare Research and Quality (AHRQ), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of disease and other health conditions. AHRQ achieves this mission through health services research designed to (1) improve clinical practice, (2) improve the health care system's ability to provide access to and deliver high

quality, high-value health care, and (3) provide policymakers with the ability to assess the impact of system changes on outcomes, quality, access to, cost, and use of health care services. AHRQ's research agenda is designed to be responsive to the needs of consumers, patients, clinicians and other providers, institutions, plans, purchasers, and public policymakers for the evidence-based information they need to improve quality and outcomes, control costs, and assure access to needed services.

- The Healthy Communities Access Program (HCAP)
  The purpose of HCAP is to assist communities and consortia of health care providers and others they represent to develop or strengthen integrated community health care delivery systems that coordinate health care services for individuals who are uninsured or underinsured and to develop or strengthen activities related to providing coordinated care for uninsured or underinsured individuals with chronic conditions.
  http://bphc.hrsa.gov/cap

- The Rural Community Development Initiative
  The Rural Community Development Initiative (RCDI) program provides grants to qualified intermediary organizations that will provide financial and technical assistance to recipients to develop their capacity and ability to undertake projects related to housing, community facilities, or community and economic development.
  http://www.rurdev.usda.gov/rhs/rcdi/index.htm

- The Universal Service Administrative Company (USAC), Rural Health Care Division
  The Rural Health Care Division of USAC is responsible for ensuring that health care providers in rural areas obtain the benefits of the Internet and current telecommunications technology as provided for by the United States Congress and the Federal Communications Commission through universal service support. The FCC established a program that will fund up to $400 million annually so that rural health care providers pay no more than their urban counterparts for the same or similar telecommunication services.
  http://www.rhc.universalservice.org/overview/rhcd.asp

- Tribe Management Grant Program
  The purpose of the Tribal Management Grant (TMG) Program is to assist federally-recognized Tribes and tribally-sanctioned Tribal organizations in assuming all or part of existing Indian Health Service programs, services, functions, and activities (PSFA) through a Title I contract and to assist established Title I contractors and Title V compactors to further develop and improve their management capability.
  http://www.ihs.gov/NonMedicalPrograms/tmg/index.asp

- Volunteer Fire Assistance Grant Program
  The Arizona State Land Department, Forestry Division, with assistance from the USDA, Forest Service, administers the Volunteer Fire Assistance Grant Program. This Program is authorized by the Cooperative Forestry Assistance Act of 1990, (Farm Bill) and provides financial assistance to train, organize, and equip fire departments in rural areas and rural communities to prevent and suppress fires. A rural community is defined as having 10,000 or less population.
  http://www.azstatefire.org

Other Funding Opportunities (con't)

- W.K. Kellogg Foundation: Rural People, Rural Policy
  Rural People, Rural Policy (RPRP) is a multi-year national initiative that energizes and equips rural organizations and networks to shape policy that will improve the lives of rural people and the vitality of rural communities. The Rural People, Rural Policy Initiative is based on the premise that rural America has abundant assets and that the brightest potential for rural America will come when rural people are stronger, more organized policy actors. The goal, therefore, of the Rural People, Rural Policy Initiative is to build and strengthen skilled networks and rural organizations to be articulate and act in the policy arena. This Initiative will make rural communities' problems and potential visible enough to gain national attention, and to change policy and practice in rural America for the better.
  http://www.wkkf.org/default.aspx?tabid=75&CID=274&NID=61&LanguageID=0

- For more grant opportunities, please visit Grants.gov at the following URL:
  http://www.grants.gov/

- For more information regarding funding opportunities, visit the Rural Assistance Center's Grant and Funding Resources section (http://www.raconline.org/info_guides/funding/) and the Rural Information Center's Funding Resources section (http://www.nal.usda.gov/ric/ruralres/funding.htm).

Opportunities for Individuals

- Indian Health Service Scholarships
  The Indian Health Service (IHS) is committed to encouraging American Indians and Alaska Natives to enter the health professions and to assuring the availability of Indian health professionals to serve Indians. Approximately 159 awards will be made under the Health Professions Preparatory and Pregraduate Scholarship Programs for Indians. The awards are for 10 months in duration and the average award to a full-time student is approximately $23,619. An estimated 273 awards will be made under the Indian Health Scholarship (Professions) Program. The awards are for 12 months in duration and the average award to a full-time student is for approximately $35,242. In FY 2006, an estimated $4,640,000 is available for continuation awards, and an estimated $6,960,000 is available for new awards. For more information, contact your local Indian Health Service office. For Phoenix Area IHS, contact: Al Peyketewa at (602) 364-5252. For Tucson Area IHS, contact: Reanetta Siquieros at (520) 295-2440. For Navajo Area IHS, contact Roselinda Allison at (928) 871-1358.

- Executive Nurse Fellowships
  The Robert Wood Johnson Foundation's Executive Nurse Fellows Program is an advanced leadership program for nurses in senior executive roles in health services, public health and nursing education and who aspire to help shape the U.S. health care system of the future. The three-year fellowships allow participating nurses to remain in their current positions while they gain experiences, insights, competencies and skills necessary for executive leadership positions in a health care system undergoing unprecedented change. The program is designed to give nursing and nurses a more influential role across many sectors of the economy.
  www.rwjf.org/cfp/executivenursefellows

Opportunities for Individuals (con't)

- Native American Congressional Internships
  The Native American Congressional Internship Program provides Native Americans and Alaska Natives with an insider's view of the federal government. The ten-week internship in Washington, D.C. places students in Senate and House offices, committees, Cabinet departments and the White House, where they are able to observe government decision-making processes first-hand. In 2006, the Morris K. Udall Foundation expects to award 12 Internships on the basis of merit to Native Americans and Alaska Natives who: are college juniors or seniors, recent graduates from tribal or four-year colleges, or graduate or law students; have demonstrated an interest in fields related to tribal public policy, such as tribal governance, tribal law, Native American education, Native American health, Native American justice, natural resource protection, and Native American economic development.
  http://www.udall.gov/internship/

X. Workforce Resources

The National Rural Recruitment and Retention Network (3R Net)

The National Rural Recruitment and Retention Network (3R Net) is made up of state organizations such as State Offices of Rural Health, Area Health Education Centers, Cooperative Agreement Agencies, and State Primary Care Associations. These not-for-profit organizations help health professionals locate practice sites in rural areas throughout the country.

Rural practice sites can post job openings on 3R Net to be viewed by health care providers seeking jobs in rural areas. Providers seeking positions can also post their availability. While provider postings largely represent physicians, the program is beginning to include nurses and dentists.

3R Net can be accessed at: http://www.3rnet.org.

Pictured: A young Augusto Ortiz, MD, former Medical Director of the Rural Health Office, tends to a young patient (circa 1985).

The Rural Health Office is the contact in Arizona for 3R Net. Any rural health facility—hospital, clinic, health center, IHS facility, or private practice—can post job openings in primary care to the Rural Recruitment and Retention (3RNet) Web site. The postings can be viewed by hundreds of health care providers seeking jobs. In 2005, over 700 health care providers interested in working in Arizona registered at the site.

How to post a position opening to the Web site:

1. Facilities that have already registered should log in under "Health Care Facilities" at the 3RNet Web site (http://www.3rnet.org).

2. Facilities that have not already registered should register at http://www.3rnet.org/facility/register.asp

3. Once you have logged into the site, click on "Edit your Contact/Login Information" and be sure everything is correct. This is especially important for previously registered users who have not visited the site in some time.

4. To post an opening, click on "Add Opportunity" and fill in all the required fields. Be as specific as possible with the information you provide.

5. After submitting the position description, click on "Facilities Home" and log out.

6. The posting will automatically be sent to the Recruitment Coordinator for approval and posting to the web site.

If you have any questions, please contact: Jennifer Peters at (520) 626-2254 or petersjs@email.arizona.edu

Arizona State 30 J-1 Visa Waiver Program

It is a requirement of the J-1 visa that physicians return to their home country for two years after their graduate medical studies have been completed. The Arizona Department of Health Services can recommend that a physician be excused from this requirement through a J-1 Visa Waiver. The Bureau of Citizenship and Immigration Services (BCIS) of the U.S. Department of Homeland Security is the federal agency that actually grants the J-1 visa waivers. A maximum of 30 J-1 visa waivers are allowed annually per state.

The Arizona Department of Health Services' J-1 Visa Waiver Program supports waivers for Primary Care Physicians (family or general practice, general internal medicine, OB/GYN, and pediatrics) in federally designated Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), or Health Professional Shortage Areas (HPSAs) throughout Arizona. In addition, waivers are supported for psychiatrists in mental health HPSAs. The program provides waivers for specialty physicians when there is a valid need for the specialty.

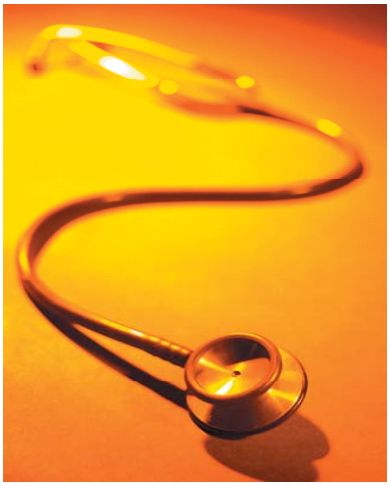


Photo courtesy of Microsoft® Office Online.

For eligibility requirements and procedure steps visit the following Web site: http://www.azdhs.gov/hsd/visa_waiver.htm.

In addition to the Arizona State 30 program, the U.S. Department of Health and Human Services can also recommend J-1 Visa Waivers. The Department of Health and Human Services can act as an Interested Government Agency (IGA) and request a J-1 Visa Waiver on the applicant's behalf. For more information or to download an application, visit http://www.globalhealth.gov/exchangevisitor.shtml.

Source: Arizona Department of Health Services. J-1 Visa Waiver Program. Available: http://www.azdhs.gov/hsd/visa_waiver.htm.

H-1B Visas

U.S. employers are allowed to temporarily hire foreign workers on a nonimmigrant basis in a specialty occupation through the H-1B program. The foreign workers may work for employers in either rural or urban areas. Medicine and health care is one of the specialty fields applicable.

H-1B visas are valid, as specified in the Labor Condition Application (LCA), for up to three years. A foreign worker, however, may be in H-1B status for a continuous period of up to six years. After the H1-B expires, the foreign worker must remain outside of the U.S. for one year before they can be approved for another H-1B petition. For qualifying criteria, instructions, and forms visit the U.S. Department of Labor's Employment and Training, H-1B Specialty (Professional) Web site at: http://workforcesecurity.doleta.gov/foreign/h-1b.asp#qc.

Source: U.S. Department of Labor Employment & Training Administration. H-1B Specialty (Professional) Workers. Available: http://workforcesecurity.doleta.gov/foreign/h-1b.asp.

Arizona Loan Repayment Program

In return for primary care service in Health Professional Shortage Areas (HPSAs), the Arizona Loan Repayment Program will repay qualifying educational loans. This program is meant to encourage primary care providers and dentists to provide care in underserved areas of Arizona.

Physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants licensed and/or certified in Arizona are eligible. The required specialties include: General Practice, Family Medicine, Dentistry, OB/GYN, Pediatrics, or Internal Medicine.

Applicants are required to: be U.S. citizens; have an offer to work at an eligible service site; be willing to contract with the State of Arizona to provide care at the approved site for at least two years; have been appropriately licensed and/or certified; maintain no other unmet obligations.

Eligible practice sites are required to be non-profit organizations, accept Medicare and AHCCCS assignments, be located in a HPSA, and have a sliding-discount-to-fee-scale. If a site wishes to be put on the list of eligible practice sites, and they meet the above mentioned criteria, contact Tanja James, Workforce Programs Specialist, Arizona Department of Health Services, at: (602) 542-1208 or jamest@azdhs.gov.

Award amounts vary depending on the provider type and priority ranking of the practice site. Priority ranking is based upon such variables as need and geographic location, etc. Award amounts are in addition to the compensation package providers receive from the practice site.

For more information and application forms visit:
http://www.azdhs.gov/hsd/az_loan_repayment.htm.

Source: Arizona Department of Health Services. AZ Loan Repayment Program. Available: http://www.azdhs.gov/hsd/az_loan_repayment.htm.

National Health Service Corps

The National Health Service Corps (NHSC) recruits primary care physicians, nurse practitioners, physician assistants, certified nurse-midwives, dentists, dental hygienists, and mental health professionals to provide care in federally designated Health Professional Shortage Areas (HPSAs) in exchange for loan repayment assistance or scholarships.

The National Health Service Corps assists underserved communities recruit and retain health care providers. The application to receive recruitment and retention assistance from the NHSC is available online at: http://nhsc.bhpr.hrsa.gov/applications/rraa.asp.

According to the NHSC's Recruitment and Retention Assistance Web site (http://nhsc.bhpr.hrsa.gov/applications/rraa.asp), the NHSC requires that a number of eligibility criteria be met in order for a site to receive assistance. These criteria include:

- Be located in a federally designated HPSA.
- Documentation of sound fiscal management.
- Use a sliding-fee schedule or documented methods to reduce fees that ensure no financial barriers to care exist, accept assignment of Medicare, and enter into an agreement with the State agency that administers Medicaid.

National Health Service Corps (con't)

- Proof of the capacity to maintain a competitive salary, benefits, and malpractice coverage package.

NHSC sites must provide requested health care services regardless of the individual's ability or method of payment. NHSC sites must not discriminate in the provision of services to an individual because of (1) the individual's ability to pay for the services; or (2) because payment for the services would be made under the Medicare, Medicaid, or State Children's Health Insurance Programs.

Photo courtesy of Microsoft® Office Online

To meet these requirements entities must:

- Provide health care services at no charge, or at a nominal charge, to patients whose incomes are at or below 200% of the federal poverty guidelines, which are revised annually in March. NHSC sites utilize different practices to ensure that no barriers to care exist, including establishing a schedule of discounts based on patients' ability to pay.
- Accept assignments under the Medicare program.
- Enter into an appropriate agreement with the State agency administering the Medicaid program.
- Enter into an appropriate agreement with the State agency administering the State Children's Health Insurance Program.
- Prominently advertise a statement that explicitly communicates the fact that no one will be denied access to services due to inability to pay. In accordance with the breadth and scope of the NHSC service area, when applicable, this signage should be translated into the appropriate language/dialect.

The entity shall take reasonable and appropriate steps to collect all payments due for health care services provided by the entity, including payments from any third party (including a Federal, State, or local government agency and any other third party) that is responsible for part or all of the charge for such services.

For more information regarding the National Health Service Corps, visit the following Web sites: http://www.azdhs.gov/hsd/nhsc.htm; http://nhsc.bhpr.hrsa.gov/.

Sources: Arizona Department of Health Services. National Health Service Corps. Available: http://www.azdhs.gov/hsd/nhsc.htm; U.S. Department of Health and Human Services Health Resources and Service Administration. National Health Service Corps. Available: http://nhsc.bhpr.hrsa.gov/index.cfm.

Arizona National Interest Waiver Program

The federal National Interest Waiver (NIW) program allows certain foreign workers with advanced degrees, including foreign physicians (MDs), or exceptional abilities to work in the United States. The national interest waiver for physicians in underserved areas relieves the foreign physician from the labor certification process, as administered by the U.S. Department of Labor. The foreign physician is required to provide primary care services full time, for an aggregate of five years, in a federally designated primary health

Arizona National Interest Waiver Program (con't)

professional shortage area (HPSA), medically underserved area (MUA), medically underserved population (MUP), or mental health professional shortage area (MHPSA). National interest waivers are granted by the U.S. Citizenship and Immigration Services (USCIS) of the Department of Homeland Security.
A foreign physician, under the federal statutes and regulations on national interest waivers, must obtain either: the support of a federal agency, such as the U.S. Department of Veterans Affairs, that has knowledge of the physician's qualifications; or a letter from a state's department of public health attesting that the physician's work at the designated site or designated sites is in the public interest. The Arizona Department of HealthServices (ADHS) will only provide NIW attestation letters to foreign physicians who haveobtaine a J-1 visa waiver based on an ADHS J-1 visa waiver letter of support for primary care physicians.

For more information about the Arizona National Interest Waiver Program, visit the following Web site: http://www.azdhs.gov/hsd/nationalinterestwaiver.htm.

Source: Arizona Department of Health Services. Office of Health Systems Development. Arizona National Interest Waiver Program. Available: http://www.azdhs.gov/hsd/nationalinterestwaiver.htm.

Medicare Incentive Payment Program Improvements for Physician Scarcity

Physicians who provide services in a Health Professional Shortage Area (HPSA) are eligible to receive a 10% increase over the amount that would normally be paid under the physician fee schedule. In the past, physicians were responsible for identifying that services were provided in a full county primary care geographic area HPSA. The new law requires that the Secretary of Health and Human Services automatically pay the 10% bonus for services provided in full county primary care geographic area HPSAs. This provision is effective as of January 1, 2005. Refer to **Appendix G** for a list of eligible zip codes.

In addition, a new incentive payment program has been established, which gives primary care and specialist care physicians, who provide services in areas that have few physicians, a 5% bonus. The 5% incentive payment program applies to services provided after January 1, 2005 and before January 1, 2008. Eligible counties must be identified based on the ratio of primary care physicians to Medicare eligible individuals residing in the county and the ratio of specialist care physicians to Medicare eligible individuals residing in the county. For the 5% bonus, as with the HPSA bonus program, payment is added after deductions for beneficiary cost sharing have been made. Refer to **Appendix G** for a list of eligible zip codes.

Source: CMS Legislative Summary. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. Available: http://www.cms.hhs.gov/mmu/hr1/PL108-173summary.asp.

Arizona Medical Student Loan and Scholarship Program

The Arizona Medical Student Loan Program provides educational loans and scholarships sponsored by the State of Arizona. Students who are Arizona residents attending either the University of Arizona College of Medicine or Midwestern University's Arizona College of Osteopathic Medicine (AZCOM) are eligible to be considered for the program. The Scholarship Program gives preference to qualified applicants who demonstrate superior academic and extracurricular merit and to qualified applicants who demonstrate a commitment to serve in underserved areas. The scholarship requires service in an eligible area in Arizona as a licensed physician and has a two-year minimum service commitment. The loan is forgiven for service as a licensed physician in an eligible area in Arizona and requires a two-year minimum service commitment. Eligible service areas include: a rural and medically underserved area of Arizona; a medically underserved area of Arizona; a medically underserved population of Arizona; or any Indian Reservation that is located

Arizona Medical Student Loan and Scholarship Program (con't)

in Arizona. Borrowers are expected to complete a residency program in Family Practice, General Internal Medicine, General Pediatrics, Obstetrics/Gynecology, or combined Medicine and Pediatrics upon graduation from medical school.

For more information regarding this program visit the following Web site: http://www.medicine.arizona.edu/financial-aid/amslp.html.

Allopathic students wanting more information should contact Maggie Gumble, University of Arizona College of Medicine Financial Aid, at: (520) 626-7145. Osteopathic students should contact Carol Dolan, Midwestern University Financial Aid, at: (623) 572-3321.

If a site would like to be considered as an eligible practice site for this program, contact Maggie Gumble, University of Arizona College of Medicine Financial Aid, at: (520) 626-7145.

Source: University of Arizona College of Medicine. Arizona Medical Student Loan Program. Available: http://www.medicine.arizona.edu/financial-aid/amslp.html.

Arizona Area Health Education Centers Program

The Arizona Area Health Education Centers (AHEC) Program began in 1984 with the formation of the first regional center in the border town of Nogales, Arizona. This center initially focused on the health service and public health needs of the border communities in the southeast region of the state. Over the years, additional regional centers have been established to address the health-related needs of medically underserved communities throughout Arizona's 15 counties.

Each regional center strives to fulfill the Program's mission by creating, coordinating, and implementing its own portfolio of activities and projects designed to address the health needs within its service area. The centers collaborate with local and regional partners, including healthcare agencies and facilities, K-12 and postsecondary institutions, and community-service organizations to coordinate and support educational and community service activities that target medically underserved rural and urban populations throughout their regions. With leadership from the Program's director, support personnel from the Program office at The University of Arizona (Tucson) collaborate with the centers to advise, assist, monitor, and evaluate these statewide efforts.

The Program director consults regularly with two advisory committees: (1) The University of Arizona (UA) Health Sciences Colleges AHEC Advisory Committee, whose members represent the UA colleges of medicine, nursing, pharmacy, and public health; and (2) The Arizona AHEC Advisory Commission, whose members are appointed by the Arizona Board of Regents (ABOR) and represent health educators, health professionals, and community members serving and/or living in rural and/or medically underserved communities throughout Arizona.

In addition to these committees, each regional center has its own ABOR-appointed advisory or governing board, comprised of healthcare providers and consumers who reflect the ethnic representation of the center's geographic area. Board members advise center directors regarding health professionals' educational needs, regional priorities, and funding allocations.

