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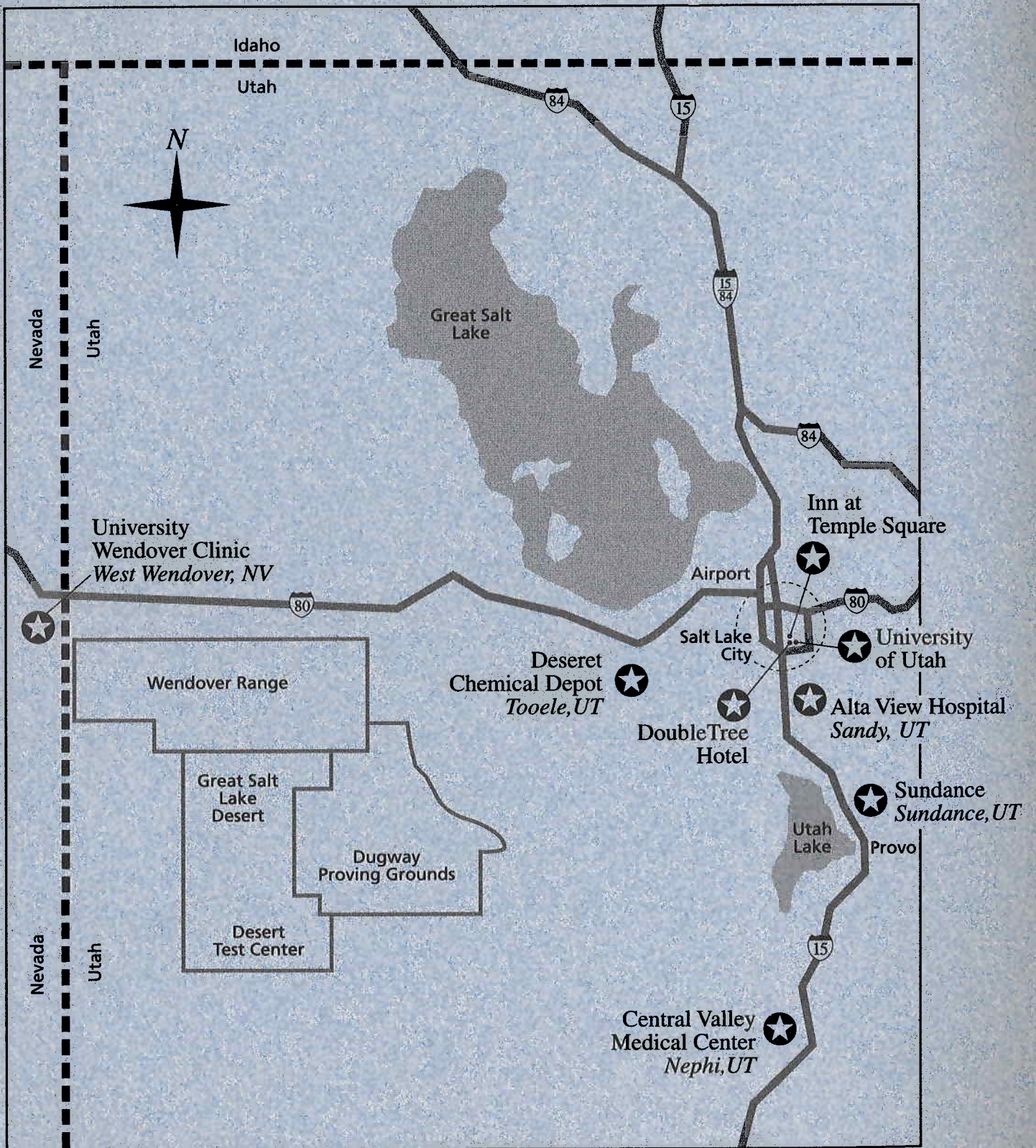
Essential Community
Health Services on
the Frontier

October 27-30, 1998
Utah & Utah-Nevada Border

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S I T E V I S I T R E P O R T



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Acknowledgments

The October 1998 *Essential Community Health Services on the Frontier* site visit was a sequel to a March 1998 trip to Philadelphia, *Providing Community-Based Care: Nursing Centers, CHCs, and Other Initiatives*. Both visits focused on safety-net issues, with the western trip serving as a frontier and rural counterpart to the urban Philadelphia visit.

The decision to go to Utah as well as to the border town of West Wendover, Nevada, resulted from a conversation early in 1998 between Marcia Starbecker, nurse consultant in the Department of Health and Human Services' Division of Nursing, Bureau of Health Professions, and NHPF Co-Director Karen Matherlee. Marcia was planning to participate in the Philadelphia visit, which included an examination of the city's strong nursing center sector in providing primary care to vulnerable populations in the city. Knowing the advance planning needed for a follow-up visit to Philadelphia, Karen was considering potential frontier sites. Marcia was familiar with the University Wendover Clinic, a nursing center in West Wendover that (aside from a-day-and-a-half-a-week prenatal clinic) was the only provider of health services in the community, and suggested the Forum take a look at the facility.

Both the W. K. Kellogg Foundation and Pew Charitable Trusts, funders of the Philadelphia site visits, had demonstrated interest in the themes of a frontier sequel. Responding to this interest, NHPF Research Associate Michael Anzick visited University Wendover Clinic and set the stage for development of a comprehensive site visit focusing on safety-net issues, with Kellogg Foundation and Pew Charitable Trusts support.

Numerous people in Utah, Nevada, and the District of Columbia provided valuable assistance along the way. Sue Huether, associate dean for clinical services, and Becky Nielson, departmental secretary, College of Nursing, University of Utah, helped significantly in setting up the nursing center segment, and Sue was a valuable resource on primary care issues. Kari Sagers, director of the emergency management department for Tooele County, advised on themes for and gave the emergency preparedness briefing. Deborah Turner, senior associate director of the Area Health Education Center, headquartered at the University of Utah, offered astute suggestions on experts to seek out, areas to explore, and themes to examine. Mark Stoddard, president, and the staff of the Rural Health Management Corporation helped organize the rural provider panel of the Central Valley segment and graciously hosted the event.

Judy Edwards, Indian health liaison in the Office of the Executive Director, Utah Department of Health, was particularly resourceful in providing both themes and briefing book materials on issues facing Indian tribes in Utah. Saul Ramos, director of Utah Farm Workers Health, Community Health Centers, Inc., helped form the panel on farm worker issues and provided information on migrant and new immigrant concerns for the briefing book.

In his capacity as director of the Bureau of Primary Care and Health Systems in the Utah Department of Health, Robert Sherwood, Jr., helped develop public health themes, while Wes Thompson, administrator and chief executive officer of Alta View Hospital, as well as the host of the panel discussion there, and Pamela Atkinson, vice president of mission services for Intermountain Health Care, were key to the unfolding of the case study of the system's public mission. Marian Bishop, professor and chair emerita of the Department of Family and Preventive Medicine, University of Utah, played a central role in shaping the workforce discussion.

All of those in Utah and Nevada who agreed to interviews, provided materials, made presentations, served on panels, hosted the group at health facilities, and gave in other ways of their time and expertise contributed significantly to the success of the site visit. Many thanks to those who are named and to those who are unnamed but deserve to be.

In addition to Marcia Starbecker, another Bureau of Health Professions staff member, F. Lawrence Clare, served as a key advisor on the visit. Deputy chief of the Special Projects and Data Analysis Branch (as well as deputy executive secretary of the Council on Graduate Medical Education) of the Division of Medicine, Larry offered themes and provided materials not only on workforce issues but also on Native American and emergency preparedness concerns. Shortly after the visit, he shared a concise summary of the trip that contributed to the preparation of this report.

Susan Bernstein, director of public affairs; Roberto Anson, public health analyst and director of the State Affairs of Rural Health Program; Thomas Morris, policy analyst; and Patricia Taylor, consultant, of HRSA's Office of Rural Health Policy also contributed ideas and documents. Others from HRSA's Bureau of Primary Health Care who helped in various ways included Jack Egan, acting director of the Migrant Health Program; Bonnie Lefkowitz, associate bureau director of Data Evaluations, Analysis, and Research; and Donald Weaver, assistant

surgeon general and director of the National Health Services Corps. Jessica Townsend, senior staff fellow in HRSA's Office of Planning, Evaluation, and Legislation, was also helpful.