Mission statement
The mission of the Arizona AHEC Program is to improve the recruitment, diversity, distribution, and

Arizona Area Health Education Centers Program (con't)

retention of culturally competent personnel providing health services in rural and urban medically under served communities.

Funding

The Arizona AHEC Program receives and distributes federal and state funds to each of five regional centers to implement workforce development activities. Additionally, these centers may obtain funds from other sources to advance the Arizona AHEC Program's education and training efforts. Rural health practitioners interested in learning more about preceptor and student-rotation opportunities as well as continuing education/continuing medical education (CE/CME) opportunities may contact the centers listed below.

Arizona AHEC Program Locations

Program Office (The University of Arizona)
Director: G. Marie Swanson, PhD, MPH
Arizona AHEC Program Office
1830 E. Broadway Blvd., Suite 136
PO Box 210547
Tucson, Arizona 85719-5968
Tele: (520) 629-4300, x 214; Fax: (520) 629-4396
E-Mail: gmarie@coph.arizona.edu

Associate Director: Donald Proulx, MEd
Arizona AHEC Program Office
1830 E. Broadway Blvd., Suite 136
PO Box 210547
Tucson, Arizona 85719-5968
Tele: (520) 629-4300, x214; Fax: (520) 629-4396
E-Mail: dproulx@u.arizona.edu

Arizona AHEC regional sites

Eastern Arizona AHEC (EAHEC)
Executive Director: Jeri Byrne
5880 S. Hospital Dr.
Globe, Arizona 85501
Tele: (928) 425-3261, x1141; Fax: (928) 425-7903
E-Mail: jbyrne@cvchospital.com

Northern Arizona AHEC (NAHEC)
Center Director: Rick Swanson
2501 N. Fourth St., Suite 5
PO Box 3630
Flagstaff, Arizona 86003
Tele: (928) 213-0125; Fax: (928) 774-7066
E-Mail: RSwanson@northcountrychc.org

Maricopa Area AHEC (MAHEC)
Interim Center Director: Donald Proulx
C/O 1830 E. Broadway Blvd., Suite 136
PO Box 210547

Arizona Area Health Education Centers Program (con't)

Maricopa Area AHEC (MAHEC) (con't)
Tucson, Arizona 85719-5968
Tele: (520) 629-4300, x214; Fax: (520) 629-4396
E-Mail: dproulx@u.arizona.edu

Southeast Arizona AHEC (SEAHEC)
Executive Director: Karen Halverson
1171 W. Target Range Road
Nogales, Arizona 85621
Tele: (520) 287-4722; Fax: (520) 287-4349
E-Mail: ahalvers@ahsc.arizona.edu

Western Arizona AHEC (WAHEC)
Center Director: Tuly Medina
1896 E. Babbit Lane
PO Box 1669
San Luis, Arizona 85349
Tele: (928) 627-1120; Fax: (928) 627-8773
E-Mail: tulymedina@rcfbh.com

University of Arizona Health-Related Student Internships/Preceptorships

Rural health care providers can provide opportunities for internships and preceptorships for public health, pharmacy, medical, and nursing students. These internships/preceptorships would provide the students with exposure to the issues surrounding rural health care. When students are exposed to health care in rural areas, they are more likely to return to these areas to practice.

If a rural health care provider is interested in becoming a possible site for student internships/preceptorships they should contact the following:

University of Arizona Mel and Enid Zuckerman College of Public Health
Contact: Linda Dobbyn
Telephone: (520) 626-3204
E-mail: ldobbyn@u.arizona.edu

University of Arizona College of Pharmacy
Contact: Lynda Klasky
Telephone: (520) 626-5067
E-mail: klasky@pharmacy.arizona.edu

University of Arizona College of Nursing
Contact: Dr. Sally Reel
Telephone: (520) 626-8769
E-mail: sreel@nursing.arizona.edu

University of Arizona College of Medicine
Contact: Dr. Carol Galper
Telephone: (520) 626-2351
E-mail: cgalper@u.arizona.edu

XI. Development Resources for Boards of Directors and Boards of Trustees

Training

The Arizona Hospital and Healthcare Association (AzHHA) provides training to advance the skills of hospital trustees and board members. Check AzHHA's Web site (http://www.azhha.org) for further information on board development training programs. The Arizona Hospital and Healthcare Association is an organization of hospitals and health systems dedicated to providing leadership on issues affecting the delivery, quality, accessibility and cost effectiveness of healthcare. The Association accepts and shares in the responsibility for improving the health status of the people of Arizona. For more information, visit: http://www.azhha.org.

The Arizona Rural Hospital Flexibility Program (Flex Program) supports targeted training for board members of the state's Critical Access Hospitals. In 2004, the Flex Program worked with consultants to determine the extent to which training of board members could assist in forwarding the mandates of CAHs, and also to elicit feedback from CAH board members regarding their training needs. Using the results of these efforts, the Flex Program subcontracted with the Arizona Hospital and Healthcare Assocation to develop training opportunities directed toward Critical Access Hospital boards of trustees and boards of directors. In 2005, the Flex Program collaborated with the Arizona Hospital and Healthcare Association to sponsor a one-day workshop for board members of Critical Access Hospitals and small rural hospitals. For more information, visit: http://azflexprogram.publichealth.arizona.edu

The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases the best practices of leading healthcare boards across the country. The Governance Institute is committed to its purpose of providing the essential knowledge and solutions necessary for hospitals and health systems to achieve excellence in governance. For more information, visit: http://www.governanceinstitute.com.

Publications

Across the Board

Across The Board is a bulletin for healthcare boards published by the Virginia Primary Care Association, with funding from the Health Resources and Services Administration, Bureau of Primary Health Care. There is also a Spanish version of *Across the Board*, titled *Desde La Junta Directiva*. The bulletins are intended to educate and assist volunteer board members of health care programs.

The bulletins are available free of charge to Board Members and Executive Directors of Community Health Centers and Migrant Health Centers. Past issues are posted online and may be accessed at no charge (http://vpca.com). Additional copies may be obtained by calling the HRSA Information Center at 1-888-ASK-HRSA.

Boards That Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations, 2nd Edition, by John Carver

John Carver's groundbreaking Policy Governance model has influenced the way public and nonprofit boards operate around the world. Now, as widespread experience with the model accumulates, Carver enriches his definitive exposition with updated policy samples, a new chapter on the process of policy development, and additional resources for various types of boards.

Carver debunks the entrenched beliefs about board roles and functions that hamper dedicated board members. With creative insight and common sense practicality, he presents a bold new approach to board job design, board-staff relationships, the chief executive role, performance monitoring, and virtually every aspect of the board-management relationship. In their stead, he offers a board model designed to produce policies that make a difference, missions that are clearly articulated, standards that are ethical and prudent, meetings, officers, and committees that work, and leadership that supports the fulfillment of long-term goals.

Boards That Make a Difference is published by Jossey-Bass and can be purchased from online bookstores.

Guidebook for Directors of Nonprofit Corporations, 2nd Edition

The second edition of the *Guidebook for Directors of Nonprofit Corporations* has been prepared by the Committee on Nonprofit Corporations of the Business Law Section of the American Bar Association. The purpose of the *Guidebook* is to assist the lay reader; the *Guidebook* provides a description of general legal principles as they apply to nonprofit corporations. On a more practical level, the *Guidebook* offers what the editors hope will be useful suggestions and procedures for both the individual director and the corporation that he or she serves.

The Guidebook for Directors of Nonprofit Corporations was edited by George W. Overton and Jeannie Carmedelle Prey. It can be purchased from online bookstores.

Free Complete Toolkit for Boards by Carter McNamara, MBA, PhD

This free toolkit includes chapters on Board Roles and Responsibilities; Documents (Charter/Constitution/Articles, Operating Rules, Policies, etc.); Staffing the Board; Ensuring Successful Committees; Ensuring Successful Meetings; Evaluating the Board; Board and Staff Relations; Evaluating Executive Directors; Board Orientation/Training; Board Operations; Accountability of Boards; and General Resources.
This free toolkit is available online at: http://www.mapnp.org/library/boards/boards.htm.

Nonprofit Boards That Work: The End of One-Size-Fits-All Governance, by Maureen K. Robinson

The number of nonprofit organizations is growing increasingly across the United States and abroad, yet many nonprofit boards find that their goodwill often outweighs their governance skills, one of the most undertaught and under-discussed areas of a nonprofit manager's job. Nonprofit Boards That Work provides hands-on advice and real-world examples for nonprofit managers and boards to apply directly to their own organizations. Backed by the National Center for Nonprofit Boards, this easy-to-read guide contains case studies, checklists, sample questionnaires, forms, and explanations to guide boards and their executive directors toward the development of a more thoughtful, intentional, and mission-conscious approach to governance that their particular nonprofit requires.

Nonprofit Boards That Work is published by Wiley and is available at http://www.wiley.com or from online bookstores.

Publications (con't)

Reinventing Your Board: A Step-by-Step Guide to Implementing Policy Governance, by John Carver and Miriam Mayhew Carver

A natural companion to *Boards That Make a Difference*, *Reinventing Your Board* is John Carver and Miriam Mayhew Carver's recipe for putting Policy Governance into practice. With 25 figures, policy samples, forms, and other practical, "put-the-model-in-motion" materials, this is the nuts-and-bolts materials that Carvers' followers have been requesting. The authors illustrate effective board decision making, show how to craft useful policies, and offer practical advice on such matters as setting the agenda, monitoring CEO performance, defining the board role, and more. Step-by-step instructions and sample policies make this a valuable resource for boards in the public and nonprofit sectors.

Reinventing Your Board is published by Jossey-Bass and is available from online bookstores.

Other Possible Publication Resources

The following publications may be purchased through BoardSource at:
http://www.boardsource.org

Assessment of the Chief Executive by Jane Pierson and Joshua Mintz

Photo courtesy of Adobe® InDesign® CS.

Assessing the chief executive is one of the board's primary governance responsibilities and is critical to the success of the chief executive and the organization as a whole. This tool clarifies the chief executive's responsibilities, job expectations, and annual goals; captures the board's perception of the executive's strengths, limitations, and overall performance; and fosters growth and development of the chief executive and the organization. *The Assessment of the Chief Executive* by Joshua Mintz and Jane Pierson enables your board to evaluate the performance of the chief executive in four key areas:

1. Annual performance goals
2. Core competencies
3. Leadership qualities
4. Accomplishments and challenges

Chief Executive Succession Planning by Nancy Axelrod

How ready are you for a leadership transition? Discover why it is important for your board to have a leadership transition plan whether or not you anticipate an upcoming executive search. Learn how to devise an ongoing chief executive officer succession plan that is linked to the strategic planning, mission, and vision of your organization. Help your board prepare for the future by tying the needs of the organization

into the chief executive officer job description and chief executive officer evaluation.

Dollars and Sense: The Nonprofit Board's Guide to Determining Chief Executive Compensation, by Brian H. Vogel and Charles W. Quatt

In light of the ever-increasing scrutiny of nonprofit practices, now more than ever, nonprofit boards must be aware of the public perception of executive salaries and benefits packages. In this tricky balancing act, your board needs to craft a competitive compensation plan that not only reflects the values and the mission of the organization, but also helps to attract and retain the right chief executive for the job.

In their book *Dollars and Sense: The Nonprofit Board's Guide to Determining Chief Executive Compensation*, experts Brian H. Vogel and Charles W. Quatt explain how nonprofits of all types can increase the transparency and integrity of chief executive compensation practices as part of their stewardship of the public trust. As the authors examine important parts of the process such as board responsibilities, chief executive assessment, contracts, IRS regulations, legal standards and compensation packages, they guide nonprofit boards through the process of setting an effective chief executive compensation plan.

Hiring the Chief Executive by Sheila Albert

Recruiting the right nonprofit executive in today's tough market can be a daunting task. BoardSource has devised a booklet that walks nonprofit board members through the steps of finding a new chief executive. It is designed for organizations that are conducting the search internally or those working with an executive search firm that want a detailed overview of the search process.

Hot topics include:

- Replacing a founding executive.
- Hiring an interim executive.
- Determining salary and benefits.
- Diversifying the candidate pool.
- Involving staff in the selection process.

This comprehensive tool takes you step-by-step through the selection process — from creating a search committee to deciding the qualifications of an ideal candidate, to screening and interviewing candidates, to making the final, important decision.

How to Help Your Board Govern More and Manage Less by Richard P. Chait

Is your board managing instead of governing? Understanding this distinction will increase your board's ability to work effectively. Discover how your board can successfully work with staff, and how this dynamic changes as the size of your organization's staff changes. Also included are specific procedures to strengthen your board's capacity to govern.

The Board Chair Handbook by William Dietel and Linda Dietel

The board chair plays an indispensable role in a nonprofit organization. Because of the chair's unique position, he or she needs knowledge and skills specific to this important role. *The Board Chair Handbook* is a complete guide to the roles and responsibilities of the chair and is designed to help board chairs perform

their duties. This booklet will also help board chair's gain a full understanding of this challenging and rewarding job. The handbook includes:

- Tips for getting started in the job
- Suggestions for developing board policies and procedures
- Recommendations for handling a variety of issues
- Advice for cultivating talent for future board leadership

Also included is a CD-ROM containing sample meeting agendas and customizable letters for the board chair's use including, asking a board member for an annual gift, cultivating and recruiting a prospective board member, inviting someone to join the board, and asking a board member to step down.

The Board-Savvy CEO: How to Build a Strong, Positive Relationship with Your Board by Douglas C. Eadie

Today's chief executives need skills that go well beyond the basic executive management competencies. They need to develop a sophisticated understanding of governance and a firm grasp of the process of helping a board to produce high-impact leadership. *The Board-Savvy CEO* will help chief executives work with the board in leading innovation and change.

Author Douglas Eadie provides directives for all chief executives who are looking to strengthen their bond with the board, including:

- Viewing the board as a resource for the nonprofit and taking responsibility for using that resource to the fullest
- Making governance education a priority for the board and self
- Promoting the board's role in leading innovation and change
- Building a feeling of ownership among board members

Eadie also describes the characteristics of high-impact governing boards — boards who make decisions that determine where the nonprofit is headed and how well it is performing.

The Strategic Board: The Step-by-Step Guide to High-Impact Governance by Mark Light

There's a strange paradox in the nonprofit world. Take top business executives, highly dedicated volunteers, and other community leaders - all with impressive records of achievement in their own fields - and put them together on a nonprofit board, and you wind up, more often than not, with a remarkably inefficient, indecisive group that seems incapable of turning ambitions into accomplishments. That nonprofit boards want to be great, but cannot make it happen, is the endless puzzle of governance.

In *The Strategic Board: The Step-by-Step Guide to High-Impact Governance*, Mark Light explains the seven realities of nonprofit governance that contribute to boards' difficulties, and then outlines the Strategic Board™ model of governance - a simple, practical, easy-to-implement solution to help every board create stability and sustainability, accomplish its purpose, and produce satisfying results.

By addressing the important questions of high-impact governance, the ordinary board becomes the strategic board and crafts a governance plan to guide the work of the organization. This practical and common sense tool combines strategic and operational planning, governance, and oversight into one simple and easy-to-use package that can be passed by the board in a single vote.

XII. Public-Sponsored Insurance Resources

Besides private insurance options, the state of Arizona has publicly-sponsored health care coverage.

Medicare

One of the Medicare Fiscal Intermediary for Arizona's non-tribal hospitals has been Blue Cross and Blue Shield of Arizona since 1966. As the Fiscal Intermediary for Medicare Part A, Blue Cross and Blue Shield of Arizona is contracted by the Centers for Medicare and Medicaid Services to monitor, process, and pay Medicare claims. For more information, please visit: http://www.medicareaz.bcbsaz.com/. For Beneficiary Services (Medicare Beneficiaries Only), call: (800)-MEDICARE (1-800-633-4227). For Provider Services, call: (877) 567-3128.

The other Fiscal Intermediary serving Arizona's non-tribal hospitals is Mutual of Omaha. For more information, visit: http://www.mutualmedicare.com/. For claim status, eligibility, patient responsibility, and provider payment inquiries, contact the Voice Response Unit (VRU) at (866) 580-5983. For Customer Service Inquiries call: (866) 580-5987.

Trailblazer Health Enterprises is the Fiscal Intermediary for Medicare Part A for Indian Health Service (IHS) hospitals and skilled nursing facilities. For more information, visit: http://www.trailblazerhealth.com/. For Beneficiary Services, call: (800)-MEDICARE (1-800-633-4227). For Provider Enrollment questions, call: (866) 528-1603.

Arizona Health Care Cost Containment System

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid Reimbursement program. The program was established on October 1, 1982, with the passage of Senate Bill 1001 creating the program. The bill was signed into law by Governor Bruce Babbitt on November 18, 1981. Before the creation of AHCCCS, Arizona was the only state that did not have a federally funded Medicaid program. Unlike some other state Medicaid programs, AHCCCS pays a capitation payment to public and private health plans upfront, instead of the usual fee-for-service reimbursement system. It is important to note that for every state dollar invested in the AHCCCS Medicaid program, two federal dollars are received.

AHCCCS must file a Medicare waiver in order to receive authorization for Arizona to participate in Medicaid. This allows AHCCCS to bring in federal funding for the Medicaid population in Arizona. The waiver is a document that AHCCCS turns in to the Centers for Medicare and Medicaid Services (CMS), which CMS must then approve. If an extension or change to a current program is needed, then AHCCCS must submit a file waiver amendment.

AHCCCS's waiver was originally awarded on July 13, 1982. An extension was approved on December 12, 2001 and is valid until September 30, 2006. In January 2001, CMS approved an amendment to expand eligibility for AHCCCS's acute care program to 100% Federal Poverty Level (FPL). In December 2001, CMS approved an amendment under the Health Insurance Flexibility and Accountability (HIFA) initiative, which allowed Arizona to use Title XXI funds to provide coverage to parents of Medicaid and State Children's Health Insurance Program children with income between 100 and 200% FPL and certain men, women, and couples without children with income below the 100% FPL.

AHCCCS gains health plan contracts by issuing requests for proposals at least once every five years,

Arizona Health Care Cost Containment System (con't)

according to the Arizona Revised Statutes. As of January 2006, AHCCCS contracted with eight health plans for their Acute Care Program and seven health plans for their Long-Term Care Program. According to the Centers for Medicaid and Medicare Services, close to 1,013,800 people were served in AHCCCS' acute care program and approximately 41,655 were enrolled in the Long-term Care program, as of October 2005. In addition, as of September 1, 2005, 50,672 children were enrolled in KidsCare.

Sources: AHCCCS. Overview of AHCCCS: Chapter 1. Available: http://www.ahcccs.state.az.us/publications/overview/2004/Chapter1.pdf; AHCCCS. Medicare Waiver. Available: http://www.ahcccs.state.az.us/Publications/PlansWaivers/Waivers/Medicaid/default.asp; Centers for Medicare and Medicaid Services. Medicaid Waivers and Demonstration List: Arizona Health Care Cost Containment System. Available: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS047959; A.R.S. 36-2906; AHCCCS. Health Plans. Available: http://www.ahcccs.state.az.us/Services/HealthPlans.asp.

AHCCCS Programs

AHCCCS Care- Income Limit: 100% FPL*

The AHCCCS Care program provides medical coverage, such as doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services.

AHCCCS For Families and Children- Income Limit: 100% FPL

AHCCCS for Families with Children (AFC) provides medical coverage, such as doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services to families. To qualify, there must be a child in the household under the age of 18 years (or 19 years if a full-time student).

Arizona Long Term Care System (ALTCS)—Income Limit: 300% of the Federal Benefit Rate (FBR)

The Arizona Long Term Care System (ALTCS) program is for aged (65 and over), blind, or disabled individuals who need ongoing services at a nursing facility level of care. However, program participants do not have to reside in a nursing home. Many ALTCS participants live in their own homes or an assisted living facility and receive needed in-home services. ALTCS participants are also covered for medical care, including doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services.

Breast and Cervical Cancer Treatment Program (BCCTP)- Income Limit: 250% FPL

The Breast and Cervical Cancer Treatment Program (BCCTP) provides full AHCCCS health insurance coverage to uninsured women who have been screened by the Department of Health Services, Well Woman Healthcheck Program or one of the three Native American programs of the National Breast and Cervical Cancer Early Detection Program and have been diagnosed as needing active treatment for breast and/or cervical cancer or pre-cancerous cervical lesions.

Family Planning Service- Income Limit- N/A

Automatic** eligibility after 6 week post-partum period with eligibility as a SOBRA Pregnant Woman (**Some exceptions).

Federal Emergency Services (FES)- Income Limits: Same as AFC (AHCCCS for Families and Children), SOBRA, or SSI Medical Assistance Only.

Individual does not meet U.S. Citizenship or Qualified Immigrant requirement for other programs. Individual or family must meet the requirements of SOBRA, SSI-Cash, SSI Medical Assistance

Only, or AHCCCS for Families and Children.