Edward Grossman, assistant counsel in the Legislative Counsel's Office, House of Representatives, who joined Deb Turner in facilitating the final wrap-up, provided a final report of his and others' reflections. His efforts are much appreciated.

For NHPF staff, this was a team effort. Michele Black, publications director, joined Mike and Karen in developing the briefing book. She also oversaw the publication of this report, which was written by Karen, with assistance from Mike. Dagny Wolf, program coordinator, managed catering, lodging, and transportation details with her usual efficiency.

Thanks to all the Washington participants who cheerfully went from early morning to late at night taking part in briefings and discussions, as the "trans-Utah bus" put on 493 miles on October 28 and 29 alone. Along with Peter Pratt, vice president of Public Sector Consultants and evaluator of the Forum's W. K. Kellogg Foundation grant, the federal participants showed keen interest in the various aspects of safety-net services in frontier and rural Utah, interest the Forum would like to pursue in follow-up Washington meetings.

Judith Miller Jones
Director

Essential Community Health Services on the Frontier

BACKGROUND

The National Health Policy Forum (NHPF) took 22 federal congressional and executive health staff and a foundation grant evaluator to Utah and the Utah-Nevada border area September 27-30, 1998, to examine essential community health services on the frontier. The trip was funded by grants to NHPF from the W. K. Kellogg Foundation and Pew Charitable Trusts. The purpose of the site visit was to provide federal health staff opportunities to learn about the health care marketplace and health services for vulnerable populations through briefings from key public and private health executives, panel discussions, and visits to health care facilities. These occurred as the "NHPF bus" crossed from Salt Lake City to the Utah-Nevada border and back again and from the city south to the small community of Nephi, with stops along the way.

Following the site visit, the Forum sent detailed evaluation forms to federal participants, most of whom completed and returned them. NHPF also held a debriefing meeting on November 24, 1998, to gain additional perspectives from Washington participants about the site visit. Drawing on both the evaluation responses and the views expressed at the meeting, this report is a summary of impressions of the visit. It also reflects notes taken during the site visit and comments made by some participants during calls following up on evaluation responses. Some portions are reinforced by information provided in the site visit briefing book as well as in post-visit supplementary materials and comments of Utah and Nevada participants. The responsibility for the report belongs to the Forum.

THE UTAH HEALTH CARE ENVIRONMENT

In leaving the Washington, D.C., area to explore health delivery and financing in another site through an NHPF program, participants immerse themselves in the health care environment they are visiting. In this case, they experienced a political and social environment that has a dominant culture based on a common heritage and a tightly held set of core beliefs. This is a product of membership in the Church of Jesus Christ of Latter-day Saints, to which the majority of Utah's population belong. Members of the church began

arriving in the Salt Lake Valley in 1847 and, until the coming of the railroad in the 1880s, experienced about 40 years of relative isolation. They formed cohesive communities, working together to survive in a formidable climate.

Stemming from the state's pioneer heritage, individual responsibility is a core value. The family is viewed as the most important institution, followed in order of significance by the church and the local community. Solving problems within the family and the local community is generally believed to be the best approach. The state and federal governments are seen as less responsive, to be relied upon only in the last resort to solve problems. This approach to problem-solving is reflected in the reliance on local initiatives, the restriction on the role of the state government, and the resistance to expansion of federal influence (and preference for private-market solutions) that site visit participants saw during their travels in the state.

It is important to note that other points of view—even within majority organizations—and other cultures abide in Utah. Of the state's 1.7 million population, according to 1990 U.S. Bureau of the Census figures, 93.9 percent were Anglo. Persons of Hispanic, Asian/Pacific Island, Native American, and African American origins made up the rest. At the time of the Mormon settlement, Native Americans—at 20,000—were in the majority, but dwindled to 11,273 by 1970. In the next 20 years, they nearly doubled (to 24,283, composed of 15,717 urban and 8,566 reservation-based, according to census figures). Drawn by the state's booming economy, newcomers from other parts of the West and the rest of the United States, as well as from foreign countries, are settling in the state. Hispanic immigrants, particularly, are a rapidly increasing minority.

Even more cultural and religious diversity is projected in the next decade, during the first part of which Utah plans to open to the world as host of the 2002 Olympic Winter Games. The existing tensions over diversity issues are likely to increase as well. In a state that is relatively well off by national standards, as reflected by its unemployment rate, percentage of uninsured, and other measures, the expectations of those who do not do well by these measures, who are not fully accepted in the dominant culture, and/or who have different core values are sharply defined, leading to demands on the state's public and private institutions and on the federal government as well.

Health Systems

While there are several health care systems in Utah, Intermountain Health Care, Inc. (IHC), is clearly dominant. Spun off from the Church of Jesus Christ of Latter-day Saints in the mid-1970s, IHC is one of the top 10 secular not-for-profit health care systems in the nation. It operates 23 hospitals, three of them located in Idaho and Wyoming and most of the rest clustered in the population centers along Utah's Wasatch Front (a 200-mile long mountain chain that runs from north to south in the upper half of the state), with some in rural areas of the state. IHC Health Plans, made up of IHC's health maintenance organizations (HMOs), has 429,000 enrollees. The HMOs are Health Choice, IHC Care, IHC Access (Medicaid), and IHC Group (Selectmed). (The Internal Revenue Service [IRS], contending that the HMOs operate like for-profits, is challenging IHC Health Plans' 501[c][3] tax exemption.) Because IHC's commercial plans have 50 percent of the market, the system influences various aspects of health delivery and financing in the state. For example, IHC's withdrawal from Medicare+Choice, Medicare's managed care option mandated by the Balanced Budget Act of 1997, is expected to have a strong impact on the Medicare program's capacity to offer choices in the state.

The next largest player in the marketplace is the University of Utah Hospitals and Clinics system. Its facilities include the University of Utah Hospital, located in Salt Lake City, and 50 general and specialty clinics for outpatients. The hospital and clinics are part of the University of Utah Health Sciences Center. The only academic health center (AHC) in the state, it is the center not only for clinical services but also for health professions education and biomedical research.

There are two other significant players in the marketplace. Columbia/HCA Healthcare Corporation operates seven hospitals and Paracelsus Healthcare Corporation runs two. In addition, there are several smaller systems with facilities in the Salt Lake area, including Community Psychiatric Centers, Pioneer Healthcare, Healthsouth Corporation, Champion Healthcare Corporation, and Ramsey Healthcare, Inc.

Health Plans

Seven health plans, offering products ranging from indemnity to closed-panel HMOs and Medicaid managed care plans, operate in Utah. Currently, 60 percent of Utah residents are enrolled in commercial managed care plans, with 38 percent in HMOs and 22 percent in preferred provider organizations (PPOs). When beneficiaries in Medicaid managed care are added, 66 percent of the population is enrolled in managed care. Medicaid managed care plans are offered by IHC, United HealthCare of Utah, University of Utah Hospitals and Clinics, Altius Health

Plans, and American Family Care. Health plans offering indemnity, PPO, HMO, and point-of-service (POS) options are IHC, Regence BlueCross BlueShield of Utah, United HealthCare of Utah, and CIGNA Healthcare of Utah, Inc. FHP, Inc., and Intergroup Utah, Inc., offer only HMOs. Eastern Utah Health Plan, Inc., a physician-hospital organization affiliated with the Columbia Castleview Hospital and the Emery Medical Clinic, also operates in the state.

Other Providers

The state also has some freestanding providers, mainly hospitals, that are operated by a government agency, independently, or as part of a small group of independent hospitals. These facilities include Beaver Valley Hospital, Gunnison Valley Hospital, Kane County Hospital, Milford Valley Memorial Hospital, San Juan Hospital, Tooele Valley Regional Medical Center, Monument Valley Regional Medical Center, Salt Lake Regional Medical Center, Central Valley Medical Center, Shriners Hospitals for Crippled Children, Utah State Hospital, Uintah Basin Medical Center, Fort Duchesne Indian Health Center, U.S. Air Force Hospital, and Veterans Affairs Medical Center.