Freedom to Work- Income Limit: 250% FPL

Disabled individuals who want to work but are worried about losing medical and Social Security benefits may qualify for the Freedom to Work program. This program is for disabled individuals aged 16 to 65 who work and whose own monthly gross income from work is $1,994 or less. Monthly premiums range from zero to $35.

KidsCare- Income Limit: 200% FPL

KidsCare (Arizona's State Children's Health Insurance Program) provides medical coverage for children who have had no health insurance for the last three months. A monthly premium is charged. It ranges from $10 to $25 a month for one child or $15 to $35 a month for two or more children.

Medical Expense Deduction (MED)- Exceeds 100% FPL; Must be less than 40% FPL after deducting allowable medical expenses (spend down).

The Medical Expense Deduction (MED) program provides medical coverage for individuals who do not qualify for other AHCCCS programs because their income is too high. However, they may be eligible for MED if they have medical expenses in the month of application (or the previous month) that reduce their monthly income to 40% of the Federal Poverty Level (FPL).

Medicare Cost Sharing (MCS)

The Medicare Cost Sharing (MCS) or Medicare Savings programs provide help with Medicare expenses for people who are age 65 or older, blind, or disabled. There is no limit on resources, such as cash, bank accounts, stocks, or bonds. Applicants for all programs must be eligible for Medicare Part A hospital insurance.

Specified Low-Income Medicare Beneficiary (SLMB)- Income Limit: 120% FPL

Qualified Individual (QI)- Income Limit: 135% FPL

Qualified Medicare Beneficiary (QMB)- Income Limit: 100% FPL

SOBRA For Children (under age 19)- Income Limits: Under Age 1—140% FPL; Ages 1-6—133%; Ages 6 and older—100% FPL

SOBRA provides medical coverage to pregnant women and children up to the age of 19 years.

SOBRA For Pregnant Women- Income Limits: 133% FPL

SOBRA provides medical coverage to pregnant women and children up to the age of 19 years.

SSI CASH/SSI Medical Assistance Only- Income Limit- 100% FPL

The Medical Assistance Only program (SSI MAO) provides medical coverage for individuals who are age 65 and over, blind or disabled, but do not receive monthly cash benefits under the Supplemental Security Income program.

Youth Adult Transitional Insurance- Income Limit: No Limit

The Young Adult Transitional Insurance program covers young adults between the ages of 18 and 20 who were in Department of Economic Security foster care when they turned 18.

AHCCCS Programs (con't)

For more information regarding these AHCCCS programs, please visit the AHCCCS Web site at: http://www.ahcccs.state.az.us/.

*New Federal Poverty Level guidelines are issued every year by the U.S. Department of Health and Human Services. As of January 1, 2006, for an AHCCCS program with an income limit of 100% FPL, the equivalent monthly income limit is $798/month for a family of one and $1070/month for a family of two.

Source: AHCCCS. Programs by Group. Available: http://www.ahcccs.state.az.us/Services/byGroup.asp; AHCCCS, Income Eligibility, January 1, 2006. Available: http://www.ahcccs.state.az.us/Publications/Reference/IncomeLimits/AHCCCSIncomeLimits.pdf.

Healthcare Group

Healthcare Group is a state-sponsored health plan that provides coverage to small businesses. The program was created in 1985 by the Arizona State Legislature to provide affordable health care coverage to sole proprietors, small businesses with 50 or fewer employees, and political subdivisions. Your business qualifies for Healthcare Group coverage if you have been in business for 60 days or more and been without health care coverage for at least six months. As a pre-paid premium based plan, employers may choose to contribute to the premiums or can offer the plan directly to their employees at no cost to the business. For more information, please visit http://www.healthcaregroupaz.com/ or call (602) 407-9600 in the Phoenix Area or (800) 545-0676 Statewide.

Source: Healthcare Group. Available: http://www.healthcaregroupaz.com/.

Pictured: Sage Memorial Hospital in Ganado, Arizona.
Critical Access Hospital, designated 12/1/2002.

XIII. Advocacy Resources

Advocacy is a vital component of developing health policy for rural communities. One important form of advocacy is to contact elected officials on issues related to rural health. This page provides you with the information needed to contact your state and federal elected officials.

Federal Government

White House
http://www.whitehouse.gov

U.S. Senate
Visit: http://www.senate.gov/general/contact_information/senators_cfm.cfm?OrderBy=state&Sort=ASC for a list of U.S. Senators organized by state.

U.S. House of Representatives
Visit: http://www.house.gov/house/MemberWWW_by_State.shtml for a list of Representatives organized by state.

Arizona State Government

Governor
http://www.governor.state.az.us

Secretary of State
http://www.azsos.gov

Attorney General
http://www.azag.gov

Arizona Senate
Visit: http://www.azleg.state.az.us/MemberRoster.asp?Body=S&SortBy=1 for the Senate Roster.

Arizona House of Representatives
Visit: http://www.azleg.state.az.us/MemberRoster.asp?Body=S&SortBy=1 for the House Roster.

To find out who your State Senator or Representative is, visit: http://az-redistricting.org/mapping/default2.asp?tname=Interim.2004.Legislative.Map&service=ircmaps&Layer4=on&Layer1=on&action=zoomin&ActiveLayer=16 and enter your address in the top right hand corner.

XIV. Other Resources of Interest

State Resources

Arizona Association of Community Health Centers

The Arizona Association of Community Health Centers (AACHC) is the Primary Care Association (PCA) for the State of Arizona. All states have one designated PCA in order to advance both the expansion of Federally Qualified Health Centers (FQHC's) and advocate for the health care interests of the medically underserved and uninsured. The AACHC as a result has many programs to assist member community health centers and the disadvantaged populations they serve.

320 E McDowell Rd., Suite 320
Phoenix, Arizona 85004
Phone: (602) 253-0090
Fax: (602) 252-3620
E-mail: info@aachc.org
Web site: http://www.aachc.org

Arizona Department of Health Services

150 North 18th Avenue
Phoenix, Arizona 85007
Phone: (602) 542-1001
Fax: (602) 542-0883
Web site: http://www.azdhs.gov

Departments pertinent to subjects discussed in this manual:

Arizona Loan Repayment, Arizona National Interest Waiver Program, Arizona Primary Care Area Statistical Profiles, Arizona State 30 J-1 Visa Waivers, Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, or National Health Service Corps:
Office of Health Systems Development
1740 W. Adams St., Suite 410
Phoenix, Arizona 85007
Phone: (602) 542-1219
Fax: (602) 542-2011
Web site: http://www.azdhs.gov/hsd

EMS Services:
Division of Public Health Services
Bureau of Emergency Medical Services
150 N. 18th Ave., Suite 540
Phoenix, Arizona 85007
Phone: (602) 364-3150 or (800) 200-8523
EMT Questions: (602) 364-3186
Fax: (602) 364-3568
Web site: http://www.azdhs.gov/bems

Critical Access Hospital and Rural Health Clinic Designation:
Division of Licensing Services
Office of Medical Facilities Licensing
150 N. 18th Avenue, 4th Floor
Phoenix, Arizona 85007
Phone: (602) 364-3030
Fax: (602) 364-4765
Web site: http://www.azdhs.gov/als/medical

Arizona Health Care Cost Containment System

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program, designed to deliver quality health care under cutting-edge concepts of managed care.
801 E. Jefferson
Phoenix, Arizona 85034
Phone: (602) 417-4000
Fax: (602) 252-2136
Web site: http://www.ahcccs.state.az.us/Site

Arizona Health Information Network, Inc.

Arizona Health Information Network (AZHIN) aims to provide an infrastructure for knowledge-based information to support health care practice and training in Arizona and to introduce, encourage, and support widespread use of electronic information management tools by Arizona's health care practitioners.
1501 North Campbell Ave.
P.O. Box 245080
Tucson, Arizona 85724
Phone: (520) 626-8287
Fax: (520) 626-2922
E-mail: coordinator@AZHIN.org
Web site: http://www.azhin.org

Arizona Hospital and Healthcare Association

The Arizona Hospital and Healthcare Association is an organization of hospitals and health systems dedicated to providing leadership on issues affecting the delivery, quality, accessibility and cost effectiveness of healthcare. The Association accepts and shares in the responsibility for improving the health status of the people of Arizona.
2901 North Central Avenue, Suite 900
Phoenix, Arizona 85012
Phone: (602): 445-4300
Fax: (602) 445-4299
Web site: http://www.azhha.org

Arizona Public Health Association

A non-profit, professional organization working to improve the public's health and to achieve health status equality for all Arizonans through advocacy, public education, and professional development.
P.O. Box 16595
Phoenix, Arizona 85011
Phone: (602) 258-3361
Web site: http://www.azpha.org

State Resources (con't)

Arizona Rural Health Association

The Arizona Rural Health Association, Inc. advocates on behalf of the health needs of rural Arizonans at national, state and local levels. Its multidisciplinary membership provides a respected and highly effective group of rural health practitioners and rural community residents. For example, the AzRHA, Inc. has actively and successfully advocated with the state legislature for funding for telemedicine and mobile clinics in all fifteen counties of the state.
P.O. Box 43370
Tucson, Arizona 85733
E-mail: info@azrha.org
Web site: http://www.azrha.org

Arizona Rural Health Dataline (ARHD)

The ARHD is a centralized collection of rural health data and links to community level data and health-related sites. The data summaries provide state, urban, and rural comparisons as well as comparisons between Arizona's 15 counties. The information is divided into seven sections. A number of partners have contributed the data to the site. They include the Arizona Department of Health Services, Arizona Health Care Cost Containment System, Indian Health Service, and the Arizona Association of Community Health Centers.
P.O. Box 245210
Tucson, AZ 85724
Express Mail (FedEx, UPS, etc.):
1295 N. Martin Avenue, Bldg. 202A
Room # A 241
Tucson, Arizona 85719
Phone: (520) 626-5840
Fax: (520) 626-3101
Web site: http://www.rho.arizona.edu/ARHD

Arizona Rural Hospital Flexibility Program

The Rural Health Office at the Mel and Enid Zuckerman College of Public Health administers the activities of the Medicare Rural Hospital Flexibility [Flex] Program. The Flex Program was created to improve the financial viability and stability of health care in rural areas across the nation. A key aspect of this program was the creation of a new designation for rural hospitals called Critical Access Hospitals (CAHs). CAHs are eligible for cost-based reimbursement for services provided to Medicare beneficiaries. Additional reimbursement is provided for serving Medicaid patients.
P.O. Box 245210
Tucson, Arizona 85724
Express Mail (FedEx, UPS, etc.):
1295 N. Martin Avenue, Bldg. 202A
Room # A245
Tucson, Arizona 85719
Phone: (520) 626-6253
Fax: (520) 626-3101
Web site: http://azflexprogram.publichealth.arizona.edu

County Health Departments:

Apache County Health Department
Location: 75 W. Cleveland St.
St. Johns, Arizona 85936
Mailing Address: P.O. Box 697
St. Johns, Arizona 85936
Phone: (928) 337-7525
Fax: (928) 337-2062
Web site: http://www.co.apache.az.us/health

Cochise County Health Department
Location: 1415 Melody Lane, Bldg. A
Bisbee, Arizona 85603
Mailing Address: Same as Above
Phone: (520) 432-9400
Fax: (520) 432-9480
Web site: http://www.co.cochise.az.us/health/HealthDepartment/Default.htm

Coconino County Department of Health Services
Location: 2625 N. King St.
Flagstaff, Arizona 86004
Mailing Address: Same as Above
Phone: (928) 522-7800
Fax: (928) 522-7808
Web site: http://co.coconino.az.us/health.aspx

Gila County Health Department
Location: 5515 South Apache Avenue, Suite 100
Globe, Arizona 85501
Mailing Address: 1400 E. Ash
Globe, Arizona 85501
Phone: (928) 425-3231 ext. 8811
Fax: (928) 425-0794
Web site: http://www.gilacountyaz.gov/dept.php?vdeptid=1034

Graham County Health Department
Location: 826 W. Main Street
Safford, Arizona 85546
Mailing Address: Same as Above
Phone: (928) 428-1962
Fax: (928) 428-8074
Web site: http://206.169.149.67/county_offices.asp?id=1389&section=Health

Greenlee County Health Department
Location: 253 Fifth Street
Clifton, Arizona 85533
Mailing Address: P.O. Box 936
Clifton, Arizona 85533
Phone: (928) 865-2601
Fax: (928) 865-1929
Web site: http://www.co.greenlee.az.us/Health/Health-HomePage.aspx

State Resources (con't)

La Paz County Health Department
Location: 1112 Joshua Ave., Suite 206
Parker, Arizona 98344
Mailing Address: Same as Above
Phone: (928) 669-1100
Fax: (928) 669-6703
Web site: http://www.co.la-paz.az.us/health.htm

Maricopa County Department of Public Health
Location: 4041 N. Central Ave.
Phoenix, AZ 85012
Mailing Address: Same as Above
Phone: (602) 506-6900
Fax: (602) 506-6885
Web site: http://www.maricopa.gov/public_health

Mohave County Department of Health
Location: 700 W. Beale St.
Kingman, Arizona 86401
Mailing Address: P.O. Box 7000
Kingman, Arizona 86402
Phone: (928) 753-0743
Fax: (928) 718-5547
Web site: http://www.co.mohave.az.us/depts/health/health_default.asp

Navajo County Public Health Department
Location: 117 E. Buffalo
Holbrook, Arizona 86025
Mailing Address: Same as Above
Phone: (928) 524-4750
Fax: (928) 524-4754
Web site: http://www.co.navajo.az.us/PubHlthSrvcs/Public_Hlth_Serv_Start_Page.aspx

Pima County Health Department
Location: 150 W. Congress
Tucson, Arizona 85701
Mailing Address: Same as Above
Phone: (520) 740-8261
Fax: (520) 623-1432
Web site: http://www.pimahealth.org

Pinal County Health and Human Services
Location: 500 S. Central Avenue
Florence, Arizona 85232
Mailing Address: P.O. Box 868
Florence, Arizona 85232
Phone: (520) 866-6753
Fax: (520) 866-6751
Web site: http://www.co.pinal.az.us/Health

Santa Cruz County Health and Human Services
Location: 2150 N. Congress Drive
Nogales, Arizona 85621
Mailing Address: Same as Above
Phone: (520) 375-7900
Fax: (520) 375-7904
Web site: http://www.co.santa-cruz.az.us/health_human/index.html

Yavapai County Health Department
Location: 1090 Commerce Drive
Prescott, Arizona 86305
Mailing Address: Same as Above
Phone: (928) 771-3122
Fax: (928) 771-3369
Web site: http://www.co.yavapai.az.us/departments/Hlt/HltHome.aspx

Yuma County Department of Public Health
Location: 2200 West 28th Street
Yuma, Arizona 85364
Mailing Address: Same as Above
Phone: (928) 317-4550
Fax: (928) 317-4591
Web site: http://www.co.yuma.az.us/health/index.htm

Health Services Advisory Group

For 25 years HSAG has provided innovative leadership in health care quality improvement for Federal, state and private clients. As agents of change in the health care industry, HSAG associates fill many roles: designing clinical studies, interpreting data, and sharing the latest evidence-based information. Our primary focus is on improving processes of care and outcomes for patients.
1600 East Northern Ave., Ste.100
Phoenix, AZ 85020
Phone: (602) 264-6382
Fax: (602) 241-0757
Web site: http://www.hsag.com/

Regional Behavioral Health Authorities (RBHAs):

Cenpatico Behavioral Health of Arizona, LLC™ (Cenpatico)
Cenpatico facilitates the delivery of mental health and substance abuse services to behavioral health recipients in the Arizona counties of Yuma, La Paz, Pinal and Gila. Cenpatico embraces the Arizona System Principles, the Arizona Children's Vision and Principles, and Principles for Person with Serious Mental Illness (Arizona principles), which express the ADHS/DBHS commitment to build a consumer-driven system that is responsive to the needs of behavioral health recipients, families, stakeholders and communities. Cenpatico is a subsidiary of Cenpatico Behavioral Health, LLC™ (CBH).
1501 W. Fountainhead Corporate Park, Suite 295
Tempe, AZ 85282
Phone: (866) 495-6738
Fax: (800) 398-6182
Web site: http://www.cenpaticoaz.com

State Resources (con't)

Community Partnership of Southern Arizona (CPSA)

CPSA is the Regional Behavioral Health Authority (RBHA) designated by the state of Arizona to coordinate and manage publicly-funded behavioral health services for children, adults, and their families in Cochise, Graham, Greenlee, Pima, and Santa Cruz counties. CPSA coordinates, by way of a provider network, the delivery of mental health and substance use treatment services, and behavioral health wellness and prevention services.
4575 E. Broadway
Tucson, Arizona 85711
Phone: (520) 325-4268 or (800) 959-1063
Fax: (520) 318-6935
Web site: http://www.cpsa-rbha.org

Northern Arizona Behavioral Health Authority

Northern Arizona Regional Behavioral Health Authority, Inc.'s mission as a non-profit managed care organization is to plan, develop, implement and administer comprehensive mental health and substance abuse services to adults and children through a provider network in Mohave, Coconino, Apache, Navajo, and Yavapai Counties.
1300 South Yale
Flagstaff, AZ 86001
Phone: (928) 774-7128 or (800) 640-2123
Fax: (928) 774-5665
Web site: http://www.narbha.org

ValueOptions

As the Regional Behavioral Health Authority (RHBA) for Maricopa County, ValueOptions manages publicly funded behavioral health services, providing services to children and adults who are not able to afford such services through insurance or other means.
444 North 44th Street, Suite 400
Phoenix, AZ, 85008
Phone: (602) 914-5800
Fax: (602) 685-3801
Web site: http://www.valueoptions.com/arizona

Rural Health Office

The mission of the Rural Health Office (RHO) is to promote the health of rural and medically underserved individuals, families, and communities through service, education, and research.
P.O. Box 245177
Tucson, AZ 85724
Express Mail (FedEx, UPS, etc.):
1295 N. Martin Avenue, Bldg. 202A
Room # A219EE
Tucson, AZ 85719
Phone: (520) 626-5823
Fax: (520) 626-3101
Web site: http://www.rho.arizona.edu

State Office of Rural Health

See Rural Health Office

Federal Resources

American Cancer Society

With chartered divisions throughout the country and over 3,400 local offices, the American Cancer Society (ACS) is committed to fighting cancer through balanced programs of research, education, patient service, advocacy, and rehabilitation.
Southeastern Arizona Region Local Office
1636 N Swan, Suite 151
Tucson, AZ 85712
Phone: (520) 321-7989
Fax: (520) 321-7988
Web site: http://www.cancer.org

American Dental Association

The ADA is the professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research and the development of standards.
211 East Chicago Ave.
Chicago, Illinois 60611
Phone: (312) 440-2500
Fax: (312) 440-7494
Web site: http://www.ada.org

American Diabetes Association

The American Diabetes Association is the nation's leading nonprofit health organization providing diabetes research, information and advocacy. Founded in 1940, the American Diabetes Association conducts programs in all 50 states and the District of Columbia, reaching hundreds of communities.
1701 North Beauregard Street
Alexandria, Virginia 22311
Phone: (800) 342-2383
Fax: (703) 549-6995
E-mail: AskADA@diabetes.org
Web site: http://www.diabetes.org

American Medical Association

The American Medical Association helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues.
515 N. State Street
Chicago, Illinois 60610
Phone: (800) 621-8335
Fax: (312) 464-4184
Web site: http://www.ama-assn.org

Federal Resources (con't)

American Heart Association
The American Heart Association is a national voluntary health agency whose mission is to reduce disability and death from cardiovascular diseases and stroke.
7272 Greenville Avenue
Dallas, Texas 75231
Phone: (800) 242-8721
Fax: (214) 570-5930
Web site: http://www.americanheart.org

American Osteopathic Association
The AOA is a member association representing more than 54,000 osteopathic physicians (D.O.s). The AOA serves as the primary certifying body for D.O.s, and is the accrediting agency for all osteopathic medical colleges and health care facilities. The AOA's mission is to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality, cost-effective healthcare within a distinct, unified profession.
142 East Ontario Street
Chicago, Illinois 60611
Phone: (800) 621-1773 or (312) 202-8000
Fax: (312) 202-8200
Web site: http://www.osteopathic.org

American Public Health Association
The American Public Health Association (APHA) is the oldest and largest organization of public health professionals in the world, representing more than 50,000 members from over 50 occupations of public health.
800 I Street, NW
Washington, DC 20001
Phone: (202) 777-APHA (2742)
Fax: (202) 777-2534
Web site: http://www.apha.org

American Red Cross
The American Red Cross, a humanitarian organization led by volunteers, guided by its Congressional Charter and the Fundamental Principles of the International Red Cross Movement, will provide relief to victims of disasters and help people prevent, prepare for, and respond to emergencies.
National Headquarters
2025 E Street, NW
Washington, DC 20006
Phone: (202) 303-4498
Web site: http://www.redcross.org

Southern Arizona Chapter
5301 East Broadway
Tucson, Arizona 85711
Phone: (520) 318-6740 or (800) 341-6943
Fax: (520) 318-6749
Web site: http://www.sazredcross.org/

Community Information Resources Center
The Rural Policy Research Institute's (RUPRI) Community Information Resource Center provides timely, policy-relevant information and decision support to government agencies, non-profit organizations, and citizen groups across the U.S. and globally. Our center works with stakeholders to link people and place through interactive visualization, analytical tools, and spatial analysis. Our mission is to make public information publicly accessible in a decision support framework.
231 Middlebush Hall, University of Missouri
Columbia, MO 65211
Phone: (573) 882-6534
Web site: http://circ.rupri.org

HRSA Office of Rural Health Policy
The Office of Rural Health Policy promotes better health care service in rural America. Established in August 1987 by the Administration, the Office was subsequently authorized by Congress in December 1987 and located in the Health Resources and Services Administration. Congress charged the Office with informing and advising the Department of Health and Human Services on matters affecting rural hospitals and health care, coordinating activities within the department that relate to rural health care, and maintaining a national information clearinghouse.
Health Resources and Services Administration
5600 Fishers Lane, 9A-55
Rockville, Maryland 20857
Phone: (301) 443-0835
Fax: (301) 443-2803
Web site: http://ruralhealth.hrsa.gov

Joint Commission on Accreditation of Healthcare Organizations
The Joint Commission evaluates and accredits nearly 16,000 health care organizations and programs in the United States. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards-setting and accrediting body in health care. Since 1951, the Joint Commission has maintained state-of-the-art standards that focus on improving the quality and safety of care provided by health care organizations. The Joint Commission's comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements.
Headquarters
One Renaissance Blvd.
Oakbrook Terrace, Illinois 60181
Phone: (630) 792-5000
Fax: (630) 792-5005
Web site: http://www.jcaho.org

Federal Resources (con't)

National Association of Public Hospitals and Health Systems

The National Association of Public Hospitals and Health Systems represents over 100 hospitals and health systems that together comprise the essential infrastructure of many of America's largest metropolitan health systems. Since its inception in 1980, NAPH has cultivated a strong presence on Capitol Hill, with the executive branch, and in many state capitols. Our association has made significant strides in its twenty-year history in educating federal, state and local decision makers about the unique needs of and challenges faced by member hospitals and the nation's most vulnerable populations.
1301 Pennsylvania Avenue, NW, Suite 950
Washington D.C., 20004
Phone: (202) 585-0100
Fax: (202) 585-0101
E-mail: NAPH@naph.org
Web site: http://www.naph.org

National Rural Health Association

The NRHA is a national nonprofit membership organization with more than 10,000 members that provides leadership on rural health issues. The association's mission is to improve the health and wellbeing of rural Americans and to provide leadership on rural health issues through advocacy, communications, education, research and leadership. The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.
NRHA Administrative Office
521 E. 63rd Street
Kansas City, Missouri 64110
Phone: (816) 756-3140
Fax: (816) 756-3144
E-mail: mail@NRHArural.org
Website: http://www.nrharural.org

NRHA Government Affairs Office
1600 Prince Street, Suite 100
Alexandria, VA 22314
Phone: (703) 519-7910
Fax: (703) 519-3865
E-mail: dc@NRHArural.org

Partners in Information Access for the Public Health Workforce

The Partners in Information Access for the Public Health Workforce helps the public health workforce find and use information effectively to improve and protect the public's health.
Website: http://phpartners.org

Rural Assistance Center

A product of the U.S. Department of Health and Human Services' Rural Initiative, the Rural Assistance Center (RAC) was established in December 2002 as a rural health and human services "information portal." RAC helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents.
P.O. Box 9037
Grand Forks, North Dakota 58202
Phone: (800) 270-1898
Fax: (800) 270-1913
E-mail: info@raconline.org
Web site: http://www.raconline.org

Rural Information Center

The Rural Information Center (RIC) of the National Agricultural Library provides information and referral services to local, tribal, state, and federal government officials; community organizations; rural electric and telephone cooperatives; libraries; businesses; and, citizens working to maintain the vitality of America's rural areas.
10301 Baltimore Avenue, Room 304
Beltsville, Maryland 20705
Phone: (800) 633-7701
Fax: (301) 504-5181
E-mail: ric@nal.usda.gov
Web site: http://www.nal.usda.gov/ric

Rural Policy Research Institute

The Rural Policy Research Institute (RUPRI) conducts policy-relevant research and facilitates public dialogue to assist policymakers in understanding the rural impacts of public policies and programs. Many policies which are not explicitly "rural policies" nevertheless have substantial implications for rural areas, and RUPRI is dedicated to understanding and articulating these implications.
214 Middlebush Hall
University of Missouri
Columbia, MO 65211
Phone: (573) 882-0316
Fax: (573) 884-5310
E-mail: office@rupri.org
Web site: http://www.rupri.org

Appendix A: Definitions of Rural

There are many methods for defining rural areas. These definitions are important because they are used to determine eligibility for resources such as federal grants, rural health clinics, and federally qualified health centers. For questions regarding your eligibility for resources or if you qualify as "rural," contact the State Office of Rural Health (see Other Resources of Interest for contact information)

Federal Definitions

Rural:

The U.S. Census Bureau defines rural as "all territory, population, or housing unit located outside of UAs [urbanized areas] and UCs [urbanized clusters]."

Source: United States Census Bureau. Census 2000 Urban and Rural Classification. http://www.census.gov/geo/www/ua/ua_2k.html.

Urban:

"For Census 2000, the Census Bureau classifies as 'urban' all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile."

Source: United States Census Bureau. Census 2000 Urban and Rural Classification. http://www.census.gov/geo/www/ua/ua_2k.html.

Urbanized Area:

According to the U.S. Census Bureau, an urbanized area "consists of contiguous, densely settled census block groups (BGs) and census blocks that meet minimum population density requirements, along with adjacent densely settled census blocks that together encompass a population of at least 50,000 people."

Source: United States Bureau of the Census. Urban Area Criteria for Census 2000. Available: http://www.census.gov/geo/www/ua/uafedreg031502.txt.

Urban Cluster:

According to the U.S. Census Bureau, an urban cluster "consists of contiguous, densely settled census [block groups] and census blocks that meet minimum population density requirements, along with adjacent densely settled census blocks that together encompass a population of at least 2,500 people, but fewer than 50,000 people."

Source: United States Bureau of the Census. Urban Area Criteria for Census 2000. Available: http://www.census.gov/geo/www/ua/uafedreg031502.txt.

Federal Definitions (con't)

Metropolitan:

The metropolitan statistical areas are defined by the United States Office of Management and Budget (OMB) using published standards applied to data from the Census Bureau. Metropolitan statistical areas are required to have at least one urbanized area of 50,000 of more persons. "Under the standards, the county (or counties) in which at least 50 percent of the population resides within urban areas of 10,000 or more population, or that contain at least 5,000 people residing within a single urban area of 10,000 or more population, is identified as a 'central county' (counties). Additional 'outlying counties' are included in the CBSA [Core Based Statistical Area] if they meet specified requirements of commuting to or from the central counties. Counties or equivalent entities form the geographic 'building blocks' for metropolitan and micropolitan statistical areas throughout the United States and Puerto Rico." A metropolitan statistical area that contains a single core of at least 2.5 million people may be subdivided into smaller groupings of counties called "metropolitan divisions."

Source: US Census Bureau. About Metropolitan and Micropolitan Statistical Areas. Available: http://www.census.gov/population/www/estimates/aboutmetro.html.

Micropolitan:

The micropolitan statistical areas are defined by the United States Office of Management and Budget (OMB) using published standards applied to data from the Census Bureau. Micropolitan statistical areas are required to have an urban cluster of at least 10,000 but less than 50,000 persons. "Under the standards, the county (or counties) in which at least 50 percent of the population resides within urban areas of 10,000 or more population, or that contain at least 5,000 people residing within a single urban area of 10,000 or more population, is identified as a 'central county' (counties). Additional 'outlying counties' are included in the CBSA [Core Based Statistical Area] if they meet specified requirements of commuting to or from the central counties. Counties or equivalent entities form the geographic 'building blocks' for metropolitan and micropolitan statistical areas throughout the United States and Puerto Rico."

Source: US Census Bureau. About Metropolitan and Micropolitan Statistical Areas. Available: http://www.census.gov/population/www/estimates/aboutmetro.html.

Core Based Statistical Area (CBSA):

Core Based Statistical Area refers collectively to metropolitan and micropolitan statistical areas.

The Centers for Medicare and Medicaid uses the Core Based Statistical Area definitions, established by the Office of Management and Budget, to define hospital geographic areas (labor market areas).

Sources: US Census Bureau. About Metropolitan and Micropolitan Statistical Areas. Available: http://www.census.gov/population/www/estimates/aboutmetro.html; Centers for Medicare and Medicaid. Wage Index. Available: http://www.cms.hhs.gov/AcuteInpatientPPS/03_wageindex.asp.

Rural-Urban Continuum Codes:

According to Economic Research Service, of the United States Department of Agriculture, the Rural-Urban Continuum Codes "form a classification scheme that distinguishes metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by degree of urbanization

and adjacency to a metro area or areas. The metro and nonmetro categories have been subdivided into three metro and six nonmetro groupings, resulting in a nine-part county codification."
Source: United States Department of Agriculture, Economic Research Services. Rural-Urban Continuum Codes. Available: http://www.ers.usda.gov/briefing/rurality/RuralUrbCon.

Rural-Urban Commuting Areas:

According to Economic Research Service, of the United States Department of Agriculture, the "rural-urban commuting area (RUCA) codes classify U.S. census tracts using measures of population density, urbanization, and daily commuting. The most recent RUCA codes are based on data from the 2000 decennial census. The classification contains two levels. Whole numbers (1-10) delineate metropolitan, micropolitan, small town, and rural commuting areas based on the size and direction of the primary (largest) commuting flows. These 10 codes are further subdivided to permit stricter or looser delimitation of commuting areas, based on secondary (second largest) commuting flows."

For more information on RUCAs, visit: http://depts.washington.edu/uwruca.

Sources: United States Department of Agriculture, Economic Research Service. Rural-Urban Commuting Areas. Available: http://www.ers.usda.gov/Data/RuralUrbanCommutingAreaCodes.

Urban Influence Codes:

The Economic Research Service, of the United States Department of Agriculture, created a set of county-level urban influence codes in order to capture some variations in economic opportunities. The 2003 urban influence codes divide the counties, county equivalents, and independent cities into 12 groups. "Metro counties are divided into two groups by the size of the metro area—those in 'large' areas with at least 1 million residents and those in 'small' areas with fewer than 1 million residents. Nonmetro micropolitan counties are divided into three groups by their adjacency to metro areas—adjacent to a large metro area, adjacent to a small metro area, and not adjacent to a metro area. Nonmetro noncore counties are divided into seven groups by their adjacency to metro or micro areas and whether or not they have their 'own town' of at least 2,500 residents."

Source: United States Department of Agriculture, Economic Research Service. Urban Influence Codes. Available: http://www.ers.usda.gov/Briefing/Rurality/urbaninf.

Health Professional Shortage Area (HPSA):

The purpose of the HPSA designation is to identify an area or population that has a shortage of dental, mental, and primary health care providers. The HPSA designation is based on the following three criteria: the geographic area involved must be rational for delivery of health services; a specified population-to-provider ratio representing shortage must be exceeded within the area; resources in contiguous areas must be shown to be overutilized, excessively distant, or otherwise inaccessible. A HPSA designation may be for a geographic area, a certain population (i.e., low-income), or a facility. HPSA designation criteria are developed by the Shortage Designation Branch in the HRSA Bureau of Health Professions, National Center for Health Workforce Analysis. For information on how to apply for a HPSA designation, visit: http://bhpr.hrsa.gov/shortage/hpsapply.htm.

Federal Definitions (con't)

In addition, automatic facility HPSA status is available for all Federally Qualified Health Centers (FQHCs) and those Rural Health Clinics (RHCs) that meet the requirement of providing access to care regardless of ability to pay. For more information, visit: http://bhpr.hrsa.gov/shortage/autoscore.htm.

Sources: Arizona Department of Health Services, Office of Health Systems Development. Health Professional Shortage Areas. Available: http://www.azdhs.gov/hsd/hpsa.htm; HRSA Bureau of Health Professions, Shortage Designation. Available: http://bhpr.hrsa.gov/shortage/; HRSA Bureau of Health Professions, Shortage Designation: Automatic Facility HPSA Scoring. Available: http://bhpr.hrsa.gov/shortage/autoscore.htm.

Medically Underserved Area (MUA):

The purpose of the MUA designation is to identify areas that are in need of medical services on the basis of demographic data. The designation is dependent on the area having an Index of Medical Underservice (IMU) score of 62.0 points or less. The IMU is a weighted score and is based on the following four criteria: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of population below the federal poverty level, and percentage of the population 65 years and older.

Source: Arizona Department of Health Services, Office of Health Systems Development. Federal Medically Underserved Areas and Populations. Available: http://www.azdhs.gov/hsd/mua_mup.htm.

Medically Underserved Population (MUP):

The purpose of the MUP designation is to identify populations (as opposed to medically underserved areas) that are in need of medical services on the basis of demographic data. The designation is dependent on the population receiving an Index of Medical Underservice (IMU) score of 62.0 points or less. The IMU is a weighted score and is based on the following four criteria: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of population below the federal poverty level, and percentage of the population 65 years and older.

Source: Arizona Department of Health Services, Office of Health Systems Development. Federal Medically Underserved Areas and Populations. Available: http://www.azdhs.gov/hsd/mua_mup.htm.

State Definitions

Arizona Medically Underserved Area (AzMUA):

According to Arizona Statute, all federally designated Arizona Primary Care Health Professional Shortage Areas (HPSAs) qualify as AzMUAs. Additionally, areas can receive the AzMUA designation through the Primary Care Index. A Primary Care Index Score is calculated for each of the Primary Care Areas in Arizona and is based on data gathered from state and federal agencies. Primary Care Areas that have a score greater than 55 (out of 121 possible points) or that score in the top 25%, whichever is greater, are designated as AzMUAs.

Source: Arizona Department of Health Services, Office of Health Systems Development. Arizona Medically Underserved Areas. Available: http://www.azdhs.gov/hsd/azmuadesignation.htm.

State Definitions (con't)

Rural:

According to Arizona Revised Statutes, rural is defined as "(a) a county with a population of less than four hundred thousand persons according to the most recent United States decennial census. (b) A census county division with less than fifty thousand persons in a county with a population of four hundred thousand or more persons according to the most recent United States decennial census."

Source: A.R.S. 36-2171. Available: http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp.

Federal Primary Care HPSAs in Arizona
(as of 1/2006)

APACHE
- Chinle
  Designation Type: Geographic
- Ganado
  Designation Type: Geographic
- Kayenta
  Designation Type: Geographic
- Sanders
  Designation Type: Geographic
- St. Johns/Springerville
  Designation Type: Geographic

COCHISE
- Arizona State Prison Complex- Douglas
  Destination Type: Facility
- Bisbee
  Designation Type: Geographic
- Douglas
  Designation Type: Geographic
- Elfrida
  Designation Type: Geographic
- Tombstone
  Designation Type: Geographic

COCONINO
- Fredonia
  Designation Type: Geographic
- Grand Canyon Village
  Designation Type: Population Low Income
- Page/Tuba City
  Designation Type: Geographic

GILA
- Globe
  Designation Type: Population Low Income
- Hayden
  Designation Type: Geographic
- Northern Young
  Designation Type: Geographic
- Young
  Designation Type: Geographic

GRAHAM
- Arizona State Prison Complex- Safford
  Designation Type: Facility
- Federal Correctional Institution- Safford
  Designation Type: Facility

GREENLEE
- Entire County
  Designation Type: Population Low Income

LA PAZ
- Entire County
  Designation Type: Geographic

MARICOPA
- Arizona State Prison Complex- Lewis
  Designation Type: Facility
- Avondale/Tolleson
  Designation Type: Population Low Income
- Buckeye
  Designation Type: Geographic
- Chandler
  Designation Type: Geographic
- El Mirage
  Designation Type: Population Low Income
- Federal Correctional Institution- Phoenix
  Designation Type: Facility
- Gila Bend
  Designation Type: Geographic
- Glendale
  Designation Type: Geographic
- Maricopa County Jails
  Designation Type: Facility
- Rio Salado
  Designation Type: Geographic
- South Central Phoenix
  Designation Type: Population Low Income
- South Mountain
  Designation Type: Population Low Income
- Southwest Phoenix
  Designation Type: Population Low Income
- West Phoenix
  Designation Type: Population Low Income
- Wickenburg
  Designation Type: Geographic

MOHAVE
- Bullhead City
  Designation Type: Population Low Income
- Dolan Springs
  Designation Type: Geographic

Federal Primary Care HPSAs in Arizona (con't)

- Fort Mohave
  Designation Type: Population Low Income
- Kingman
  Designation Type: Population Low Income
- Mohave North
  Designation Type: Geographic

NAVAJO

- Arizona State Prison Complex-Winslow
  Designation Type: Facility
- Chinle
  Designation Type: Geographic
- Dilkon
  Designation Type: Geographic
- Heber/Overgaard
  Designation Type: Geographic
- Holbrook
  Designation Type: Population Low Income
- Hopi
  Designation Type: Geographic
- Kayenta
  Designation Type: Geographic
- Snowflake
  Designation Type: Population Low Income
- Winslow
  Designation Type: Population Low Income

PIMA

- Ajo
  Designation Type: Geographic
- Arivaca
  Designation Type: Geographic
- Arizona State Prison Complex- Tucson
  Designation Type: Facility
- Children's Rehabilitative Services of Tucson
  Designation Type: Facility
- Continental
  Designation Type: Geographic
- Federal Correctional Institution- Tucson
  Designation Type: Facility
- Marana
  Designation Type: Geographic
- Tucson Central
  Designation Type: Geographic
- Tucson Southeast
  Designation Type: Geographic
- Tucson Southwest
  Designation Type: Geographic

PINAL

- Apache Junction
  Designation Type: Geographic
- Arizona State Prison Complex- Eyman
  Designation Type: Facility
- Central/West Pinal
  Designation Type: Population Low Income/ Migrant Farm Worker
- Florence Prison, INS
  Designation Type: Facility
- San Pedro Valley
  Designation Type: Geographic
- Superior/Kearny
  Designation Type: Population Low Income

SANTA CRUZ

- Entire County
  Designation Type: Geographic

YAVAPAI

- Ash Fork
  Designation Type: Geographic
- Cordes Junction
  Designation Type: Geographic
- Yavapai South
  Designation Type: Geographic

YUMA

- Arizona State Prison Complex- Yuma
  Designation Type: Facility
- Somerton
  Designation Type: Geographic
- Wellton/Mohawk
  Designation Type: Geographic

Source: Arizona Department of Health Services, Office of Health Systems Development. Primary Care HPSAs (by County). Available: http://www.azdhs.gov/hsd/pc_hpsa.htm.