Safety Net Providers

Entities that primarily provide health care services to medically underserved and vulnerable populations include community health centers (CHCs), migrant health centers (MHCs), rural health clinics, and district and county and county/city public health departments. There are numerous facilities within each category, with 13 CHCs, six MHCs, 15 rural health clinics, and six district public health departments as well as six county and city/county public health departments. There also are some solo practitioner or small-group practitioner offices that cater to the medically underserved. In addition, there are community agencies, such as the Wasatch Homeless Health Care Program, and special programs, including "Baby Your Baby" (a prenatal care program) and the state Child Health Insurance Program (CHIP), which provide support to targeted populations.

Concentration of Resources on the Wasatch Front

Although the site visit focused on frontier and rural essential community services, it highlighted the differences between the Wasatch Front, the area including and around Salt Lake City, where most of the population and the resources are concentrated, and the rest of the state. In fact, it included a trip to Wendover on the Utah-Nevada border in order to show the dearth of people and infrastructure to the west of Salt Lake City and to indicate the outreach of

the University of Utah—located in Salt Lake City—in the form of a nursing center clear across the state.

The briefings and panel discussions centered on these differences. From the opening comments, in which “frontier” was defined, to the subsequent policy discussions, the discrepancy between the populous and endowed and the isolated and sparse was stressed. Health facilities, health practitioners, and public and private health and health professions programs all seemed to be concentrated in an area that is relatively small compared to the rest of the state. That made it difficult to gain an in-depth perspective of the frontier; time and distance barriers allowed only a snapshot, taken as participants ventured from Salt Lake City west and then south and then returned to the city.

But certain challenges seemed apparent: the dominance of IHC in terms of both competition from other systems and choices for practitioners, the underpricing of the health care market, the threat of rising premium costs to private health insurance coverage, the future of managed care (and the alternative, if it fails), the need for a continuing supply of physicians, the strains on the University of Utah AHC, the uneven distribution of the uninsured (much lower in the Wasatch Front but rising to approximately 17 percent in rural areas), and the influx of new residents. These are reflected, in one way or another in the impressions that participants took away.

IMPRESSIONS

Following are some of those impressions:

■
A definition of “frontier” is evolving that sharply distinguishes it from “rural,” giving rise to various policy considerations.

Distinctions between “frontier” and “rural” emerged during the opening briefings and occurred repeatedly during the site visit, as federal participants sought both their geographic and experiential bearings. They came away with the strong impression that “frontier” significantly differs from “rural,” which is the term—along with “nonmetropolitan”—used by the federal government to govern various policy decisions. Coming from the East Coast, they also gained a sense of frontier as “wide open spaces.” For instance, Tooele County (home of the chemical weapons storage site), which they crossed on the way to Wendover, is nearly 40 percent larger than the entire state of Connecticut.

The opening presenter offered a matrix to serve as a tool for designating an area as “frontier.” Based on a point system, it graded population density in terms of persons

per square mile, distance in miles to a service/market, and time in minutes to a service/market (with documentation of weather, geography, and seasonal considerations). This matrix—and normative definitions of “frontier,” such as rural areas west of the Mississippi River—raised questions regarding the appropriateness of treating frontier and rural areas similarly in implementing public programs, such as Medicare prospective payment, initiatives based on health professions shortage area designations, and CHIP.

In distinguishing between “frontier” and “rural,” participants also debated the application of the label “frontier”: Is Wendover truly frontier? Is Nephi? In seeking criteria for definition, federal and Utah participants alike looked at grass-roots acceptance of health delivery and financing models, in addition to density, distance, and time measures. For example, is the University Wendover Clinic an urban model of care because it is an outreach initiative of the University of Utah College of Nursing? Or, is it a frontier service model because it responds to the needs of the community and has acquired community ownership, without which it could not succeed?

■
Utah is a study of extremes, with strong implications for the delivery and financing of health care. Both people and resources are concentrated in the Wasatch Front, with Salt Lake City serving as a government, religious, transportation, economic, and health care center for all of Utah. Aside from the Cache and St. George areas, which are also becoming population centers, the rest of the state ranges from rural to frontier.

Participants came away with mixed images of Utah. Based on the concentration of people and resources in the Wasatch Front, they saw Utah as highly urban and suburban. The four counties—Weber, Davis, Salt Lake, and Utah—that comprise Salt Lake City and areas to its north and south have nearly 80 percent of the state’s population but only slightly more than 4 percent of its area. Based on the dearth of population and infrastructure to the west of Salt Lake City and to the south of Utah County (below Salt Lake City), participants viewed Utah as rural to frontier. If time had allowed them to travel to the counties—most of them frontier—in the southern half of the state, they most likely would have gotten another perspective.

For some participants—particularly those who had taken part in other NHPF site visits—Utah confirmed that health delivery and financing responds to local and, in some cases, regional needs. As one participant commented, “To see one area [whether it is frontier Utah or

border El Paso] is to see one area." In terms of this visit, the overwhelming impression was of an urban center, Salt Lake City, that has most of the resources, with other parts of the state operating "catch as catch can."

As the state capital, Salt Lake City is the government center. As the headquarters of the Church of Jesus Christ of Latter-day Saints—to which 80 percent of the citizens of Utah belong—as well as the location of historic Temple Square, it is the religious center. As the hub of the east-west and north-south interstate highways—Routes 80 and 15, respectively—as well as of air and rail travel, it is the transportation center. As the base for most commercial activity, it is the center of the professional and business community. As the location of the Utah Department of Health, of the home office and major facilities of the dominant IHC system as well as of other health systems, of the University of Utah Health Sciences Center, of most physicians who practice in the state, of the medical society, of the hospital and health system association, and of the primary care association, it is the health care center.

The only other population centers are Cache County to the far north, bordering Idaho, and Washington County, a retirement community to the far southwest. But they lack the population density of Salt Lake City, which is more than 500 persons per square mile. Most of the state has fewer than 10 persons per square mile, a contrast—in the extreme—that poses various health care delivery and financing challenges. For example, with major employers located in the Wasatch Front—in a state in which 80 percent of employment is in service industries—the basis for insurance outside this highly populated area is in question. As managed care models—health maintenance organizations, preferred provider organizations, and independent practice associations—take hold in the Wasatch Front, the efficacy of such models in frontier settings is in doubt. With resources concentrated in the front, the extent of the safety net in the rest of the state is uncertain. A key question is, Who is responsible for building and maintaining it?

■

Because the economy is doing well, concern varies about access to as well as affordability of care. There is recognition, however, that the market is underpriced, which is a challenge to insurers and providers alike. There is some concern about the impact of a downturn in the economy on the availability, cost, and level of services for vulnerable populations.

Participants heard from several panelists that times are good—in fact, the economy has never been better, as

measured by unemployment, growth of real wages, and similar factors. Percentage-wise at least, the good times are reflected in the percentage of those without health insurance: currently, an estimated 10 percent to 12 percent overall, compared with a U.S. figure of approximately 18 percent. Moreover, participants saw for themselves the building boom—business, home, and highway construction, the latter in large part in preparation for the upcoming Winter Olympics—in Salt Lake City and its surrounding suburbs.

Although the economy has thrived over the last decade, there is concern—and some preparation for—a downturn. The extent to which the state is dependent upon the public sector, as reflected in the large amounts of military and park land under the control of the federal government, and upon the service sector, much of it existing because of tourism, came out in discussions of the economic marketplace in general and of the health marketplace in particular.

Much of the concern rests on the health market's being underpriced, with increases of 10 to 20 percent expected in the near future. Private and public payers' concerns about rising costs threaten health coverage, particularly in terms of employers' worries about paying higher premiums. Participants learned that Utah is, in some ways, a victim of its own success at cost-efficiency; for example, its Medicare capitation rate—adjusted average payment per capita (AAPPC)—of \$380 per month in Medicare managed care is the second lowest in the nation. (A Data Advantage Corporation survey released after the visit ranked Utah the seventh "cheapest per case" state in the nation for Medicare inpatient treatment, according to the December 1998 issue of *Hospitals & Health Networks*.) The state's rankings are in part due to the historic cost efficiency of IHC and Blue Cross/Blue Shield in keeping costs down, one panelist commented, adding that, under Medicare's new Medicare+Choice managed care initiative, plans would be hard-pressed to provide extra benefits in order to entice enrollees away from fee-for-service Medicare.