Federal MUAs/MUPs in Arizona
(as of 1/2006)

APACHE
- Entire County
  Designation Type: MUA

COCHISE
- Benson Division
  Designation Type: MUA
- Bisbee
  Designation Type: MUP-Low Income
- Bowie/Willcox
  Designation Type: MUA
- Douglas
  Designation Type: MUA
- Elfrida Division
  Designation Type: MUA
- Sierra Vista Division
  Designation Type: MUA

COCONINO
- Flagstaff- Medically Indigent
  Designation Type: Governor's Request
- Kaibab Division
  Designation Type: MUA
- Tuba City
  Designation Type: MUA

GILA
- Entire County
  Designation Type: MUA

GRAHAM
- Entire County
  Designation Type: MUP-Low Income

GREENLEE
- Duncan Division
  Designation Type: MUA

LA PAZ
- Parker
  Designation Type: MUP-Low Income
- Quartzsite
  Designation Type: MUA
- Salome
  Designation Type: MUA

MARICOPA
- Avondale/Tolleson
  Designation Type: MUP- Low Income
- Chandler
  Designation Type: MUA
- El Mirage
  Designation Type: MUA
- Gila Bend Division
  Designation Type: MUA
- Glendale
  Designation Type: MUA
- Guadalupe
  Designation Type: MUA
- North Tempe
  Designation Type: MUA
- Rio Salado
  Designation Type: MUA
- South Central Phoenix
  Designation Type: MUP-Low Income
- South Mountain
  Designation Type: MUA
- West Phoenix
  Designation Type: MUA
- Wickenburg
  Designation Type: MUA

MOHAVE
- Bullhead City
  Designation Type: MUP- Low Income
- Dolan Springs
  Designation Type: MUA
- Ft. Mohave
  Designation Type: MUP- Low Income
- Kingman
  Designation Type: MUA
- Mohave North Division
  Designation Type: MUA
- Peach Springs
  Designation Type: MUA

NAVAJO
- Entire County
  Designation Type: MUA

PIMA
- Ajo Division

Federal MUAs/MUPs in Arizona (con't)

Designation Type: MUA
- Arivaca
  Designation Type: MUA
- Marana
  Designation Type: MUA
- South Tucson
  Designation Type: MUA

PINAL
- Apache Junction
  Designation Type: MUA
- Central-West Pinal
  Designation Type: MUP-Low Income
- Gila River Division
  Designation Type: MUA
- Superior
  Designation Type: MUA

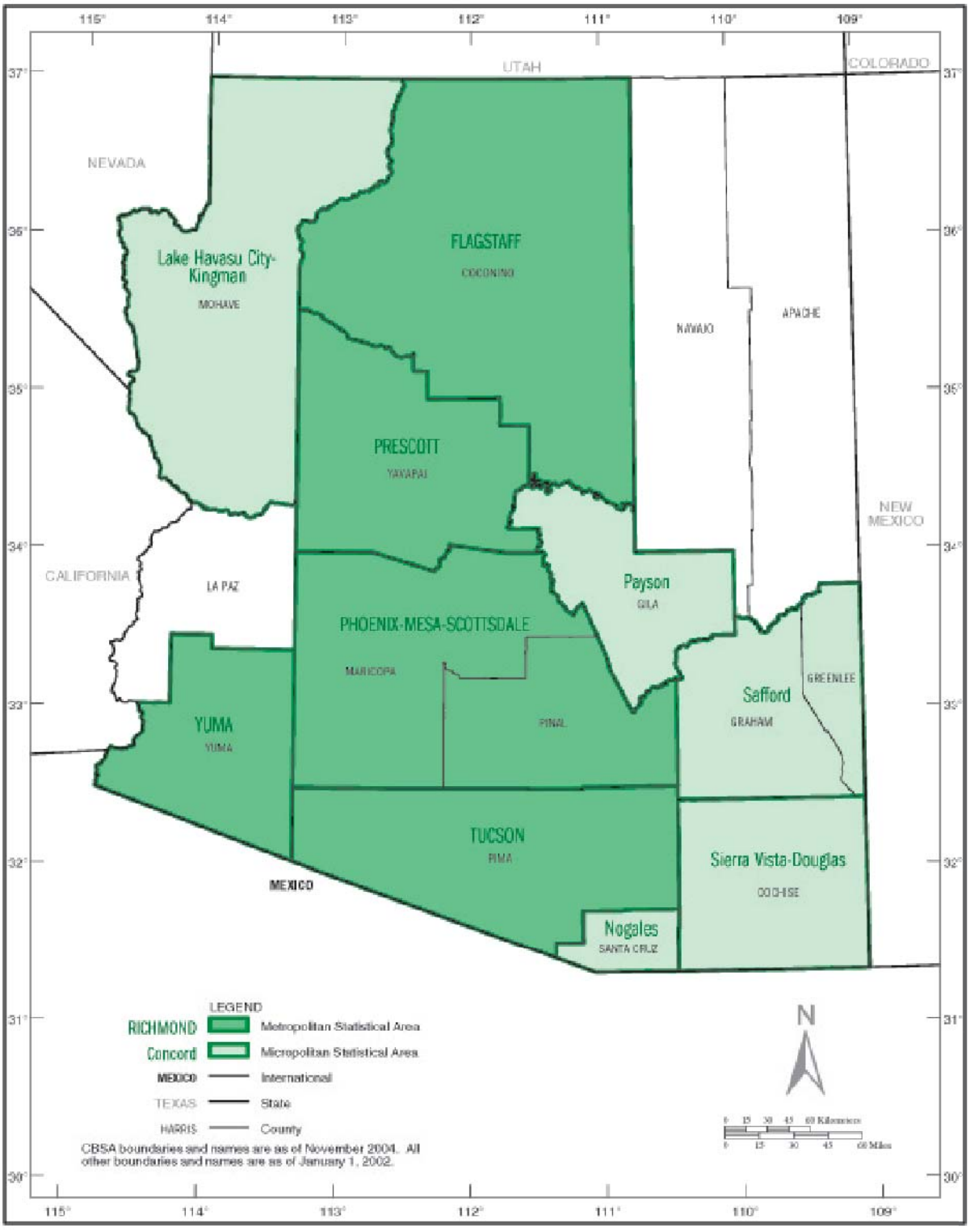
SANTA CRUZ
- Entire County
  Designation Type: MUA

YAVAPAI
- Entire County
  Designation Type: MUP- Low Income

YUMA
- Somerton Division
  Designation Type: MUA
- Yuma North
  Designation Type: MUA
- Yuma West
  Designation Type: MUA

Source: Arizona Department of Health Services, Office of Health Systems Development. Federal Medically Under-served Areas and Populations. Available: http://www.azdhs.gov/hsd/mua_mup.htm.

ARIZONA - Core Based Statistical Areas and Counties



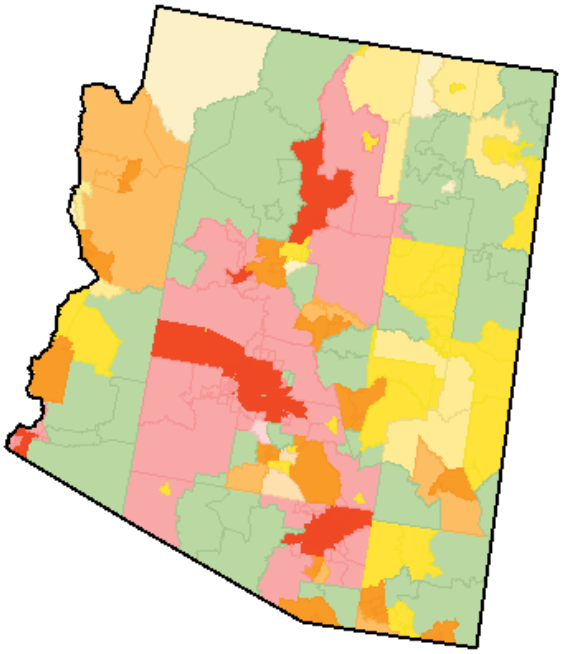
U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration U.S. Census Bureau

Rural-Urban Continuum Codes for Arizona

FIPS Code	State	County name	2003 Rural-urban continuum code	Description	2000 population
4001	AZ	Apache County	6	Nonmetro county with urban population of 2,500-19,999, adjacent to a metro area	69,423
4003	AZ	Cochise County	4	Nonmetro county with urban population of 20,000 or more, adjacent to a metro area	117,755
4005	AZ	Coconino County	3	County in metro area of fewer than 250,000 population	116,320
4007	AZ	Gila County	4	Nonmetro county with urban population of 20,000 or more, adjacent to a metro area	51,335
4009	AZ	Graham County	6	Nonmetro county with urban population of 2,500-19,999, adjacent to a metro area	33,489
4011	AZ	Greenlee County	7	Nonmetro county with urban population of 2,500-19,999, not adjacent to a metro area	8,547
4012	AZ	La Paz County	6	Nonmetro county with urban population of 2,500-19,999, adjacent to a metro area	19,715
4013	AZ	Maricopa County	1	County in metro area with 1 million population or more	3,072,149
4015	AZ	Mohave County	4	Nonmetro county with urban population of 20,000 or more, adjacent to a metro area	155,032
4017	AZ	Navajo County	4	Nonmetro county with urban population of 20,000 or more, adjacent to a metro area	97,470
4019	AZ	Pima County	2	County in metro area of 250,000 to 1 million population	843,746
4021	AZ	Pinal County	1	County in metro area with 1 million population or more	179,727
4023	AZ	Santa Cruz County	4	Nonmetro county with urban population of 20,000 or more, adjacent to a metro area	38,381
4025	AZ	Yavapai County	3	County in metro area of fewer than 250,000 population	167,517
4027	AZ	Yuma County	3	County in metro area of fewer than 250,000 population	160,026

Source: USDA, Economoic Research Service. Data: Rural-Urban Continuum Codes. Available: http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes/2003/LookUpRUCC.asp?C=R&ST=AZ

Rural-Urban Commuting Areas in Arizona



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Legend

State Boundaries

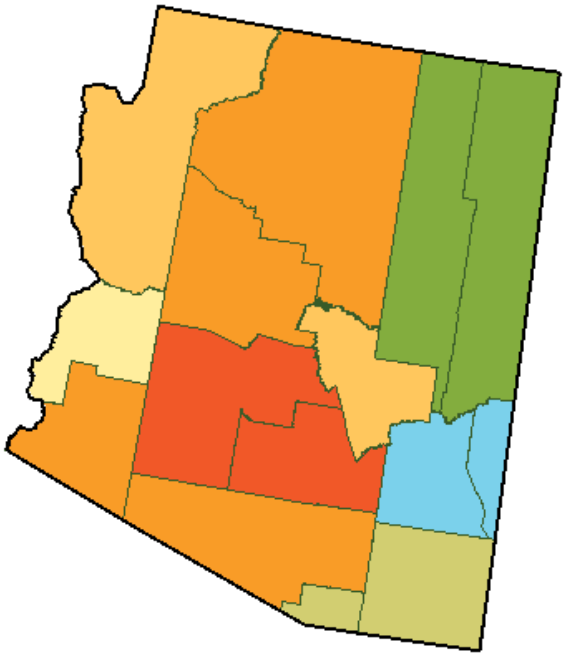
State Boundaries
Rural-Urban Commuting Areas
(RUCAs) by Census Tract

- Urban Core
- High Commuting to Urban Core
- Low Commuting to Urban Core
- Large Town
- High Commuting to Large Town
- Low Commuting to Large Town
- Small Town
- High Commuting to Small Town
- Low Commuting to Small Town
- Rural Areas

Location Map

Map prepared by:
http://circ.rupri.org, 3/21/2006.

Urban Influence Codes in Arizona



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Legend

State Boundaries

State Boundaries
Urban Influence Codes

- Noncore not adjacent to metro or micro with no own town
- Noncore not adjacent to micro or micro with own town
- Noncore adjacent to micro with no own town
- Noncore adjacent to micro with own town
- Micropolitan not adjacent to a metro area
- Noncore adjacent to small metro no own town
- Noncore adjacent to small metro with own town
- Micropolitan adjacent to small metro
- Noncore adjacent to large metro
- Micropolitan adjacent to large metro
- In small metro area of less than 1 million residents
- In large metro area of 1+ million residents

Location Map

Map prepared by:
http://circ.rupri.org, 3/22/2006.

Appendix B: Conditions of Participation: Critical Access Hospitals

The following is the list of conditions of participation for Critical Access Hospitals. These conditions can be viewed at: http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr485_05.html.

Information regarding "swing beds" can be found at: http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp#TopOfPage.

[Code of Federal Regulations]
[Title 42, Volume 3]
[Revised as of October 1, 2005]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR485.601]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 485
CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

Subpart F--Conditions of Participation: Critical Access Hospitals (CAHs)

Sec. 485.601 Basis and scope.

(a) Statutory basis. This subpart is based on section 1820 of the Act which sets forth the conditions for designating certain hospitals as CAHs.
(b) Scope. This subpart sets forth the conditions that a hospital must meet to be designated as a CAH.

Sec. 485.602 Definitions.

As used in this subpart, unless the context indicates otherwise: Direct services means services provided by employed staff of the CAH, not services provided through arrangements or agreements.

Sec. 485.603 Rural health network.

A rural health network is an organization that meets the following specifications:
(a) It includes--
(1) At least one hospital that the State has designated or plans to designate as a CAH; and
(2) At least one hospital that furnishes acute care services.
(b) The members of the organization have entered into agreements regarding--
(1) Patient referral and transfer;
(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and
(3) The provision of emergency and nonemergency transportation among members.
(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least--
(1) One hospital that is a member of the network when applicable;
(2) One QIO or equivalent entity; or
(3) One other appropriate and qualified entity identified in the State rural health care plan.

Conditions of Participation: Critical Access Hospitals (con't)

Sec. 485.604 Personnel qualifications.

Staff that furnish services in a CAH must meet the applicable requirements of this section.

(a) Clinical nurse specialist. A clinical nurse specialist must be a person who performs the services of a clinical nurse specialist as authorized by the State, in accordance with State law or the State regulatory mechanism provided by State law.

(b) Nurse practitioner. A nurse practitioner must be a registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualification of nurse practitioners, and who meets one of the following conditions:

(1) Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates.

(2) Has successfully completed a 1 academic year program that--

(i) Prepares registered nurses to perform an expanded role in the delivery of primary care;

(ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and

(iii) Awards a degree, diploma, or certificate to persons who successfully complete the program.

(3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of paragraph (a)(2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding June 25, 1993.

(c) Physician assistant. A physician assistant must be a person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:

(1) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians.

(2) Has satisfactorily completed a program for preparing physician assistants that--

(i) Was at least one academic year in length;

(ii) Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

(iii) Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.

(3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (c)(2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding June 25, 1993.

Sec. 485.606 Designation and certification of CAHs.

(a) Criteria for State designation.

(1) A State that has established a Medicare rural hospital flexibility program described in section 1820(c) of the Act may designate one or more facilities as CAHs if each facility meets the CAH conditions of participation in this subpart F.

(2) The State must not deny any hospital that is otherwise eligible for designation as a CAH under this paragraph (a) solely because the hospital has entered into an agreement under which the hospital may provide posthospital SNF care as described in Sec. 482.66 of this chapter.

(b) Criteria for CMS certification. CMS certifies a facility as a CAH if--

(1) The facility is designated as a CAH by the State in which it is located and has been surveyed by the State survey agency or by CMS and found to meet all conditions of participation in this Part and all other applicable requirements for participation in Part 489 of this chapter.

(2) The facility is a medical assistance facility operating in Montana or a rural primary care hospital designated by CMS before August 5, 1997, and is otherwise eligible to be designated as a CAH by the State under the rules in this subpart.

Conditions of Participation: Critical Access Hospitals (con't)

Sec. 485.608 Condition of participation: Compliance with Federal,

State, and local laws and regulations.

The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.

(a) Standard: Compliance with Federal laws and regulations. The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.

(b) Standard: Compliance with State and local laws and regulations.
All patient care services are furnished in accordance with applicable State and local laws and regulations.

(c) Standard: Licensure of CAH. The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.

(d) Standard: Licensure, certification or registration of personnel. Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.

Sec. 485.610 Condition of participation: Status and location.

(a) Standard: Status. The facility is--

(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;

(2) A recently closed facility, provided that the facility—

(i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) Meets the criteria for designation under this subpart as of the effective date of its designation; or

(3) A health clinic or a health center (as defined by the State) that--

(i) Is licensed by the State as a health clinic or a health center;

(ii) Was a hospital that was downsized to a health clinic or a health center; and

(iii) As of the effective date of its designation, meets the criteria for designation set forth in this subpart.

(b) Standard: Location in a rural area or treatment as rural. The CAH meets the requirements of either paragraph (b)(1) or (b)(2) or (b)(3) of this section.

(1) The CAH meets the following requirements:

(i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under Sec. 412.64(b), excluding paragraph (b)(3) of this chapter;

(ii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board under Sec. 412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under Sec. 412.232 of this chapter.

(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with Sec. 412.103 of this chapter.

(3) Effective only for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(c) Standard: Location relative to other facilities or necessary provider certification. The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation after January 1, 2006.

(d) Standard: Relocation of CAHs with a necessary provider designation. A CAH that has a necessary provider designation from the State that was in effect prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility meets the requirements as specified in paragraph (d)(1) of this section.

(1) If a necessary provider CAH relocates its facility and begins providing services in a new location, the CAH can continue to meet the location requirement of paragraph (c) of this section based on the

necessary provider designation only if the CAH in its new location--
(i) Serves at least 75 percent of the same service area that it served prior to its relocation;
(ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and
(iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location.
(2) If a CAH that has been designated as a necessary provider by the State begins providing services at another location after January 1, 2006, and does not meet the requirements in paragraph (d)(1) of this section, the action will be considered a cessation of business as described in Sec. 489.52(b)(3).

Sec. 485.612 Condition of participation: Compliance with hospital requirements at the time of application.

Except for recently closed facilities as described in Sec. 485.610(a)(2), or health clinics or health centers as described in Sec. 485.610(a)(3), the facility is a hospital that has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.

Sec. 485.616 Condition of participation: Agreements.

(a) Standard: Agreements with network hospitals. In the case of a CAH that is a member of a rural health network as defined in Sec. 485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for--
(1) Patient referral and transfer;
(2) The development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and
(3) The provision of emergency and nonemergency transportation between the facility and the hospital.
(b) Standard: Agreements for credentialing and quality assurance. Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least--
(1) One hospital that is a member of the network;
(2) One QIO or equivalent entity; or
(3) One other appropriate and qualified entity identified in the State rural health care plan.

Sec. 485.618 Condition of participation: Emergency services.

The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.

(a) Standard: Availability. Emergency services are available on a 24-hours a day basis.
(b) Standard: Equipment, supplies, and medication. Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:
(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.
(2) Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.
(c) Standard: Blood and blood products. The facility provides, either directly or under arrangements, the following:
(1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis.
(2) Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under The control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the persons directly responsible for the operation of the facility.
(d) Standard: Personnel.

(1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care on call and immediately available by telephone or radio contact, and available onsite within the following timeframes:

(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or

(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.

(B) The State has determined, under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

(3) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if--

(i) The CAH has no greater than 10 beds;

(ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section;

(iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural healthcare plan with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section;

(iv) Once a Governor submits a letter, as specified in paragraph (d)(2)(iii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in this paragraph (d).

(3) The request, as specified in paragraph(d)(2)(iii) of this section, and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.

(e) Standard: Coordination with emergency response systems. The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.

Sec. 485.620 Condition of participation: Number of beds and length of stay.

(a) Standard: Number of beds. Except as permitted for CAHs having distinct part units under Sec. 485.647, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.

(b) Standard: Length of stay. The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

Sec. 485.623 Condition of participation: Physical plant and environment.

(a) Standard: Construction. The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of direct services.

(b) Standard: Maintenance. The CAH has housekeeping and preventive maintenance programs to ensure that-

(1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;
(2) There is proper routine storage and prompt disposal of trash;
(3) Drugs and biologicals are appropriately stored;
(4) The premises are clean and orderly; and
(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.

(c) Standard: Emergency procedures. The CAH assures the safety of patients in non-medical emergencies by--
(1) Training staff in handling emergencies, including prompt reporting of fires, extinguishing of fires, protection and, where necessary, evacuation of patients, personnel, and guests, and cooperation with fire fighting and disaster authorities;
(2) Providing for emergency power and lighting in the emergency room and for battery lamps and flashlights in other areas;
(3) Providing for an emergency fuel and water supply; and
(4) Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.

(d) Standard: Life safety from fire.
(1) Except as otherwise provided in this section--
(i) The CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101[reg] 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal--register/code--of--federal--regulations/ibr--locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.
(2) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.
(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients.
(4) The CAH maintains written evidence of regular inspection and approval by State or local fire control agencies.
(5) Beginning March 13, 2006, a critical access hospital must be in compliance with Chapter 9.2.9, Emergency Lighting.
(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to critical access hospitals.
(7) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a critical access hospital may install alcohol-based hand rub dispensers in its facility if--
(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;
(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;
(iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and
(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00-1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00-1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A

copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any additional changes are made to this amendment, CMS will publish notice in the Federal Register to announce the change.

Sec. 485.627 Condition of participation: Organizational structure.

(a) Standard: Governing body or responsible individual. The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

(b) Standard: Disclosure. The CAH discloses the names and addresses of--

(1) Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with subpart C of part 420 of this chapter;

(2) The person principally responsible for the operation of the CAH; and

(3) The person responsible for medical direction.

Sec. 485.627 Condition of participation: Organizational structure.

(a) Standard: Governing body or responsible individual. The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

(b) Standard: Disclosure. The CAH discloses the names and addresses of--

(1) Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with subpart C of part 420 of this chapter;

(2) The person principally responsible for the operation of the CAH; and

(3) The person responsible for medical direction.

Sec. 485.631 Condition of participation: Staffing and staff responsibilities.

(a) Standard: Staffing—

(1) The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.

(2) Any ancillary personnel are supervised by the professional staff.

(3) The staff is sufficient to provide the services essential to the operation of the CAH.

(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.

(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

(b) Standard: Responsibilities of the doctor of medicine or osteopathy.

(1) The doctor of medicine or osteopathy--

(i) Provides medical direction for the CAH's health care activities and consultation for, and medical supervision of, the health care staff;

(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH's written policies governing the services it furnishes.

(iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; and

(iv) Periodically reviews and signs the records of patients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.

(2) A doctor of medicine or osteopathy is present for sufficient periods of time, at least once in every 2 week period (except in extraordinary circumstances) to provide the medical direction, medical care services, consultation, and supervision described in this paragraph, and is available through direct radio or telephone communication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are documented in the records of the CAH. A site visit is not required if no patients have been treated since the latest site visit.

(c) Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities.

(1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH's staff--

(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and

(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.

(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:

(i) Provides services in accordance with the CAH's policies.

(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.

(4) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.

Sec. 485.635 Condition of participation: Provision of services.

(a) Standard: Patient care policies.

(1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

(2) The policies are developed with the advice of a group of professional personnel that includes one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of Sec. 485.631(a)(1); at least one member is not a member of the CAH staff.

(3) The policies include the following:

(i) A description of the services the CAH furnishes directly and those furnished through agreement or arrangement.

(ii) Policies and procedures for emergency medical services.

(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.

(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.

(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.

(vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.

(vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of Sec. 483.25(i) is met with
respect to inpatients receiving posthospital SNF care.

(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

(b) Standard: Direct services—

(1) General. The CAH staff furnishes, as direct services, those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health

care delivery system, such as a low intensity hospital outpatient department or emergency department. These direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.

(2) Laboratory services. The CAH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include:

(i) Chemical examination of urine by stick or tablet method or both (including urine ketones);

(ii) Hemoglobin or hematocrit;

(iii) Blood glucose:

(iv) Examination of stool specimens for occult blood;

(v) Pregnancy tests; and

(vi) Primary culturing for transmittal to a certified laboratory.

(3) Radiology services. Radiology services furnished at the CAH are provided as direct services by staff qualified under State law, and do not expose CAH patients or staff to radiation hazards.

(4) Emergency procedures. In accordance with the requirements of Sec. 485.618, the CAH provides as direct services medical emergency procedures as a first response to common life-threatening injuries and acute illness.

(c) Standard: Services provided through agreements or arrangements.

(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including--

(i) Inpatient hospital care;

(ii) Services of doctors of medicine or osteopathy; and

(iii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH.

(iv) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.

(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.

(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.

(4) The person principally responsible for the operation of the CAH under Sec. 485.627(b)(2) of this chapter is also responsible for the following:

(i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.

(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.

(d) Standard: Nursing services. Nursing services must meet the needs of patients.

(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.

(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.

(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.

(4) A nursing care plan must be developed and kept current for each inpatient.

Sec. 485.638 Conditions of participation: Clinical records.

(a) Standard: Records system.—

(1) The CAH maintains a clinical records system in accordance with written policies and procedures.

(2) The records are legible, complete, accurately documented, readily accessible, and systematically

organized.

(3) A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.

(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable--

(i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;

(ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;

(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment; and

(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.

(b) Standard: Protection of record information—

(1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.

(2) Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.

(3) The patient's written consent is required for release of information not required by law.

(c) Standard: Retention of records. The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.

Sec. 485.639 Condition of participation: Surgical services.

Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH in accordance with the designation requirements under paragraph (a) of this section.

(a) Designation of qualified practitioners. The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by--

(1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;

(2) A doctor of dental surgery or dental medicine; or

(3) A doctor of podiatric medicine.

(b) Anesthetic risk and evaluation.

(1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

(c) Administration of anesthesia. The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope-of-practice laws.

(1) Anesthesia must be administered by only--

(i) A qualified anesthesiologist;

(ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;

(iii) A doctor of dental surgery or dental medicine;

(iv) A doctor of podiatric medicine;

(v) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter;

(vi) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or

(vii) A supervised trainee in an approved educational program, as described in Sec. Sec. 413.85 or

413.86 of this chapter.

(2) In those cases in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.

(d) Discharge. All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.

(e) Standard: State exemption.

(1) A CAH may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.

Sec. 485.641 Condition of participation: Periodic evaluation and quality assurance review.

(a) Standard: Periodic evaluation—

(1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of--

(i) The utilization of CAH services, including at least the number of patients served and the volume of services;

(ii) A representative sample of both active and closed clinical records; and

(iii) The CAH's health care policies.

(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.

(b) Standard: Quality assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--

(1) All patient care services and other services affecting patient health and safety, are evaluated;

(2) Nosocomial infections and medication therapy are evaluated;

(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;

(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—

(i) One hospital that is a member of the network, when applicable;

(ii) One QIO or equivalent entity; or

(iii) One other appropriate and qualfied entity identified in the State rural health care plan; and (5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.

(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.

(iii) The CAH documents the outcome of all remedial action.

Sec. 485.643 Condition of participation: Organ, tissue, and eye procurement.

The CAH must have and implement written protocols that:

(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in

the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;

(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(f) For purposes of these standards, the term ``organ'' means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

Sec. 485.645 Special requirements for CAH providers of long-term care services (``swing-beds'')

A CAH must meet the following requirements in order to be granted an approval from CMS to provided post-hospital SNF care, as specified in Sec. 409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.

(a) Eligibility. A CAH must meet the following eligibility requirements:

(1) The facility has been certified as a CAH by CMS under Sec. 485.606(b) of this subpart; and

(2) The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.

(b) Facilities participating as rural primary care hospitals (RPCHs) on September 30, 1997. These facilities must meet the following requirements:

(1) Notwithstanding paragraph (a) of this section, a CAH that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions and limitations that were applicable at the time those approvals were granted.

(2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section and may not request reinstatement under paragraph (b)(1) of this section.

(c) Payment. Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with Sec. 413.70 of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in Sec. 413.114 of this chapter.

(d) SNF services. The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

(1) Residents rights (Sec. 483.10(b)(3) through (b)(6), (d) (e), (h), (i), (j)(1)(vii) and (viii), (l), and (m) of this chapter).

(2) Admission, transfer, and discharge rights (Sec. 483.12(a) of this chapter).

(3) Resident behavior and facility practices (Sec. 483.13 of this chapter).

(4) Patient activities (Sec. 483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of Sec. 485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a

therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.

(5) Social services (Sec. 483.15(g) of this chapter).

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (Sec. 483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under Sec. 483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in Sec. 413.343(b) of this chapter).

(7) Specialized rehabilitative services (Sec. 483.45 of this chapter).

(8) Dental services (Sec. 483.55 of this chapter).

(9) Nutrition (Sec. 483.25(i) of this chapter).

Appendix C: Rural Hospitals in Arizona

KEY

^ Denotes Rural Hospital according to the Arizona Hospital and Healthcare Association's list of Arizona Hospitals with Bed Size (as of 1/2006)
 # Denotes Rural Hospital, as defined by A.R.S. 36.2905.02 (as of 5/2006)
*** Denotes Critical Access Hospital (as of 5/2006)**
+ Denotes Sole Community Hospital according to *AHA Guide*, 2006 Edition (as of 5/2005)
& Denotes Rural Referral Center according to *AHA Guide*, 2006 Edition (as of 5/2005)

Benson Hospital ^#*
450 South Ocotillo Street
Benson, AZ 85602
Phone: (520) 586-2261
Web site: www.bensonhospital.org

Carondelet Holy Cross Hospital – Nogales ^#+
1171 West Target Range Road
Nogales, AZ 85621
Phone: (520) 285-3000
Web site: www.carondelet.org

Casa Grande Regional Medical Center ^
1800 East Florence Boulevard
Casa Grande AZ, 85222
Phone: (520) 381-6300
Web site: www.casagrandehospital.com

Chinle Comprehensive Health Care Facility ^#
Highway 191
P.O. Box "PH"
Chinle, AZ 86503
Phone: (928) 674-7001
Website: www.ihs.gov

Cobre Valley Community Hospital ^#+
5880 South Hospital Drive
Globe, AZ 85501
Phone: (928) 425-3261
Web site: www.cvchospital.com

Copper Queen Community Hospital ^#*+
101 Cole Avenue
Bisbee, AZ 85603
Phone: (520) 432-5383
Web site: www.cqch.org

Flagstaff Medical Center ^+&
1200 North Beaver Street
Flagstaff, AZ 86001
Phone: (928) 779-3366
Web site: www.flagstaffmedicalcenter.com

Havasu Regional Medical Center ^+
101 Civic Center Lane
Lake Havasu City, AZ 86403
Phone: (928) 855-8185
Web site: www.havasuregional.com

Hopi Health Care Center ^#*
P.O. Box 4000
Polacca, AZ 86042
Phone: (928) 737-6000

Hu Hu Kam Memorial Hospital ^#*
483 W. Seed Farm Road
P.O. Box 38
Sacaton, AZ 85247
Phone: (520) 562-3321
Web site: www.grhc.org

Kingman Regional Medical Center ^+
3269 Stockton Hill Road
Kingman, AZ 86401
Phone: (928) 757-2101
Web site: www.azkrmc.com

La Paz Regional Hospital ^#+
1200 Mohave Road
Parker, AZ 85344
Phone: (928) 669-9201

Little Colorado Medical Center ^#*+
1501 N. Williamson Avenue
Winslow, AZ 86047
Phone: (928) 289-4691

Rural Hospitals in Arizona (con't)

Mt. Graham Regional Medical Center ^#+
1600 20th Avenue
Safford, AZ 85546
Phone: (928) 348-4000
Web site: www.mtgraham.org

Navapache Regional Medical Center ^#+
2200 Show Low Lake Road
Show Low, AZ 85901
Phone: (928) 537-4375
Web site: www.nrmc.org

Northern Arizona VA Healthcare System ^
500 Highway 89 North
Prescott, AZ 86313
Phone: (928) 445-4860
Web site: www.va.gov

Northern Cochise Community Hospital ^#*+
901 West Rex Allen Drive
Willcox, AZ 85643
Phone: (520) 384-3541
Web site: www.ncch.net

Page Hospital ^#*
501 North Navajo
P.O. Box 1447
Page, AZ 86040
Phone: (928) 645-2424
Web site: www.bannerhealth.com

Payson Regional Medical Center ^#+
807 South Ponderosa Street
Payson, AZ 85541
Phone: (928) 474-3222
Web site: www.paysonhospital.com

Sage Memorial Hospital ^#*+
Hwys. 264 and 191
P.O. Box 457
Ganado, AZ 86505
Phone: (928) 755-4500
Web site: www.navajosage.org

Sierra Vista Regional Health Center ^#+
300 El Camino Real
Sierra Vista, AZ 85635
Phone: (520) 458-4641
Web site: www.svrhc.org

Southeast Arizona Medical Center ^#*
2174 West Oak Avenue
Douglas, AZ 85607
Phone: (520) 364-7931

Tuba City Regional Healthcare Corporation ^#
167 Main Street
P.O. Box 600
Tuba City, AZ 86045
Phone: (928) 283-2501
Web site: http://www.tcrhcc.org/

USPHS Indian Hospital - Fort Yuma ^#*
P.O. Box 1368
Yuma, AZ 85366
Phone: (760) 572-0217
Web site: www.ihs.gov

USPHS Indian Hospital – Ft. Defiance ^#
P.O. Box 649
Ft. Defiance, AZ 86504
Phone: (928) 729-8000
Web site: www.ihs.gov

USPHS Indian Hospital - Parker ^#*
Route 1, Box 12
Parker, AZ 85344
Phone: (928) 669-2137
Web site: www.ihs.gov

USPHS Indian Hospital - San Carlos ^#
P.O. Box 208
San Carlos, AZ 85550
Phone: (928) 475-2371
Web site: www.ihs.gov

USPHS Indian Hospital – Sells ^#
P.O. Box 548
Sells, AZ 85634
Phone: (520) 383-7251
Web site: www.ihs.gov

Rural Hospitals in Arizona (con't)

USPHS Indian Hospital - Whiteriver ^#
State Route 73, Box 860
Whiteriver, AZ 85941
Phone: (928) 338-4911
Web site: www.ihs.gov

Verde Valley Medical Center ^+
269 South Candy Lane
Cottonwood, AZ 86326
Phone: (928) 634-2251
Web site: www.nahealth.com

Western Arizona Regional Medical Center ^
2735 Silver Creek Road
Bullhead City, AZ 86442
Phone: (928) 763-2273
Web site: www.warmc.com

White Mountain Regional Medical Center ^#+
118 South Mountain Avenue Springerville, AZ 85938
Phone: (928) 333-4368
Web site: www.wmrmc.com

Wickenburg Community Hospital ^#*
520 Rose Lane
Wickenburg, AZ 85390
Phone: (928) 684-5421
Web site: www.wickenburgregional.com

Yavapai Regional Medical Center ^+
1003 Willow Creek Road
Prescott, AZ 86301
Phone: (928) 445-2700
Web site: www.yrmc.org

Yuma Regional Medical Center, Inc. ^+&
2400 South Avenue A
Yuma, AZ 85364
Phone: (928) 344-2000
Web site: www.yumaregional.org

Sources: Arizona Healthcare and Hospital Association. Arizona Hospitals with Bed Size (updated January 2006). Available: http://www.azhha.org/public/stats; Arizona Revised Statutes. A.R.S. 36.2905.02. Available: http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp; American Hospital Association. *AHA Guide to the Health Care Field.* 2006 Edition.

Appendix D: Health Clinics in Arizona

Rural Health Clinics (RHCs) (as of 5/2006)

1) Copper Queen Medical Associates-Bisbee
   Location: 101 Cole Avenue
   Bisbee, Arizona 85603
   Mailing Address: Same as Above
   Phone: (520) 432-2042
   Fax: (520) 432-2098

2) Copper Queen Medical Associates-Douglas
   Location: 100 East 5th Street
   Douglas, Arizona 85607
   Mailing Address: Same as Above
   Phone: (520) 364-7659
   Fax: (520) 364-8541

3) Greasewood Clinic
   Location: Off Route 15
   Greasewood, AZ
   Mailing Address: P.O. Box 457
   Ganado, AZ 86505
   Phone: (928) 654-3208
   Fax: (928) 654-3478

4) La Paz Medical Services, Quartzsite
   Location: 150 East Tyson Road
   Quartzsite, AZ
   Mailing Address: P.O. Box 4618
   Quartzsite, AZ 85359
   Phone: (928) 927-8747
   Fax: (928) 927-8748

5) Pleasant Valley Community Medical Center
   Location: 288 Tewksbury
   Young, AZ 85554
   Mailing Address: Same as Above
   Phone: (928) 462-3435
   Fax: (928) 462-6644

6) Regional Center for Border Health/San Luis Walk-In Clinic
   Location: 1896 East Babbitt Lane, Suite D
   San Luis, Arizona 85349
   Mailing Address: Same as Above
   Phone: (928) 722-6112
   Fax: (928) 722-6113

7) Sage Outpatient Clinic
   Location: Ganado, AZ
   Mailing Address: P.O. Box 457, Highway 264
   Ganado, AZ 86505
   Phone: (928) 755-4640
   Fax: N/A

8) Sulphur Springs Medical Center
   Location: 900 W Scott Street
   Willcox, Arizona 85643
   Mailing Address: Same as Above
   Phone: (520) 384-4421
   Fax: (520) 384-4645

9) Sunsites Medical Clinic
   Location: 225 Frontage Road
   Pearce, Arizona 85625
   Mailing Address: P.O. Box 186
   Pearce, Arizona 85625
   Phone: (520) 826-1088
   Fax: (520) 826-1089

10) Superior Clinic
    Location: 14 N Magma Ave.
    Superior, AZ 85273
    Mailing Address: Same as Above
    Phone: (520) 689-2423
    Fax: (520) 689-5237

11) Tri-Valley Medical Center
    Location: 39726 Harquahala Road
    Salome, AZ 85348
    Mailing Address: Same as Above
    Phone: (928) 859-3460
    Fax: (928) 859-3475

12) Wide Ruins Clinic
    Location: Wide Ruins, AZ
    Mailing Address: P.O. Box 457
    Ganado, AZ 86505

Rural Health Clinics (con't)

Phone: (928) 652-3231
Fax: N/A

Source: Arizona Department of Health Services, Division of Licensing Services, Office of Medical Facilities Licensing. Available: http://www.azdhs.gov/als/medical/index.htm.

Federally Qualified Health Centers (FQHCs) (as of 3/2006)

1) Canyonlands Community Health Care
Location: 827 Vista Avenue
Page, AZ 86040
Mailing Address: P.O. Box 1625
Page, AZ 86040
Phone: (928) 645-9675
Fax: (928) 645-2626

Satellite Clinics:

Chilchinbeto Clinic
Chilchinbeto Chapter House Complex
P.O. Box 1496
Kayenta, AZ 86033
Phone: (928) 697-8154
Fax: (928) 697-8559

Kaibeto Clinic
Kaibeto Boarding School Dorm #4
P.O. Box 2121
Kaibeto, AZ 86053
Phone: (928) 673-3491
Fax: (928) 673-3494

Northwest Arizona Regional Health Center
I-15 Exit 9 at Fire station
P.O. Box 490
Littlefield, AZ 86432
Phone: (928) 347-5971
Fax: (928) 347-5793

Northwest Canyonlands Urgent Care
440 N. Navajo Dr.
Page, AZ 86040
Phone: (928) 645-1700
Fax: (928) 645-1701

Fredonia Community Health Center
100 E. Wood Hill Rd.
P.O. Box 175
Fredonia, AZ 86022
Phone: (928) 643-6215
Fax: (928) 643-6218

Lake Powell Medical Center
467 Vista Avenue
P.O. Box 1625
Page, AZ 86040
Phone: (928) 645-8123
Fax: (928) 645-3862

Morenci Healthcare Center
10 A Ward Canyon Road.
Clifton, AZ 85533
P.O. Box 159
Morenci, AZ 85540
Phone: (928) 865-4511
Fax: (928) 865-2481

Duncan Clinic
227 Main Street
Duncan, AZ 85534
Phone: (928) 359-1380
Fax: (928) 359-1381

Safford Clinic
618 Central Avenue
Safford, AZ 85546
Phone: (928) 428-1500
Fax: (928) 428-1555

2) Chiricahua Community Health Centers, Inc.
Cliff Whetten Clinic
Location: 10566 Highway 191
Elfrida, AZ 85610
Mailing Address: P.O. Box 263
Elfrida, AZ 85610
Phone: (520) 642-2222
Fax: (520) 642-3591

Federally Qualified Health Centers (con't)

Satellite Clinics:

Chiricahua Community Health Center
- Douglas
1205 F Avenue
Douglas, AZ 85607
Phone: (520) 364-3285
Fax: (520) 364-3378

Chiricahua Community Health Center
- Bisbee
108 Arizona Street
Bisbee, AZ 85603
Phone: (520) 432-3309
Fax: (520) 432-3717

3) Clinica Adelante, Inc.
Location: 16551 North Dysart Road,
Suite 104-A
Surprise, AZ 85374
Mailing Address: Same as Above
Phone: (623) 583-3001
Fax: (623) 583-3007

Satellite Clinics:

Tidewell Family Care Center
16560 N. Dysart Road
Surprise, AZ 85374
Phone: (623) 546-2294
Fax: (623) 546-3514

Adelante Women's Health Care
14300 West Granite Valley Drive #A1
Sun City West, AZ 85375
Phone: (623) 544-3214
Fax: (623) 544-3441

Buckeye Family Care Center
306 East Monroe
Buckeye, AZ 85326
Phone: (623) 386-4814
Fax: (623) 364-4593

Gila Bend Primary Care Center
100 N. Gila Blvd.
Gila Bend, AZ 85337
Phone: (602) 241-0909
Fax: (602) 932-5725

Wickenburg Family Care Center
466 W. Wickenburg Way
Wickenburg, AZ 85390
Phone: (928) 684-9555
Fax: (623) 583-8330

Buckeye Dental Care
306 East Monroe
Buckeye, AZ 85326
Phone: (623) 386-1630
Fax: (623) 386-1635

East Valley Family Care
2204 S. Dobson Road, # 101
Mesa, AZ 85202
Phone: (480) 491-6235
Fax: (480) 491-6239

Rural Health Team
306 East Monroe
Buckeye, AZ 85326
Phone: (623) 386-6114
Fax: (623) 386-6124

School Based:

Aguila Elementary School
50023 N 514th Avenue
Aguila, Arizona 85320
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Arlington Elementary School
9410 S 355th Ave
Arlington, AZ 85322
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Federally Qualified Health Centers (con't)

Buckeye Union High School
902 E Eason Avenue
Buckeye, AZ 85326
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Gila Bend Unified School District
308 N Martin Avenue
Gila Bend, AZ 85337
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Liberty Elementary School
19818 W Hwy 85
Buckeye, AZ 85326
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Paloma Elementary School
38739 W Hwy 8/Paloma Rd
Gila Bend, AZ 85337
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Palo Verde Elementary School
10700 S Palo Verde Road
Palo Verde, AZ 85343
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Rainbow Valley Elementary School
19716 W Narramore
Buckeye, AZ 85326
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Ruth Fisher Elementary
38201 W Indian School Rd
Tonopah, AZ 85354
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

Tolleson High School
9419 W Van Buren
Tolleson, AZ 85353
Phone: (623) 386-6114 or (602) 402-3264
Fax: (623) 386-6124

4) Community Health Center of West Yavapai
Location: 3212 N Windsong Drive
Prescott Valley, AZ 86314
Mailing Address: Same as Above
Phone: (928) 583-1000
Fax: (928) 771-3379

Satellite Clinics:

Chino Valley
1951 Voss Drive
Chino Valley, AZ 86323
Phone: (928) 583-1000
Fax: (928) 771-3369