■

Workers who are uninsured (many working for small employers and/or on a part-time basis) and underinsured (some with poor benefits and/or high co-payments) join the indigent in posing challenges to the safety net.

While there was much talk about "good times," there also was a lot of concern about Utah residents—especially the working poor—who lack health insurance. In focusing

on the uninsured, participants tended to single out males 18 to 34 years of age, who tend not to qualify for Medicaid, which targets low-income women and children, and are too old for the new CHIP initiative, which targets younger persons. They also centered on employers in the service sector, who are more likely than other employers to hire part-time workers and not to offer health insurance to their employees.

Although Utah's uninsured rate, as already mentioned, is lower than that of the nation as a whole, it is increasing. Particularly affected are certain pockets of vulnerable people—migrant workers and “settled out” farm workers and other new immigrants, for instance—who tend to be uncovered. Moreover, there are persons who are underinsured, whether in terms of certain services, varying periods of time, or high co-pays. There are also those people who may have coverage but lack access due to where they live, such as in isolated frontier areas.

■

In a state that is resistant to federal control, CHIP is popular, in part because the state has flexibility for design and implementation. There are claims, however, of federal bias against categorical programming (and preference for Medicaid expansions) and calls for more flexibility in administrative budgeting, collection of data, outreach, and coordination of the child health insurance initiative with other benefits.

From various quarters, participants picked up considerable enthusiasm in the state for CHIP. The program seems to be popular because local political leaders had the responsibility of designing a program that reflects their own cultural and political values and of setting up the necessary infrastructure to make it work, instead of following a federal mandate. Lack of health insurance for children is viewed as a community problem that can best be solved by using a community-based approach. Utah's CHIP program is based on this assumption even though it is lodged in the Utah Department of Health. The program's bureaucratic roots are downplayed and community outreach is highlighted, in the hope that identifying and covering children without health insurance can help them get—and stay—healthy and can, in the long term, benefit both them and the communities in which they live.

Outreach efforts have relied heavily on community organizations to get the message out. Participants heard that communities in the state are generally cohesive and organized, and entities such as schools and churches have

been particularly good at informing the public about the new program. Community and migrant health centers, local health departments, tribal councils, and the Utah Hospitals and Health Systems Association have also been effective means of educating the public.

Participants also heard about the state's desire to distinguish CHIP from the Medicaid program to lessen any welfare stigma. The program is being marketed as serving “working” families. The “Baby Your Baby” program—a means-tested, prenatal care initiative that also is administered through the Utah Department of Health and does not have a public welfare image—was cited as a model for how the state wants the public to perceive CHIP.

Participants also gained a sense of CHIP issues that are frustrating to the state. In keeping with Utah's philosophy of favoring local over federal control, the state chose to maximize its flexibility by designing a plan using a state-only approach and perceived that it had been required to jump a significantly greater number of administrative hurdles to get federal approval than those states that had opted to use a traditional Medicaid-expansion approach. Other issues of concern to the state were perceived inadequate budget allowances for administrative costs—particularly during start-up years—as well as data collection requirements and coordination of CHIP with other benefits.

Despite its popularity with the public, the program concerns the three managed care organizations who are participating in the program. Dubious about accepting risk for a relatively unknown population in a capitated environment, they agreed to contract with the state to provide CHIP services. Whether the health plans will continue to contract with the state is an open question that will depend upon the claims they receive. Participants gained the impression that, if the costs are too high, plans may pull out of the market, as has happened with the Medicare+Choice program.

■

Homelessness seems to be more of an urban than a frontier or a rural problem. As such, it appears to be growing, challenging both the private and public sectors to develop prevention strategies; form partnerships to provide services; and accomplish related goals, such as keeping the hospital emergency room from being an entry point for primary health care.

Whether it was due to the organization of the visit or to the concentration of homeless persons in Salt Lake City, where the services are also located, participants for the

most part saw homelessness as an urban problem. Therefore, homelessness did not figure significantly in discussions of frontier and rural services. In contrast, in the earlier site visit to Philadelphia on essential community health services, homelessness provided a prevailing theme.

In Salt Lake City, Wasatch Homeless Health Care, Inc., is a major center for provision of primary and other services—in shelters and camps as well as on the streets—for adults and children who are homeless. The program is supported by IHC and by federal Stewart B. McKinney Act health care for the homeless funds, among other sources. In 1997, the Wasatch program served 6,500 persons.

Given IHC's involvement with Wasatch Homeless Health Care, the panel discussion on IHC's outreach to vulnerable populations focused in part on the need for prevention of homelessness; private-public initiatives centered on homeless services; and effective ways of providing preventive, primary, first-aid, and other care. Because diabetes, pneumonia, and high blood pressure are frequent health problems of persons who are homeless, outreach emphasizes screening for these illnesses. Moreover, because 37 percent of the homeless persons in the area are diagnosed with mental illness and many have substance abuse addictions, mental health and drug treatment are factors as well. Given the significance of drug use, prevention of HIV is stressed, too; for example, users are provided with bleach kits.

Public and private health and social services organizations, such as Child and Family Services and the Salvation Army, also join in partnership to provide prevention and care. A major effort, participants learned, is to reduce emergency room admissions—25,000 of which could have been handled by more cost-effective providers last year in Salt Lake City alone—by establishing more appropriate intake points for persons needing primary care and other nonemergency services. Because homeless persons, along with many others who lack health coverage, tend to go to—or be transported to—hospital emergency rooms, the shelter, camp, and street outreach seems to be having a positive effect.

■

There are several organizational models for addressing the needs of vulnerable populations in frontier and rural areas for essential health services: the nursing center, solo or small group practice, migrant health center, rural health clinic, and community health center. Because of the scarcity of providers in rural and frontier Utah, competition among providers is fairly low.

Competition among the models themselves, however, seems fairly high.

Because the need for essential health services in frontier and rural Utah is so great, the competition among individual providers—the nursing center, solo or small group practice, rural health clinic, migrant health center, and community health center—was not readily apparent to participants. Following up on tours of nursing centers in the earlier Philadelphia visit on essential community health services, the group went to University Wendover Clinic on the Utah-Nevada border. A nurse-managed center—linked to the University of Utah's College of Nursing—in which five nurse practitioners provide health services and have clinical rotations for 40 to 70 nursing students a year, University Wendover Clinic not only offers preventive and primary services but also serves as an emergency and trauma unit. Last year, it arranged for 860 ambulance runs and 235 air transport flights. Through a "telehealth" program, it has links to specialists, who also are available through referral.

Although participants did not visit a solo or group practice, they learned that 10 percent to 25 percent of physicians in the state are still in solo practice and that, in frontier and rural areas, 25 percent to 30 percent are "going solo." Relative to group practice, 66 percent of all physicians who practice in the state are members of groups with fewer than 30 members. Given the dominance of IHC, which provides services to more than half the population of the state, these percentages seemed high. Sometimes the practice includes other clinicians, such as nurse practitioners and physician assistants. A panel member, for instance, who is a solo practicing physician employing advanced practice clinicians (and operator of two offices that have rural health clinic designations), indicated that he was in the process of broadening his practice to include another full-time physician.

Just as there seem to be clear links between frontier and rural practices and rural health clinic designations, there are historic connections between migrant health services and community health centers. There are four CHCs in Utah that the Association for Utah Community Health lists as rural: Carbon Medical Service Association, Enterprise Valley Medical Clinic, Green River Medical Center, and Wayne County Medical Clinic (whose director was on the site visit panel on rural providers). In 1997, the four served 42,602 persons (in 138,943 encounters): 18.3 percent under Medicaid, 5.7 percent under Medicare, 19.6 percent under private insurance, and 56.4 percent uninsured. Participants learned that the relatively low permanent populations of the centers' catchment areas are swelled by tourists, who, due to accidents and other health problems, turn to the centers for services.