Cottonwood
10 S. 6th Street
Cottonwood, AZ 86326
Phone: (928) 639-8132
Fax: (928) 639-8179

Prescott
1090 Commerce Drive
Prescott, AZ 86305
Phone: (928) 583-1000
Fax: (928) 771-3369

Sedona
3700 W. Highway 89A
Sedona, AZ 86336
Phone: (928) 639-8132
Fax: (928) 639-8179

5) Desert Senita Community Health Center
Location: 410 Malacate Street
Ajo, AZ 85321
Mailing Address: Same as Above
Phone: (520) 387-5651
Fax: (520) 387-5347

Federally Qualified Health Centers (con't)

Satellite Clinic:

Desert Senita Dental Center
140 Estrella Ave.
Ajo, AZ 85321
Phone: (520) 387-4500
Fax: (520) 387-3509

6) El Rio Health Center
Location: 839 West Congress Street
Tucson, AZ 85745
Mailing Address: Same as Above
Phone: (520) 792-9890
Fax: (520) 205-4940

Satellite Clinics:

COPE/El Rio Integrated Health Care
1101 East Broadway
Tucson, Arizona 85719
Phone: (520) 624-7750
Fax: (520) 624-5352

El Rio Special Immunology Associates
1701 West St. Mary's Road Suite #160
Tucson, AZ 85745
Phone: (520) 628-8287
Fax: (520) 628-8749

El Rio Northwest Clinic
330 W. Prince Rd.
Tucson, Arizona 85705
Phone: (520) 388-7171
Fax: (520) 388-7169

El Rio Southwest II, Internal Medicine
1510 West Commerce Court
Tucson, AZ 85746
Phone: (520) 806-2650
Fax: (520) 806-2609

El Rio Pascua Yaqui Clinic
7490 South Camino de Oeste
Tucson, AZ 85746
Phone: (520) 883-5025
Fax: (520) 883-1057

COPE/El Rio Behavioral Health
839 West Congress St.
Tucson, AZ 85745
Phone: (520) 623-9312
Fax: (520) 623-9034

El Rio OB/GYN Associates
225 West Irvington
Tucson, AZ 85714
Phone: (520) 884-7304
Fax: (520) 623-0992

El Rio Southwest, Pediatrics
1500 West Commerce Court
Tucson, AZ 85746
Phone: (520) 806-2650
Fax: (520) 806-2609

El Rio Southwest Dental
1530 West Commerce Court
Tucson, Arizona 85746
Phone: (520) 806-2650
Fax: (520) 806-2609

Homeless Program
1101 East Broadway
Tucson, Arizona 85719
Phone: (520) 624-7750
Fax: (520) 624-5352

Pima Community Access Program
655 East River Rd.
Tucson, AZ 85704
Phone: (520) 694-0418
Fax: (520) 694-0410

School Based:

Summit View Elementary School Based Clinic
1900 East Summit Street
Tucson, AZ 85706
Phone: (520) 545-3860

Federally Qualified Health Centers (con't)

El Rio Sunnyside District Teenage Parent Program
1725 E. Bilby Road
Tucson, AZ 85706
Phone: (520) 741-2400

MEL Center School Based Clinic
5101 South Liberty Avenue
Tucson, AZ 85706
Phone: (520) 545-2302

7) Marana Health Center
Location: 13644 N. Sandario Road
Marana, AZ 85653
Mailing Address: Same as Above
Phone: (520) 682-4111
Fax: (520) 682-4570
Administration:
Location: 11981 W. Grier Road
Marana, AZ 85653
Mailing Address: Same as Above
Phone: (520) 682-4560
Fax: (520) 682-4570

Satellite Clinics:

Santa Catalina Health Center
15631 N. Oracle Road, Suite 141
Tucson, AZ 85739
Phone: (520) 825-6763
Fax: (520) 825-6841

El Pueblo Health Center
101 W. Irvington Road
Tucson, AZ 85714
Phone: (520) 573-0096
Fax: (520) 741-8818

MHC Obstetrics and Gynecology
2055 W. Hospital Drive
Tucson, AZ 85704
Phone: (520) 797-0011
Fax: (520) 797-7550

Ortiz Community Health Center
12635 W. Rudasill
Tucson, AZ 85743
Phone: (520) 682-3777
Fax: (520) 682-2333

School Based:

Catalina Health Center
3645 E. Pima Street
Tucson, AZ 85730
Phone: (520) 232-8438
Fax: (520) 232-8511

Erickson Health Center
6750 E. Stella Road
Tucson, AZ 85716
Phone: (520) 584-5010
Fax: (520) 584-5045

Freedom Park Health Center
5000 E. 29th Street
Tucson, AZ 85711
Phone: (520) 790-8500
Fax: (520) 790-8505

Keeling Health Center
435 E. Glenn Road
Tucson, AZ 85705
Phone: (520) 696-6969
Fax: (520) 696-6971

Marana Middle School Teen Wellness
11279 W. Grier
Marana, AZ 85653
Phone: (520) 682-4730
Fax: (520) 682-4790

Marana High School Teen Wellness
12000 W. Emigh
Tucson, AZ 85743
Phone: (520) 682-6400
Fax: (520) 682-9136

Federally Qualified Health Centers (con't)

8) Maricopa County- Department of Public Health Services
The Homeless Clinic
Location: 220 S. 12th Avenue
Phoenix, AZ 85007
Mailing Address: Same as Above
Phone: (602) 372-2100
Fax: (602) 372-2120

9) Mariposa Community Health Center, Inc.
Location: 1852 North Mastick Way
Nogales, AZ 85621
Mailing Address: Same as Above
Phone: (520) 281-1550
Fax: (520) 281-1112

Satellite Clinic:

Family Health Center - Patagonia
101 Taylor Avenue
Patagonia, AZ 85624
Phone: (520) 394-2262
Fax: (520) 394-2753

10) Mountain Park Center
Location: 2702 N. 3rd Street, Suite 4020
Phoenix, AZ 85004
Mailing Address: Same as Above
Phone: (602) 323-3242
Fax: (602) 323-3496

Satellite Clinics:

Mountain Park Health Center- Baseline
635 East Baseline Road
Phoenix, AZ 85042
Phone: (602) 243-7277
Fax: (602) 276-4427

Mountain Park Health Center -
East Phoenix
690 North Cofco Center Court, Suite 230
Phoenix, AZ 85008
Phone: (602) 323-8200
Fax: (602) 286-0808

Mountain Park Health Center - Maryvale
4616 N. 51st Ave., Suite 203
Phoenix, AZ 85031
Phone: (623) 247-6266
Fax: (623) 247-9742

Mountain Park Health Center - Tolleson
9169 W. Van Buren
Tolleson, AZ 85353
Phone: (623) 478-0774
Fax: (623) 478-8150

11) North County Community Health Center
Location: 2500 North Rose Avenue
Flagstaff, AZ 86004
Mailing Address: P.O. Box 3630
Flagstaff, AZ 86003
Phone: (928) 213-6101 (Clinic)
Phone: (928) 774-6687 (Administration)
Fax: (928) 774-1652 (Administration)

Satellite Clinics:

North Country Community Health Center
Ashfork
112 Park Avenue
P.O. Box 919
Ashfork, AZ 86320
Phone: (928) 637-2305
Fax: (928) 637-2343

North Country Community Health Center
Grand Canyon
1 Clinic Road
Grand Canyon, AZ 86023
Phone: (928) 638-2551
Fax: (928) 638-2598

North Country Community Health Center
Round Valley
830 E. Main Ste. 230
P.O. Box 880
Springerville, AZ 85938
Phone: (928) 333-0127
Fax: (928) 333-4799

Federally Qualified Health Centers (con't)

North Country Community Health Center
St. Johns
625 N. 13th West
P.O. Box 1019
St. Johns, AZ 85936
Phone: (928) 337-3705
Fax: (928) 337-3780

North Country Community Health Center
Seligman
22585 West Oak Street
P.O. Box 776
Seligman, AZ 86337
Phone: (928) 422-4017
Fax: (928) 422-4018

North Country Community Health Center
Winslow
620 W. Lee Street
Winslow, AZ 86047
Phone: (928) 289-2000
Fax: (928) 289-0036

12) Sun Life Family Health Center, Inc.
Location: 865 North Arizola Road
Casa Grande, AZ 85222
Mailing Address: P.O. Box 10097
Casa Grande, AZ
85230
Phone: (520) 836-3446
Fax: (520) 836-8807

Satellite Clinics:

Sun Life Family Health Center- Coolidge
1284 North Arizona Blvd.
Coolidge, AZ 85228
Phone: (520) 723-9131
Fax: (520) 723-7974

Sun Life Family Health Center- Eloy
501 N. Main Street
Eloy, AZ 85231
Phone: (520) 466-7883
Fax: (520) 466-3946

Sun Life Family Health Center- Mammoth
110 Main Street
Mammoth, AZ 85618
Phone: (520) 487-0322
Fax: (520) 487-2463

Sun Life Family Health Center- Maricopa
44765 Hathaway Avenue
P.O. Box 545
Maricopa, AZ 85239
Phone: (520) 568-2245
Fax: (520) 568-2316

Sun Life Family Health Center- Oracle
1870 W. American Ave.
Oracle, AZ 85623
Phone: (520) 896-2091
Fax: (520) 866-7891

Sun Life Family Health Center-
San Manuel
23 McNab Parkway
San Manuel, AZ 85631
Phone: (520) 385-2234
Fax: (520) 385-2113

13) Sunset Community Health Center, Inc.
Location: 115 North Somerton Avenue
Somerton, AZ 85350
Mailing Address: P.O. Box 538
Somerton, AZ 85350
Phone: (928) 627-2051
Fax: (928) 627-3857

Satellite Clinics:

Sunset Community Health Center- Adults
1945 West 24th Street
Yuma, AZ 85364
Phone: (928) 344-4216
Fax: (928) 726-3799

Sunset Community Health Center-
Pediatrics
2435 S. Avenue A, Suite A
Yuma, AZ 85364
Phone: (928) 344-5112
Fax: (928) 344-5766

Federally Qualified Health Centers (con't)

Sunset Community Health Center-
San Luis
744 E. Juan Sanchez Boulevard
San Luis, AZ 85349
Phone: (928) 627-3822
Fax: (928) 627-3989

Sunset Community Health Center-
San Luis Dental
801 N. 2nd Avenue
San Luis, AZ 85349
Phone: (928) 627-8584
Fax: (928) 627-8949

Sunset Community Health Center- Wellton
10425 Williams Street
P.O. Box 686
Wellton, AZ 85356
Phone: (928) 785-3256
Fax: (928) 785-3258

Sunset Women's Health Group
1965 W. 24th Street, Suite B
Yuma, AZ 85364
Phone: (928) 726-5950
Fax: (928) 726-3797

14) United Community Health Center, Inc.
Location: 81 W. Esperanza Blvd.,
Suite 201
Green Valley, AZ 85614
Mailing Address: Same as Above
Phone: (520) 625-4401
Fax: (520) 625-8504

Satellite Clinics:

Arivaca Clinic
17388 West 3rd Street
P.O. Box 233
Arivaca, AZ 85601
Phone: (520) 398-2621
Fax: (520) 398-2613

Continental Pediatrics
1150 Whitehouse Canyon Road
P.O. Box 1354
Green Valley, AZ 85622
Phone: (520) 399-9430
Fax: (520) 399-9524

Continental Family Medical Center
1260 S. Campbell Road
P.O. Box 1354
Green Valley, AZ 85622
Phone: (520) 625-3691
Fax: (520) 625-2894

Three Points Clinic
15921 West Ajo Way
Tucson, AZ 85735
Phone: (520) 822-2335
Fax: (520) 822-2362

School Based:

Altar Valley Middle School
16350 Ajo Way
Tucson, AZ 85736
Phone: (520) 822-9343, x 101
Fax: (520) 822-5801
Robles Elementary School
9875 S. Sasabe Road
Tucson, AZ 85736
Phone: (520) 822-9418, x 147
Fax: (520) 822-9428

Continental Wellness Center
1991 E. Whitehouse Canyon Road
Green Valley, AZ 85614
Phone: (520) 625-4581, x 346
Fax: (520) 648-2569

Sahuarita Wellness Center
350 W. Sahuarita Road
Sahuarita, AZ 85629
Phone: (520) 625-3502, x 1211
Fax: (520) 648-6181

Federally Qualified Health Centers (con't)

Sopori Elementary School
5000 E. Arivaca Road
Amado, AZ 85645
Phone: (520) 625-3502, x 1313
Fax: (520) 398-2024

Sources: Arizona Association of Community Health Centers. Members List. Available: http://www.aachc.org/memberslist.html.

Free Clinics (as of 3/2006)

1. Escalante Clinic
   Location: 2150 E. Orange St.
   Tempe, AZ 85281
   Mailing Address: Same as Above
   Phone: (480) 350-5878
   Fax: (480) 350-5875
2. Las Fuentes Health Clinic of Guadalupe
   Location: 8625 Avenida del Yaqui
   Guadalupe, Arizona 85283
   Mailing Address: Same as Above
   Phone: (480) 777-2263
   Fax: (480) 777-2264
3. Mission of Mercy
   Location: Traveling clinic; please visit
   http://www.amissionofmercy.org/
   for specific locations and dates
   Mailing Address: PMB 134, 5515 N. 7th
   Street, Ste. 5
   Phoenix, AZ 85014
   Phone: 602-288-7234
   Fax: 602-288-8386
4. Neighborhood Christian Clinic
   Location: 1929 W. Fillmore, Bldg. C
   Phoenix, AZ 85009
   Mailing Address: Same as Above
   Phone: (602) 258-6008
   Fax: (602) 258-8388
   *Please note: This clinic is not currently accepting new patients.
5. Stanfield Free Clinic
   Location: 36680 W. Cooper Drive
   Stanfield, AZ 85272
   Mailing Address: 1780 E. Florence
   Blvd, Suite 108
   Casa Grande, AZ 85222
   Phone: (520) 381-6541
   Fax: (520) 381-6031
6. St. Vincent de Paul Free Medical and Virginia G. Piper Dental Clinic
   Location: 420 West Watkins
   Phoenix, AZ 85002
   Mailing Address: P.O. Box 13600
   Phoenix, AZ 85002
   Phone: (602) 261-6868
   Fax: (602) 261-6816
7. Women's Wellness Clinic
   Location: 500 W. Thomas Rd., # 800
   Phoenix, AZ 85013
   Mailing Address: Same as Above
   Phone: (602) 406-6570
   Fax: (602) 406-4011

Source: National Association of Free Clinics.

Appendix E: Tribes in Arizona

- Ak-Chin Indian Community
  42507 West Peters & Nall Rd
  Maricopa, Arizona 85239
  Phone: (520) 568-1000
  Fax: (520) 568-4566
  E-mail: N/A
  Web site: http://www.ak-chin.nsn.us

- Cocopah Tribe
  Avenue G & County 15
  Somerton, Arizona 85350
  Phone: (928) 627-2102
  Fax: (928) 627-3173
  E-mail: cocopah@cocopah.com
  Web site: http://www.cocopah.com

- Colorado River Indian Tribes
  (Includes members of the Chemehuevi, Mohave, Hopi, and Navajo Tribes)
  Route 1, Box 23-B
  Parker, Arizona 85344
  Phone: (928) 669-1271
  Fax: (928) 669-1391
  E-mail: critnews@aol.com
  Web site: http://www.critonline.com/

- Fort McDowell Yavapai Nation
  P.O. Box 17779
  Fountain Hills, Arizona 85269
  Phone: (480) 837-5121
  Fax: (480) 816-9524
  E-mail: cdebo@ftmcdowell.org
  Web site: http://www.ftmcdowell.org/

- Fort Mojave Indian Tribe
  500 Merriman Avenue
  Needles, California 92363
  Phone: (760) 629-4591
  Fax: (760) 629-5767
  E-mail: info@fortmojave.com
  Web site: http://www.fortmojave.com

- Fort Yuma-Quechan Tribe
  P.O. Box 1899
  Yuma, Arizona 85366
  Phone: (760) 572-0213
  Fax: (760) 572-2102
  E-mail: N/A
  Web site: N/A

- Gila River Indian Community
  P.O. Box 97
  Sacaton, Arizona 85247
  Phone:(520) 562-6000
  Fax: (520) 562-6445
  E-mail: executivemail@gric.nsn.us
  Web site: http://gric.nsn.us/

- Havasupai Tribe
  P.O. Box 10
  Supai, Arizona 86435
  Phone: (928) 448-2731
  Fax: (928) 448-2551
  E-mail: Havasupai@nbs.nau.edu
  Web site: http://www.havasupaitribe.com

- Hopi Tribe
  P.O. Box 123
  Kykotsmovi, Arizona 86039
  Phone: (928) 734-3000
  Fax: (928) 734-2435
  E-mail: info@hopi.nsn.us
  Web site: http://www.hopi.nsn.us/

- Hualapai Tribe
  P.O. Box 179
  Peach Springs, Arizona 86434
  Phone: (928) 769-2216
  Fax: (928) 769-2343
  E-mail: N/A
  Web site: N/A

- Kaibab-Paiute Tribe
  HC 65, Box 2
  Fredonia, Arizona 86022
  Phone: (928) 643-7245
  Fax: (928) 643-7260
  E-mail: N/A
  Web site: N/A

- Navajo Nation
  P.O. Drawer 9000
  Window Rock, Arizona 86515
  Phone: (928) 871-6000

Tribes in Arizona (con't)

Fax: (928) 871-4025
E-mail: N/A
Web site: http://www.navajo.org/

- Pascua Yaqui Tribe
  7474 South Camino de Oeste
  Tucson, Arizona 85746
  Phone: (520) 883-5000
  Fax: (520) 883-5014
  E-mail: contact@pascuayaqui-nsn.gov
  Web site: http://www.pascuayaqui-nsn.gov/

- Salt River Pima-Maricopa Indian Community
  10005 East Osborn Road
  Scottsdale, Arizona 85256
  Phone: (480) 850-8000
  Fax: (480) 850-8014
  E-mail: N/A
  Web site: http://www.saltriver.pima-maricopa.nsn.us/

- San Carlos Apache Tribe
  P.O. Box 0
  San Carlos, Arizona 85550
  Phone: (928) 475-2361
  Fax: (928) 475-2567
  E-mail: N/A
  Web site: N/A

- San Juan Southern Paiute Tribe
  P.O. Box 1989
  Tuba City, Arizona 86045
  Phone: (928) 283-4587
  Fax: (928) 283-5761
  E-mail: N/A
  Web site: N/A

- Tohono O'odham Nation
  P.O. Box 837
  Sells, Arizona 85634
  Phone: (520) 383-2028
  Fax: (520) 383-3379
  E-mail: N/A
  Web site: N/A

- Tonto Apache Tribe
  #30 Tonto Apache Reservation
  Payson, Arizona 85541
  Phone: (928) 474-5000
  Fax: (928) 474-9125
  E-mail: N/A
  Web site: N/A

- White Mountain Apache Tribe
  P.O. Box 700
  Whiteriver, Arizona 85941
  Phone: (928) 338-4346
  Fax: (928) 338-1514
  E-mail: N/A
  Web site: http://www.wmat.nsn.us/

- Yavapai-Apache Nation
  2400 W. Datsi Street
  Camp Verde, Arizona 86322
  Phone: (928) 567-1004
  Fax: (928) 567-3994
  E-mail: N/A
  Web site: http://www.yavapai-apache-nation.com/

- Yavapai-Prescott Indian Tribe
  530 East Merritt Street
  Prescott, Arizona 86301
  Phone: (928) 445-8790
  Fax: (928) 778-9445
  E-mail: N/A
  Web site: http://www.ypit.com

- Zuni Tribe
  P.O. Box 339
  Zuni, New Mexico 87327
  Phone: (505) 782-7000
  Fax: (505) 782-782-7002
  E-mail: N/A
  Web site: http://www.ashiwi.org/

- Kickapoo Tribe*
  P.O. Box 70
  McLoud, Oklahoma 74851
  Phone: (405) 964-2075
  Fax: (405) 964-2745
  E-mail: N/A
  Web site: N/A

Tribes in Arizona (con't)

Satellite office:
1645 N H Ave.
Douglas, Arizona 85607
Phone: (520) 364-6111

*Please note: The Kickapoo Tribe is a federally recognized tribe of Oklahoma, however, approximately 150 of its members reside in and around the Douglas area of Arizona.

Sources: Arizona Commission of Indian Affairs. Arizona Tribes. Available: http://www.indianaffairs.state.az.us/tribes/tribes.html; Inter Tribal Council of Arizona. Member Tribes. Available: http://www.itcaonline.com/tribes.html; Oklahoma Indian Affairs Commission. Tribal Governments, Officials and Locations. Available: http://www.oiac.state.ok.us/tgo.html.

Appendix F: Arizona Telemedicine Program Network Membership Services

ARIZONA TELEMEDICINE PROGRAM

ARIZONA TELEMEDICINE PROGRAM NETWORK MEMBERSHIP SERVICES

rev. 12/04

Arizona Telemedicine Program Network

Congratulations on your decision to join the exciting world of telemedicine!