The association classifies Clinicas de Buena Salud, a migrant health center, under special populations. The clinic had 1,939 users—70 percent needing interpretive services—in 1997; 11.2 percent were under Medicaid, 15.5 percent under Medicare, 38.5 percent under private insurance, and 34.8 percent uninsured. The total of migrant and seasonal farm workers in Utah, according to Utah Farm Workers Health, was 10,210, including nonworking dependents. Providers and farm worker representatives alike emphasized that agricultural workers tend to be cash payers, whether for deductibles and co-pays or for the services themselves. Participants also heard from a family practice that had just started providing farm worker health services and from a rural health clinic system with outreach to former farm worker immigrants who had “settled out.” Cross-fertilization of essential community provider “types” appeared fairly common.

Although there seemed to be collaboration and overlap among the models, each seemed to have its proponents. Competition seemed to focus on whether the model represents outreach from an urban center or is a grass-roots initiative, what kind of provider base it has (for example, physician- or nurse-run, system or individual ownership), and how it is supported (for example, federal, state, local, or university). Participants struggled with various questions—some of which are discussed later and some of which remain “lingering questions”—involving this competition.

■

Essential community providers must maintain capacity despite problems in getting capital, malpractice insurance, assistance with pharmaceutical supplies, and a reliable supply of practitioners, as well as difficulties caused by fluctuations in population (for example, tourist flows) and other factors.

“Economy of scale” was a constant refrain during the visit, as both public and private essential community providers mentioned difficulties in being small players in a health marketplace that is increasingly geared to large players. Access to capital for construction and improvement of facilities as well as for purchase or leasing of equipment is a major factor. For example, for nursing centers and CHCs, as well as for systems such as Rural Health Management Corporation, capital is a major concern. It explains in part why the University Wendover Center is linked to the University of Utah, why some CHCs look to IHC for assistance, and why Rural Health Management Corporation has gradually absorbed several cash-poor rural hospitals.

In terms of operating costs, malpractice insurance, especially for providers offering prenatal care and obstetrical services, was mentioned often. Moreover, as public payers (such as the Veterans Health Administration and Medicaid) and private systems (such as IHC) get discounts on pharmaceuticals, some essential community providers who do not get them pointed to the need for them to do so. In fact, developments in the pharmaceutical industry, such as discounts under mass-purchasing or shared-service arrangements, pharmacy-benefit management, and disease management, seem to figure largely in the evolution of health care delivery.

Difficulty in attracting and retaining practitioners, while addressed more specifically in the visit’s workforce discussions, also is an ongoing problem. Despite an oversupply of physicians and other practitioners in some areas of the country, the supply and distribution of clinicians in frontier and rural Utah worry providers. One panelist mentioned that Utah, despite having a major health sciences center with medical, nursing, and allied health professions units, is a net importer rather than an exporter of health practitioners.

■

Paying the costs of graduate medical education (GME) is a growing problem in Utah. Teaching hospitals—including the University of Utah Hospital, which is linked to the state’s only medical school—receive less than the national average per resident from the federal government under Medicare, have difficulty competing with other educational interests to get state dollars for medical education, and are gradually losing private (especially for-profit) health sector support for residency programs.

Participants’ perspective on health workforce issues was influenced by GME concerns. In a state that is a net importer of the physicians who practice within its borders, the University of Utah AHC is the health professions education, tertiary health service, and health research center. Its effectiveness in attracting, training, and retraining physicians as well as in teaching medical students and residents clinical services across a continuum from primary to specialty care is linked to the GME support that it receives from various quarters.

In addition to University Hospital, the LDS Hospital, Primary Children’s Medical Center, Salt Lake Regional Medical Center, and Veterans’ Affairs (VA) Medical Center (all in Salt Lake City) and McKay-Dee Hospital Center in Ogden train residents. Aside from the VA’s facility (whose

costs are calculated separately), the teaching hospitals receive less, on average, per resident slot from Medicare than like institutions in the rest of the country. In 1995, for example, they gained an average of \$47,280 per resident, compared to a U.S. average of \$60,000.

For the AHC, underfunding of GME costs has become a critical problem. Because GME costs are linked to the provision of clinical services under the Medicare program, the AHC contends that it is being penalized for its—indeed, the provider community's—efficiency in providing cost-effective care. Moreover, the AHC cannot count on state subsidies. Although the University of Utah is a state institution, it appears to be “a state university that is not state-supported.” It is hard-pressed—in a state with the highest birthrate in the nation—to compete with primary and secondary education for funding from the state legislature.

In terms of GME funding, the AHC has never relied heavily on public support, reflecting the prevailing view in the state that it should follow a course of self-determination, with support from the private sector. But the state legislature seems to be taking a new look at providing support, especially now that it has established a Medical Education Council to provide focus and guidance.

Similarly, the AHC is experiencing a withdrawal of support from private systems. As for-profit health plans leave the state or cut back on adjustments—such as GME—that affect their profit margin, the AHC must rely on the not-for-profit sector, most conspicuously IHC, for support.

Squeezed on the clinical care side by low payment rates and on the subsidy side by adverse factors, the AHC has little room in which to maneuver. Its position is complicated by its being the only AHC in Utah and its serving two adjacent states and one nearby state that have no AHC at all. Moreover, it is pressured by the need to maintain quality standards, such as Residency Review Committee minimums for its residency programs. This has caused it to examine its situation carefully and to look at innovative solutions, in an environment in which both Congress and the Clinton administration are considering GME reforms.

■

Several institutions based at the University of Utah—the Area Health Education Center (AHEC), the College of Nursing, and the School of Medicine—have developed approaches to overcoming frontier barriers. Their outreach activities link the health science center to delivery of care in frontier areas of Utah and adjacent states.

Participants got the impression that the AHEC, started in 1995 with support from the Utah state legislature, has an aggressive agenda relative to health services for underserved populations in frontier and rural Utah. Headquartered at the University of Utah, with local offices in or projected for four quadrants of the state, the AHEC partners with various public and private organizations, such as essential community provider organizations and university health professions units. It emphasizes recruitment, training, and continuing education for health professionals (primary-care physicians, advanced practice nurses, and physician assistants); workforce planning; special problems, such as shortages of health professionals in certain areas; and improvement of primary care education. Among its special efforts are clubs, workshops, and other activities exposing junior-high and high school students to health professions careers. Others include site rotations in AHEC sites in underserved areas for nursing, medical, and pharmacy students.

In addition to its baccalaureate and master's degree programs, the College of Nursing has a rural outreach family nurse practitioner program, a nurse-midwifery program with a rural outreach initiative, and a gerontology center. It also provides distance learning for 30 nurse practitioners in rural areas, so that they can live in their home counties and come to the university for short training experiences. The college also includes an Office of Community Service to provide opportunities for continuing education for practicing nurses. “Traditionally, nursing has links to the underserved,” one panelist commented, responding to remarks by another panelist that nursing had taken the lead in reaching out to frontier and rural communities in the state.

The School of Medicine, especially the Department of Family and Preventive Medicine, is strengthening its outreach to frontier and rural communities. The admissions department has changed its criteria in order to recruit more students from rural areas. The department has shifted from a curriculum based on tertiary care to one oriented to primary services. The family practice residency has a rural track and new initiatives are being developed. One is a community-based residency program that emphasizes training family physicians to serve rural areas. Another is support for physicians in practice.

■

Intermountain Health Care, Inc., is a standard-setter for the provision of health services throughout the state. Because of its reputation and size, it is the reference point for actual and potential competitors as well as for providers throughout the state. Its position, compared with health systems in other areas NHPF has visited, seems unique.

IHC, a nonprofit integrated health system, was established in 1975, when the Church of Jesus Christ of Latter-day Saints divested itself of 15 hospitals. Since then, the community health care system has grown to include 23 hospitals, as well as physicians and health plans. Participants heard again and again that IHC is the dominant system in the state—as insurer through its managed care plans, as provider of services, and as supporter of community agencies that promote wellness and access to services for vulnerable people. IHC is the benchmark for other insurers, providers, and charitable groups in the state in the quality as well as the volume of services.

The subject of an 1994 Utah Supreme Court decision on the tax-exempt status of its nonprofit hospitals, IHC provides charitable benefits far in excess of its \$12 million potential annual property tax liability, according to a panelist at a discussion at IHC's Alta View Hospital in Sandy. (As indicated earlier, the IRS is now questioning the tax exemption of IHC Health Plans.) Participants heard about the system's Healthy Sandy Partnership, a community initiative focused on wellness. They heard about its support of Wasatch Homeless Health Care, the center of its initiatives for the homeless. They heard about its provision of capital and operating funds to Mountainlands Community Health Center in Provo and grants to other CHCs. They heard about its contributions to school-based health and its funding for services for Native Americans and other targeted vulnerable populations. Not only at Alta View but throughout the visit, they heard comments about IHC's charitable mission. (While NHPF has a policy of not singling out—or quoting—individuals in its site visit reports, it would be remiss if it did not mention that participants came away from Utah commending IHC Vice President for Mission Services Pamela Atkinson for her personal as well as organizational commitment to IHC's charitable endeavors.)

Participants also received a less benign assessment of IHC—as a benevolent giant some like to hate. Due to its size (it has facilities in urban, suburban, rural, and some frontier areas of the state) and strength, it draws ambivalent responses. Because IHC provides services to over half the “covered lives” in Utah in a cost-effective way according to high quality standards (as indicated by fans and critics alike), other systems find it a formidable presence in the health care marketplace. Some have moved into the Utah market in the past few years and then backed out, attributing their failure to IHC's dominance. This may mean, according to one commentator, that “Utah may not have a competitive market in five years.”

Physicians, 80 percent of whom participate in IHC panels, are concerned about IHC's dominance, with some seeing it as reducing their options. For example, some of those who remain independent think that their only other

choice would be to become employees of IHC. At the same time, there is clear acknowledgment of IHC's influence on the way physicians practice and on the quality review of physician performance.

The greatest compliment paid IHC was its depiction as the system “around which others have to plan.” Described as well-managed, “absolutely debt-free,” innovative in its adoption of quality systems, and oriented to the communities it serves, it obviously is both standard- and pace-setter, locally and regionally as well as nationally.

■

The University of Utah—in addition to Intermountain Health Care, Inc.—is positioned to provide “safety-net services.” Along with IHC, its academic health center was singled out—and praised—for the nature of its responses.

Along with IHC, the University of Utah is a prominent provider of safety-net services. Praised as a “world-class” academic health center, the university was described as helping to staff Wasatch Homeless Health Care; of joining with IHC in caring for indigent persons in its facilities; of addressing the need for services in rural and, to some extent, frontier areas of the state; and of having outreach initiatives (such as the College of Nursing's University Wendover Clinic).

■

Being an independent health care organization in a rural or frontier area involves “economy of scale” issues: having the capacity to provide a range of services, paying for malpractice insurance and other costs of doing business, maintaining cash flow, gaining capital to improve or add new facilities and equipment, attracting and retaining practitioners, and developing data and information resources.

Participants received stark lessons on economy of scale in Utah: the dominance of the large IHC system, the concentration of resources in urban and suburban areas and in communities on the major highways radiating from Salt Lake City, and the difficulties of being a small player. While a great deal of lip service is given to grass-roots models, such models find it difficult to establish themselves and to survive in marketplaces in which the demand for any given service is small and in which the costs of doing business—such as malpractice insurance—may not be justified for certain services (such as obstetrics). Maintaining cash flow, due to slowness in payment from

both private and public insurers and high bad-debt and charity caseloads, may also be a problem. Such models also are more vulnerable to economic downturns and to changes in payer policy (such as changes in federal Medicare and state Medicaid payments) because of these cost, cash flow, and associated factors.

For small operators, capital may be difficult or impossible to obtain from the financial markets, and tax-exempt bonds may be problematic as well. Moreover, attracting and retaining physicians and other practitioners are challenges for a host of reasons, including financial, peer support, lifestyle, and other considerations. And getting and monitoring the data essential to marketing to private plans as well as dealing with public payers may be burdensome, putting the provider at a competitive disadvantage. Whether in drawing members of private plans or in attracting beneficiaries of public programs, the independent hospital or small health system may also have an image problem; those members of the community who can bypass it by may do so because of the sense that it is not as good as the urban AHC or the big system facility. Moreover, federal regulations may lack flexibility—an example cited is the inability of a hospital to utilize “swing beds” (beds that shift from acute to long-term care, depending upon community need) if it has a distinct-part skilled-nursing facility.

■

The National Health Service Corps (NHSC) is credited with bringing practitioners to underserved areas, whether in urban, rural, or frontier areas of the state. As a loan repayment (as well as scholarship) program, it seems to be contributing both to the provision of health services to vulnerable populations and to facilitation of public service careers for health practitioners.

The NHSC, the federal loan repayment and scholarship program, was described as having 52 participants in the state: 48 loan repayment, three scholarship, and one assignment. Of those, most have medical degrees and the rest are dentists, physician assistants, and advanced practice nurses. Participants heard that loan repayment seems to result in higher retention of primary care practitioners because scholarship students are more apt to want to enter a specialty rather than primary care after having accepted the funds.

From a provider point of view, the NHSC makes available practitioners for CHCs and other safety-net settings that are vital to their survival in a state in which there is an inadequate supply of primary care practitioners.

From a physician point of view, NHSC loan repayment facilitates the choice of primary care practice as a career and provides a base for working with vulnerable populations.

While the NHSC program may not be as critical in Utah as in some other states, it appears to have a lot of support. Utahns seem proud that the current director of the NHSC, Donald Weaver, M.D., fulfilled part of his own NHSC commitment at Tooele Valley Healthcare System.

■

Utah is a leader in telehealth, in part because of the extremes in the state (concentration and scarcity of resources) and in part because of the needs of people in isolated frontier areas outside the Wasatch Front.

Telehealth (or telemedicine) seems ideally suited to a state in which 80 percent of its population lives in 4 percent of its land mass, its proponents contend. Certainly, the Utah TeleHealth Network is a national model. A partnership of the University of Utah, the Utah Area Health Education Center, the Utah Department of Health, and rural hospitals, it has video and data sites throughout the state, including at University Wendover Clinic on the Utah-Nevada border.

During participants' visit to University Wendover Clinic, a dermatologist at the University of Utah and a nurse practitioner at the clinic held two sessions on interactive video. Using volunteers from the group who had skin problems, the clinicians uncovered a likely case of skin cancer and an inadequately treated dermatitis. Both volunteers were referred to their home physicians for follow-up.

Although participants were caught up in the technology, they found some perplexing barriers. These include licensing of practitioners (because the telemedicine site is on the Nevada side of the border, clinicians have to be licensed in both Nevada and Utah), communications technology and costs, reimbursement or payment amounts, and bundling of patient services. Moreover, they learned that nonprocedural specialties and certain services—for example, nutrition—were better suited to the technology. On the bus ride to Nephi, participants saw a telehealth interview involving an Indian Health Service (IHS) nurse practitioner, a child who was suspected of being abused, and a pediatrician. Child protection and other social services also seem suited to the use of telehealth. Certain sites appear well-suited, too. Due to the difficulties inherent in moving and securing prisoners, penal institutions were cited as an example.

■

State barriers—for example, practice laws and fees—hamper the provision of health care to vulnerable people.

Often during the visit, participants heard of state barriers to practice. Because the states have jurisdiction over physician and nurse practice laws, partnerships that cross state lines pose particular problems. For the University Wendover Clinic, these include the need for nurse practitioners who work there to be licensed both in Utah and Nevada and to pay high practice fees in Nevada. In some states, but not in Nevada, advance practice nurses are restricted from prescribing or dispensing drugs. They also may receive only a percentage (for example, 85 percent) of the fee a physician would receive for the same service. While the federal group did not want to get in the middle of inter- and intra-state disputes or professional group disagreements, its members did gain an appreciation of the role of state restrictions and, to some extent, of their interplay with federal regulations.