The Arizona Telemedicine Program (ATP) team, in existence since July of 1996, has developed a great deal of expertise in all aspects of telemedicine and has had many "lessons learned". That expertise and those lessons will be shared with you to help integrate telemedicine into your facility with as little difficulty and stress as possible. Our team includes experts in the field of network design and management, administration, clinical care, protocol development, billing and reimbursement, evaluation, legal and regulatory issues, telemedicine technology, training, marketing, outreach, on-line information resources, and distance education. The Director of the program, Dr. Ronald S. Weinstein, has been a national and international leader in telemedicine since 1986. He is a past President of the American Telemedicine Association, the largest telemedicine association in the world.

We know you have a lot of questions and many decisions to make. The Arizona Telemedicine Program team is going to guide you through the process of creating a program tailored to your individual needs.

Because the Arizona Telemedicine Program is a state-funded, not-for-profit organization we are able to provide these services for a minimal fee. This fee offsets costs of personnel involved in:

- Site Assessment
- Equipment Selection and Installation
- Network Design and Installation
- Formal Training in theory and use of telemedicine in a clinical environment
- Coordination of Continuing Education Activities, Events & Meetings
- Network Management & Technical Services
- Billing and Reimbursement Training
- FCC Universal Services Fund Reimbursement

Each of these activities is complex and there are, of course, some limitations inherent when multiple healthcare organizations and telecommunications networks are involved. We will address these as well as solutions in the Membership Services Guide included in this packet.

Membership Services Guide

The Arizona Telemedicine Membership Model is based on the ability to target your needs to the offerings of the program. The following provides details on the full membership model.

Arizona Telemedicine Program Network Membership Services (con't)

Site Assessment:
An ATP Network Membership will include an on-site assessment of the clinic and/or conference space targeted for use for telemedicine or teleconferencing activities. Recommendations will be made on lighting, paint colors, sound proofing, furniture and other needs to optimize your telemedicine capabilities.

Equipment Selection and Installation:
ATP staff will provide specifications of ATP Network compatible telemedicine applications and network equipment. Sites are strongly urged to select ATP Network compatible telemedicine applications equipment. Failure to do so may result in inability to successfully utilize the network's clinical and educational capabilities.

Teleradiology and Network Equipment Contact:
Questions regarding teleradiology applications equipment and network connections should be directed to the Associate Director for Network Architecture.

Network Design and Installation:
An ATP Network Membership will include the development of a working plan to estimate costs of incorporating the networking, telecommunications, end user equipment, and membership requirements for each site to connect to the Arizona Telemedicine Program network. Actual costs could vary from estimates due to timing, types of equipment, etc; actual costs will be billed back to the member site on a mutually agreed upon payment schedule.

Technical Services:
An ATP Network membership provides access to the following technical services:

- Technical information and consulting as necessary to support a Private Network Interface between the Arizona telemedicine communications network and the member site.

- Consultation to member site personnel in the techniques for conducting successful telemedicine operations, including support for connection of telemedicine equipment.

Network Management & Technical Services

- ATP staff will monitor network operations and troubleshoot any network problems, working with member network staff, network equipment vendors, and telecommunications carriers as necessary to resolve any operational issues relating to communications over the Arizona Telemedicine Program network infrastructure.

Telemedicine Training in theory and use of telemedicine in a clinical environment:

Under the network membership agreement, the University of Arizona's Telemedicine Program will:

- Provide a two (2) day training seminar covering a broad range of telemedicine topics including, but not limited to, business and reimbursement, clinical protocols, technical operations and legal/ regulatory issues.

Arizona Telemedicine Program Network Membership Services (con't)

Coordination of Continuing Education Activities, Events & Meetings

- Provide access to Continuing Medical Education/Continuing Education content offered by any member of the network.
- Sites may view a listing of upcoming educational events at the Arizona Telemedicine Program Web Educational Event Calendar: http://calendar.aztel.arizona.edu/cme
- A 3-month archive of past educational events is available via the University of Arizona Streaming Video Server at: http://video.biocom.arizona.edu/video/
- ATP can coordinate national broadcasts of interest if the program is offered free of charge. ATP does not have the capability of collecting fees for participation in activities.
- ATP is responsible for processing CME/CE credit offered by the University of Arizona.
- Network members providing CME/CE content will be responsible for processing credits for their offerings.

Note:
If there is interest in participating in an event, call/email the CE Coordinator as soon as possible to be connected for the event. The CE Coordinator will help coordinate Continuing Education credit for your site personnel who participate. These connections are two-way interactive video; therefore your staff may have questions answered by presenting faculty/instructors.

Business Services:

- Billing and Reimbursement Training
  ATP personnel can provide individualized billing and reimbursement training to network members. This can be provided by video conferencing or by special phone conferencing. However, an overview is provided in the 2-day training program.

- FCC Universal Services Fund Reimbursement Application:
  The FCC Universal Services Fund – Rural Health Care Division - is a federal government program to "level the playing field" for qualifying rural health care sites to offset the high costs for the long telecommunications lines needed to connect rural sites to the network. The ATP Business Office can provide assistance to member sites in filing for FCC Universal Services Fund reimbursements for rural telecommunications lines. This service could save qualifying member sites significant amounts of money on their network connectivity expenses. FCC Universal Fund credits are applied to the respective telecommunications line charges, and future invoices are credited until the credit balance is $-0-.

- Network Telecommunications and Equipment Procurement:
  ATP can act as the purchasing agent for network equipment, telecommunications circuits and network equipment maintenance agreements required to facilitate connectivity to the Arizona Telemedicine Program network. A purchase order to ATP covering each item is required from the ATP member site in advance to utilize this service. Actual costs are recharged to the member organization based on payment schedule mutually agreed upon by the member organization and ATP.

Access to Network Member Sites:
Any network member site can interact with other providers of services using the Arizona Telemedicine

Program (ATP) Network with the understanding that all providers utilizing the network to provide service must have a membership agreement in place with the Arizona Telemedicine Program. However, member sites are responsible for contacting other sites that they wish to interact with in advance to assure compatibility of applications equipment, and to arrange scheduling of facilities and staff. No member site is in any way required to so participate.

Note: Refer to the map on the ATP Web Site: www.telemedicine.arizona.edu to identify other network member sites. Sites wishing to connect with other network sites should discuss need for connection with staff at the site of interest prior to requesting connection. If a network connection is determined to be mutually agreeable with all sites in question, contact the Associate Director for Network Architecture to schedule the connection. Connection issues vary depending on network application. Since the network is "always on" most point-to-point data and video connections can be made directly by user site staff. Multisite video connections for educational or administrative purposes require advanced scheduling through the CE and Administrative Event Coordinator.

Clinical Network Use:
Generally, connections for clinical telemedicine require some form of business agreement between the participating sites that is negotiated in advance. Arrangements to obtain professional services for specific clinical specialties, network management or other specialized services are covered in separate agreements with the appropriate provider and are not part of this Agreement. It is necessary to take into consideration credentialing, licensure and malpractice issues when establishing clinical contracts between sites.

Arizona Telemedicine Program Network Membership Services (con't)

Contacts:

Administration:	Sandy Beinar, Associate Director, Administration 520-626-2493 beinars@email.arizona.edu
Business:	Gail Barker, PhD, Associate Director, Finance 520-626-7330 barkerg@u.arizona.edu
· **Universal Service**	Bob Kerr, Senior Accountant 520-626-8775 rkerr@email.arizona.edu
· **Purchase Orders**	Bonnie Schellenberg, Accounting Manager 520-626-7981 schelleb@u.arizona.edu
Clinical:	Ana Maria Lopez, MD, MPH, Medical Director 520-626-2271 alopez@azcc.arizona.edu
Continuing Education/ Administrative Events & Meetings	Tracy Skinner, Cont. Ed. & Admin. Event Coordinator 520-626-6103 tskinner@email.arizona.edu
Network Equipment and Management:	Mike Holcomb Associate Director, Network Architecture, 520-626-4496 pager: 520-694-4480 PIN 3850. holcomb@email.arizona.edu
Site Assessments and Telemedicine Equipment:	Rick McNeely, Co-Director 520-626-7343 rmcneely@biocom.arizona.edu
Telemedicine Training	Janae Cooley, Marketing & Training Coordinator 520-626-4786 Janae@u.arizona.edu

Appendix G: Eligible Zip Codes for Special Medicare Reimbursements

Rural Ambulance and Outpatient Lab Reimbursement

The zip codes in Arizona that are eligible to receive rural ambulance and outpatient lab reimbursement from Medicare are: 85228, 85232, 85235, 85292, 85321, 85322, 85324, 85325, 85326, 85328, 85332, 85333, 85334, 85337, 85341, 85342, 85343, 85344, 85346, 85347, 85348, 85354, 85357, 85358, 85359, 85360, 85362, 85371, 85390, 85501, 85502, 85530, 85531, 85532, 85533, 85534, 85535, 85536, 85539, 85540, 85541, 85542, 85543, 85544, 85545, 85546, 85547, 85548, 85550, 85551, 85552, 85553, 85554, 85602, 85603, 85605, 85606, 85607, 85608, 85609, 85610, 85613, 85615, 85616, 85617, 85620, 85625, 85626, 85627, 85630, 85632, 85634, 85635, 85636, 85638, 85643, 85644, 85650, 85655, 85670, 85671, 85901, 85902, 85911, 85912, 85920, 85922, 85923, 85924, 85925, 85926, 85927, 85928, 85929, 85930, 85932, 85933, 85934, 85935, 85936, 85937, 85938, 85939, 85940, 85941, 85942, 86021, 86022, 86023, 86024, 86025, 86028, 86029, 86030, 86031, 86032, 86033, 86034, 86035, 86036, 86039, 86040, 86042, 86043, 86044, 86045, 86046, 86047, 86053, 86054, 86301, 86302, 86303, 86304, 86305, 86312, 86313, 86314, 86320, 86321, 86322, 86323, 86324, 86325, 86326, 86327, 86329, 86330, 86331, 86332, 86333, 86334, 86335, 86336, 86337, 86338, 86340, 86341, 86342, 86343, 86351, 86401, 86402, 86403, 86404, 86405, 86406, 86412, 86413, 86426, 86427, 86429, 86430, 86431, 86432, 86433, 86434, 86435, 86436, 86437, 86438, 86439, 86440, 86441, 86442, 86443, 86444, 86502, 86503, 86504, 86505, 86506, 86507, 86508, 86510, 86511, 86512, 86514, 86515, 86520, 86535, 86538, 86540, 86544, 86545, 86547, 86549, 86556.

Medicare Incentive Payment Program Improvements for Physician Scarcity

The following Arizona zip codes represent the 2006 primary care HPSAs. Physicians who provide services in these zip codes are eligible for the automated payment of the HPSA bonus: 85322, 85325, 85328, 85333, 85334, 85337, 85342, 85343, 85344, 85346, 85348, 85354, 85357, 85359, 85361, 85371, 85601, 85603, 85611, 85617, 85618, 85620, 85621, 85624, 85628, 85637, 85640, 85645, 85646, 85648, 85662, 85701, 85702, 86030, 86033, 86034, 86039, 86040, 86042, 86043, 86044, 86053, 86054, 86343, 86435, 86441, 86445, 86503, 86504, 86505, 86506, 86507, 86508, 86510, 86511, 86514, 86515, 86520, 86535, 86538, 86540, 86544, 86545, 86547, 86556.

The following Arizona zip codes represent the 2006 mental health HPSAs. Psychiatrists who provide services in these zip codes are eligible for the automated payment of the HPSA bonus: 85218, 85221, 85222, 85223, 85228, 85230, 85232, 85237, 85272, 85279, 85291, 85328, 85333, 85334, 85347, 85360, 85362, 85364, 85366, 85367, 85369, 85501, 85502, 85544, 85618, 85623, 85924, 85928, 85929, 85931, 85933, 85935, 85936, 85937, 85938, 85939, 85940, 85942, 86001, 86002, 86003, 86004, 86011, 86015, 86016, 86017, 86018, 86020, 86021, 86022, 86023, 86024, 86025, 86028, 86029, 86030, 86031, 86032, 86033, 86034, 86035, 86036, 86038, 86039, 86040, 86042, 86043, 86044, 86045, 86046, 86047, 86052, 86053, 86054, 86301, 86302, 86303, 86304, 86305, 86312, 86313, 86314, 86320, 86321, 86322, 86323, 86324, 86325, 86326, 86327, 86329, 86330, 86331, 86332, 86333, 86334, 86335, 86336, 86337, 86338, 86339, 86340, 86341, 86342, 86343, 86351, 86401, 86402, 86403, 86405, 86406, 86411, 86412, 86413, 86431, 86432, 86433, 86434, 86435, 86436, 86437, 86438, 86439, 86440, 86442, 86443, 86444, 86446, 86502, 86503, 86504, 86505, 86506, 86507, 86508, 86510, 86511, 86512, 86514, 86515, 86520, 86535, 86538, 86540, 86544, 86545, 86547, 86556.

The Arizona zip codes listed below are eligible for Primary Care Physician Scarcity Area bonus payments: 85070, 85217, 85218, 85219, 85220, 85245, 85278, 85320, 85321, 85322, 85324, 85325, 85326, 85328, 85332, 85333, 85334, 85337, 85341, 85342, 85343, 85344, 85346, 85347, 85348, 85354, 85357, 85358, 85359, 85360, 85361, 85362, 85371, 85387, 85390, 85530, 85531, 85535, 85536, 85543, 85546, 85548, 85551, 85552, 85601, 85602, 85603, 85605, 85606, 85607, 85608, 85609, 85610, 85613, 85614, 85615, 85616, 85617, 85620, 85622, 85625, 85626, 85627, 85629, 85630, 85632, 85633, 85634, 85635, 85636, 85638, 85639, 85643, 85644, 85650, 85655, 85670, 85671, 85736, 86021, 86301, 86302, 86303, 86304, 86305, 86312, 86313, 86314, 86320, 86321, 86322, 86323, 86324, 86325, 86326, 86327, 86329, 86330, 86331, 86332, 86333, 86334, 86335, 86336, 86337, 86338, 86340, 86341, 86342, 86343, 86351, 86401, 86402, 86403, 86404, 86405, 86406, 86411, 86412, 86413, 86426, 86427, 86429, 86430, 86431, 86432, 86433, 86434, 86436, 86437, 86438, 86439, 86440, 86441, 86442, 86443, 86444, 86445, 86446.

Eligible Zip Codes for Special Medicare Reimbursements (con't)

The Arizona zip codes listed below are eligible for Specialist Care Physician Scarcity Area bonus payments: 85070, 85217, 85218, 85219, 85220, 85221, 85222, 85223, 85228, 85230, 85231, 85232, 85235, 85237, 85239, 85241, 85245, 85247, 85272, 85273, 85278, 85279, 85291, 85292, 85320, 85321, 85322, 85325, 85326, 85328, 85333, 85334, 85337, 85341, 85342, 85343, 85344, 85346, 85347, 85348, 85354, 85357, 85358, 85359, 85360, 85361, 85371, 85387, 85390, 85501, 85502, 85530, 85531, 85532, 85533, 85534, 85535, 85536, 85539, 85540, 85541, 85542, 85543, 85544, 85545, 85546, 85547, 85548, 85550, 85551, 85552, 85553, 85554, 85601, 85602, 85603, 85605, 85606, 85607, 85608, 85609, 85610, 85611, 85613, 85614, 85615, 85616, 85617, 85618, 85620, 85621, 85622, 85623, 85624, 85625, 85626, 85627, 85628, 85629, 85630, 85631, 85632, 85633, 85634, 85635, 85636, 85637, 85638, 85639, 85640, 85643, 85644, 85645, 85646, 85648, 85650, 85655, 85662, 85670, 85671, 85736, 85901, 85902, 85911, 85912, 85922, 85923, 85926, 85928, 85929, 85933, 85934, 85935, 85937, 85939, 85941, 85942, 86021, 86025, 86029, 86030, 86031, 86032, 86033, 86034, 86039, 86042, 86043, 86047, 86054, 86401, 86402, 86403, 86404, 86405, 86406, 86411, 86412, 86413, 86426, 86427, 86429, 86430, 86431, 86432, 86433, 86434, 86436, 86437, 86438, 86439, 86440, 86441, 86442, 86443, 86444, 86445, 86446, 86510, 86520.

Appendix H: Glossary of Acronyms

AACHC- Arizona Association of Community Health Centers
ADHS- Arizona Department of Health Services
AHCCCS- Arizona Health Care Cost Containment System
AHRQ- Agency for Healthcare Research and Quality
ALTCS - Arizona Long Term Care System
AMA- American Medical Association
AOA- American Osteopathic Association
APHA- American Public Health Association
ARS- Arizona Revised Statutes
ATP- Arizona Telemedicine Program
AzAHEC- Arizona Area Health Education Center
AZHIN- Arizona Health Information Network
AzPHA- Arizona Public Health Association
AzRHA- Arizona Rural Health Association
BEMS- Bureau of Emergency Medical Services
BG- Census Block Group
BPHC- Bureau of Primary Health Care
CAH- Critical Access Hospital
CAP- Community Access Program
CBSA- Core Based Statistical Area
CDC- Centers for Disease Control and Prevention
CHC- Community Health Center
CIRC- Community Informatics Resource Center
CMS- Centers for Medicare and Medicaid Services
CON- Certificate of Necessity
CUP- Commitment to Underserved People
EMS- Emergency Medical Services
EMT- Emergency Medical Technician
FESC- Frontier Extended Stay Clinic
FHA- Federal Housing Administration
FPL- Federal Poverty Level
FQHC- Federally Qualified Health Center
HHS- U.S. Department of Health and Human Services
HPSA- Health Professional Shortage Area
HRSA - Health Resources and Services Administration
HSD- Office of Health Systems Development
HUD- U.S. Department of Housing
HSAG- Health Services Advisory Group
IHS- Indian Health Service
JCAHO- Joint Commission on Accreditation of Healthcare Organizations
MEZCOPH- Mel and Enid Zuckerman College of Public Health
MHC- Migrant Health Center
MHP- Mobile Health Program
MMA- Medicare Modernization Act
MUA- Medically Underserved Area
MUP- Medically Underserved Population
NHSC- National Health Service Corps
NIDA- National Institute on Drug Abuse
NIH- National Institutes of Health
NIMH- National Institute of Mental Health
NRHA- National Rural Health Association
OAT- Office of Advancement of Telehealth
OMB- Office of Management and Budget
ORHP- Office of Rural Health Policy
PCA- Primary Care Association (AACHC is the PCA for Arizona)
PCA- Primary Care Area
PCO- Primary Care Office (ADHS is the PCO for Arizona)
PHS- Public Health Service
RAC- Rural Assistance Center
RAED- Rural Access to Emergency Devices
RBHA- Regional Behavioral Health Authority
RCDI- Rural Community Development Initiative
RFA- Request for Application
RFP- Request for Proposal
RHC- Rural Health Clinic
RHO- Rural Health Office
RUCA- Rural-Urban Commuting Areas
RUPRI- Rural Policy Research Institute
SAMHSA- Substance Abuse and Mental Health Services Administration
SCHIP- State Children's Health Insurance Program
SHIP- Small Rural Hospital Improvement Grant Program
SORH- State Office of Rural Health
TMG- Tribal Management Grant
TOP- Technology Opportunities Program
UA- Urbanized Area
UC- Urbanized Cluster
USC- United States Code
USAC- Universal Service Administrative Company
USDA- United States Department of Agriculture

Appendix I: Quick Links

The following is a list of links to websites mentioned throughout this manual:

Arizona Association of Community Health Centers: http://www.aachc.org
Arizona Department of Health Services: http://www.azdhs.gov
Arizona Health Care Cost Containment System: http://www.ahcccs.state.az.us/site
Arizona Health Information Network: http://www.azhin.org
Arizona Hospital and Healthcare Association: http://www.azhha.org
Arizona Revised Statutes: http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp
Arizona Rural Hospital Flexibility Program: http://azflexprogram.publichealth.arizona.edu
Bureau of Primary Health Care: http://bphc.hrsa.gov
Centers for Medicare and Medicaid Services: http://www.cms.hhs.gov
Federal Agency Grant Opportunities: http://www.grants.gov
Federal Office of Rural Health Policy: http://ruralhealth.hrsa.gov
Health Resources and Services Administration: http://www.hrsa.gov
Indian Health Service: http://www.ihs.gov
Inter Tribal Council of Arizona: http://www.itcaonline.com
Mel and Enid Zuckerman College of Public Health: http://www.publichealth.arizona.edu
National Indian Health Board: http://www.nihb.org
National Rural Health Association: http://www.nrharural.org
Rural Assistance Center: http://www.raconline.org
Rural Health Office: http://www.rho.arizona.edu
Rural Information Center: http://www.nal.usda.gov/ric
U.S. Department of Health and Human Services: http://www.hhs.gov