■

In order to provide essential health services to vulnerable populations, providers need to have more than infrastructure and resources; they need community input and acceptance as well as understanding of patient needs, including cultural and language barriers. People, whether or not they are insured, seek health care services where they feel vested, share common culture, understand the language, and think their needs are being addressed.

Much of the site visit discussion of models of health care for vulnerable people centered on whether the models are community-vested or outside-imposed. It also focused on individual practitioners' understanding and sensitivity to the culture and language of the people they treat and on individual patients' expectations of them. As Utah becomes more diverse, there seems to be some appreciation that "one size doesn't fit all."

Participants gained the impression that Utah has been fairly homogeneous and is having to adjust its health delivery and financing operations to increased numbers of immigrants—particularly Hispanics and Asian/Pacific Islanders. In fact, the growth rate for minority populations (including African Americans as well as the immigrant groups) is higher than that of much of the nation. As new entrants stake their claims, Native Americans—exercising long-standing treaty rights—are seeking greater recognition of their health needs and of federal and state commitments to address them.

Hispanics, some who are migrants and others who have "settled out," contend that they face anti-immigrant bias. For example, some farm workers indicate that they work hard and long, face pesticide and other dangers, pay cash for services (such as health care), and have a strong sense of family and community but are resented (or ignored) because they are "outsiders." Needed in a thriving economy, they have become indigenous to the farm, service, and other sectors but are not viewed as such.

Providers, aware of charges of bias, at times indicated understanding, such as "Health care reflects the values of an area" and "It's important to look at the total needs of the patient." Moreover, a couple of Anglo physicians who served as panelists know Spanish, one because he grew up in an area where it was spoken and the other because he felt the need to learn it in order to serve Spanish-speaking patients. While their sensitivity to the language needs of certain patients is incidental and anecdotal, it points to recognition by some, at least, of the demands of cross-cultural competency.

■

There is a dearth of resources for Native Americans. Split among Indian Health Service regional offices in Phoenix, Albuquerque, Window Rock, and Portland and with only one IHS facility at Fort Duchesne, the Indian tribes in Utah have significant needs that the governor's liaison, tribal representatives, and others are seeking to address. Lack of service facilities, bureaucratic barriers, problems with coordination of benefits among federal programs, shortage of native workers to link tribal members to health and related services, and other problems seem to be the major obstacles.

Participants, some of whom had taken part in earlier Forum visits to New Mexico and to the New Mexico-Texas-Mexico border area, gained a view of scarce resources in Utah. Or perhaps the word is "scarcer": knowing that the American Indian has fewer health resources than the average American, participants learned that a member of a Utah tribe has even fewer than the average American Indian. There is only one IHS facility in the state—Fort Duchesne Indian Health Center, an ambulatory clinic in the northeast part of the state. There seem to be no facilities that are operated under tribal self-determination—the national movement under which tribes take over IHS resources under Section 638 agreements—most likely because there are few resources in Utah for the tribes to assume. Moreover, while Medicaid is 100 percent federally matched for eligible American Indians,

enrollment and follow-through are problematic. Additionally, there are various bureaucratic hurdles for those who might qualify for contract services.

The Phoenix Indian Health Service (IHS) office seems to have major responsibility for tribes in the state—with Window Rock (Arizona) responsible for Navahos in the Four Corners area. However, for geographic and historic (and probably affinity) reasons, some tribes relate to Portland or Albuquerque. A major problem arises when tribal members whose reservations are in other states (for example, the Northwest Shoshone, whose reservation is in southern Idaho, or the White Mesa Utes, whose governance is based in the Mountain Ute reservation in Colorado) need contract care. The bills for services provided to them must be sent to Portland (in the case of the Northwest Shoshone) or Albuquerque (in the case of the White Mesa Utes). Generally, when they receive services in Utah, they have to pay out of pocket or the provider is stuck with the bill.

Clear needs came out in the site visit discussion. One is to grant presumptive eligibility to Native Americans who are seeking health services (such as care under Medicaid and CHIP). Another is to straighten out coordination of benefits problems among IHS and other federal programs, which obviously is easier said than done. Still another is to identify and train native people to serve as benefits workers (or bridges between public programs and tribal people). Still another is to involve tribal elders and community representatives to a greater extent in decision-making on health delivery and workforce issues.

Given the health statistics of Native Americans in the state and the outmigration from reservations to urban areas, the burden of health care for many Native Americans falls on the outreach efforts of organizations such as IHC. In line with nationwide patterns (because only a little over 1 percent of the overstrained IHS budget goes to urban programs), the stress seems especially obvious in Utah. While there was little time to go in detail into the substance of the various problems facing Native Americans in the state, there was interest in pursuing them in other policy settings.

■

The availability and distribution of practitioners—physicians, nurses, and allied health professionals—continue to be major problems, despite nationwide trends.

Participants, used to hearing that there is a glut of physicians and competition with them from other practitioners, got a different message on this site visit. There are 6,000 licensed physicians in Utah, 3,000 of whom are providing care. (Two thousand, dual licensees, live out of state, and the rest of those who are not practicing in the

state work in other jobs, are retired, or fall into some other category.) As already indicated, most physicians are connected with IHC.

Roughly 20 percent of the physician providers are in frontier and rural areas; all are said to be within 30 miles of a hospital. (The hospitals tend to be near the major highways.) While some specialists travel from site to site in isolated areas, most specialists are in the Salt Lake City-Provo area on the Wasatch Front.

Other practitioners, who in other markets may vie with physicians for patients, are more likely in Utah to link with physicians. For example, 80 percent of nurse practitioners, who have prescriptive authority and can practice independently, tend to be in physician offices. All physician assistants work under physician supervision. With too few primary care practitioners to care for those who need health services, Utah seems to have more of a collaborative than a competitive model.

The University of Utah, as already noted, plays a central role in providing health professions education, training, and continuing education. Because it supplies health professionals to Idaho, Montana, and Wyoming as well as Utah, which has significant health professional shortage areas, it is hard-pressed to fill current needs. In addition to training physicians, the university has advanced practice nursing, physician assistant, and allied health professional programs. Four years ago, the Utah Department of Health, Utah AHEC, and University of Utah established a workforce planning committee to address the problem.

■

Emergency preparedness and emergency medical services take high priority in a state in which nearly half of the nation's chemical weapons are stored, terrain and weather contribute to accidents, and the population swells by two million each year due to tourists.

Because of the presence of Deseret Chemical Depot, a chemical weapons storage and incineration facility in Tooele County, this site visit offered a unique opportunity to look at emergency preparedness. Located in a unique setting, the depot also provided an opportunity to examine the role of public health and of emergency medical services (EMS) in preventing, responding to, and planning for emergencies. Not only the presence of the depot but also geographic and climatic characteristics of the area in which it is located—conductive to highway, sport, and other accidents—called for a high degree of readiness.

Participant reactions to these themes ranged from “the briefing by the chemical stockpile representative was very

interesting” to “Deseret Chemical Depot—didn’t understand the link to the rest of the trip/themes.” There seemed to be a greater acceptance of EMS as mainstream because of the vastness of the open spaces and the size of the mountains. Moreover, the emphasis—particularly from safety-net providers—of having facilities for treating tourists in remote areas was a twist on usual themes. All in all, most participants came away with an expanded perspective of “emergency,” in terms of both preparedness and service. In a single day, they drove by the Deseret Chemical Depot (where a Sarin leak had occurred several weeks before), travelled on a highway known for its frequent rollovers of cars and trucks, and spent time in a town where one clinic—University Wendover Clinic—covered the gamut from primary through trauma care.



The main keys to development of an effective emergency preparedness system are integrated communications and coordination of public agencies.

In preparation for the visit, participants read fact sheets on Deseret Chemical Depot and looked at excerpts from a June 1997 General Accounting Office report, *Chemical Weapons Stockpile: Changes Needed in the Management of the Emergency Preparedness Program*, that indicated progress at 10 chemical weapons sites. The report based readiness on a site’s having an automated information system, an emergency operations center, an integrated communications system, personal protective equipment, personnel decontamination equipment, sheltering-in-place enhancements, a siren system, and tone-alert radios.

During the briefing on the emergency preparedness system, participants learned that preparedness rests on two key aspects: integrated communications and coordination of public agencies. For policy people who work with a health system that is disparate rather than integrated and compartmentalized rather than coordinated, the emphasis on integrative communications and coordination of public agencies was particularly challenging, though not surprising.

—Karen Matherlee and Michael Anzick

Utah Health Marketplace*

HEALTH CARE SYSTEMS

■ Intermountain Health Care (IHC)

IHC, which has 429,000 enrollees in its health plans, is ranked among the 10 largest secular not-for-profit health care systems. Its HMO is ranked 99 among the 100 largest HMOs.

Hospitals

- Alta View Hospital, Sandy
- American Fork Hospital, American Fork
- Bear River Valley Hospital, Tremonton
- Cottonwood Hospital, Murray
- Delta Community Medical Center, Delta
- Dixie Regional Medical Center, St. George
- Fillmore Community Medical Center, Fillmore
- Garfield Memorial Hospital and Clinics, Panguitch
- LDS Hospital, Salt Lake City
- Logan Regional Hospital, Logan
- McKay-Dee Hospital Center, Ogden
- Orem Community Hospital, Orem
- Primary Children's Medical Center, Salt Lake City
- Sanpete Valley Hospital, Mt. Pleasant
- Sevier Valley Hospital, Richfield
- Utah Valley Regional Medical Center, Provo
- Valley View Medical Center, Cedar City
- Wasatch County Hospital, Heber City
- Cassia Regional Medical Center, Burley, Idaho
- Pocatello Regional Medical Center, Pocatello, Idaho
- IHC Evanston Regional Hospital, Evanston, Wyoming
- Star Valley Hospital, Afton, Wyoming

■ University of Utah Hospitals and Clinics

The University of Utah Hospital and Clinics offer 50 general and specialty clinics for outpatients.

Facilities

- University of Utah Hospital
- University Research Park (preventive cardiology program, a pain management center, and sports medicine)

- University Wasatch Clinics (family medicine, an aesthetic surgery center, a general internal medicine clinic, and the University's Student Health Service)
- PediCenter (a pediatric facility)
- Northeast Family Practice Clinic (family medicine services associated with University Hospital)
- University Hospital Spine Rehabilitation Center (collaborative effort by orthopedics, neurosurgery, and physical medicine and rehabilitation physicians)
- Park City Family Health Center
- University Wendover Clinic
- Solitude Ski Resort Sports Injury Clinic
- The John A. Moran Eye Center (ophthalmology research, teaching, patient care, and administrative services)
- The University of Utah Neuropsychiatric Institute (acute-care setting for patients requiring full-time care, day treatment programs for youth and adults, and outpatient services)

■ Columbia/HCA Healthcare Corporation

Hospitals

- Columbia Ashley Valley Medical Center, Vernal
- Columbia Brigham City Community Hospital, Brigham City
- Columbia Castleview Hospital, Price
- Columbia Lakeview Hospital, Bountiful
- Columbia Mountain View Hospital, Payson
- Columbia Ogden Regional Medical Center, Ogden
- Columbia St. Mark's Hospital, Salt Lake City

■ Paracelsus Healthcare Corporation

- Davis Hospital and Medical Center, Layton
- Pioneer Valley Hospital, West Valley City

■ Other

- Community Psychiatric Centers (CPC Olympus View Hospital, Salt Lake City)
- Pioneer Healthcare (Highland Ridge Hospital, Salt Lake City)
- Healthsouth Corporation (Healthsouth Rehabilitation Hospital of Utah, Salt Lake City)

- Champion Healthcare Corporation (Jordan Valley Hospital)
- Ramsey Healthcare, Inc. (Benchmark Regional Hospital, Woods Cross)

HEALTH PLANS

- **Intermountain Health Care:** indemnity, PPO, HMO, point of service, Medicaid managed care
- **Regence BlueCross BlueShield of Utah:** indemnity, PPO, HMO, point of service, Medicare supplement
Began in 1942 and serves 624,000 members throughout the state.
- **United HealthCare of Utah:** indemnity, PPO, HMO, point of service, Medicaid managed care
Started in 1984 by community physicians, it has grown to be part of United HealthCare Corporation's national operations. United HealthCare of Utah and United HealthCare Insurance Company contract with 18 area hospitals and more than 1,700 physicians and have more than 170,000 enrollees.
- **CIGNA Healthcare of Utah, Inc.:** indemnity, PPO, HMO, point of service.
Established in 1985, the plan has more than 31,000 participants.
- **FHP Incorporated:** HMO
- **Intergroup Utah Incorporated:** HMO
- **Eastern Utah Health Plan, Inc.**
This plan, officially incorporated in December 1993, is a physician hospital organization. It is composed of physician and hospital/clinic providers who are health plan members. The affiliated hospital is Columbia Castleview Hospital in Price, Utah, and the affiliated clinic is Emery Medical Clinic in Castle Dale, Utah.

MEDICAID MANAGED CARE

- **American Family Care - Utah, American Family Care - Utah Plus**
- 4,500 enrollees
- **Altius Health Plans**
- 8,000 enrollees

- **Healthy U Medicaid**
- 10,000 enrollees
- **IHC Access**
- 30,000 enrollees
- **United HealthCare of Utah/MedChoice**
- 20,000 enrollees

SAFETY NET PROVIDERS

- **Community Health Centers**
 - Wayne County Medical Clinic, Inc., Bicknell
 - Carbon Medical Service Association, Inc., East Carbon
 - Enterprise Valley Medical Clinic, Enterprise
 - Green River Medical Center, Green River
 - Salt Lake Community Health Center, Midvale
 - Midtown Community Health Center, Ogden
 - Mountainlands Community Health Center, Provo
 - Central City Community Health Center, Salt Lake City
 - Northwest Community Health Center, Salt Lake City
 - Wasatch Homeless Health Care, Salt Lake City
 - Oquirrah View Community Health Center, Salt Lake City
 - Copperview Community Health Center, Salt Lake City
 - Utah Farm Workers Health, Brigham City, Salt Lake City, Ogden, Provo
- **Migrant Health Centers**
 - Utah Farm Workers Health, Brigham City, Salt Lake City, Ogden, Provo
 - Mountainlands Community Health Center, Provo
 - Copperview Community Health Center, Salt Lake City
 - Central City Community Health Center, Salt Lake City
 - Northwest Community Health Center, Salt Lake City
 - Wasatch Homeless Health Care, Salt Lake City
- **Rural Health Clinics**
 - Beaver Medical Clinic, Beaver
 - Milford Valley Medical Clinic, Milford
 - Mountain Utah Family Medicine, Richfield
 - Hurricane Family Practice Center, Hurricane
 - Kamas Health Center, Kamas
 - Coalville Health Center, Coalville

- Duchesne County Clinic, Duchesne
- Circleville Clinic, Circleville
- Bryce Valley Clinic, Cannonville
- Ivan W. Kazan Memorial Clinic, Escalante
- Garfield Memorial Clinic, Panguitch
- Emery Medical Center, Castle Dale
- Monument Valley Hospital Clinic, Monument Valley
- Parowan Medical Clinic, Parowan
- Montezuma Creek, Montezuma Creek

■ **Public Health Departments**

- District Health Departments
 - Bear River District Health Department
 - Central Utah District Health Department
 - Southeastern District Health Department
 - Southwest District Health Department
 - Tricounty Public Health Department
 - Weber-Morgan District Health Department
- County and City/County Health Departments
 - Utah County Health Department
 - Summit County Health Department
 - Salt Lake City/County Health Department
 - Davis County Health Department
 - Wasatch County Health Department
 - Tooele County Health Department

OTHER HOSPITALS

- **Beaver Valley Hospital, Beaver**
- **Gunnison Valley Hospital, Gunnison**
- **Kane County Hospital, Kanab**
- **Milford Valley Memorial Hospital, Milford**
- **Allen Memorial Hospital, Moab**
- **San Juan Hospital, Monticello**
- **Tooele Valley Regional Medical Center, Tooele**
- **Monument Valley Hospital, Monument Valley**
- **Salt Lake Regional Medical Center, Salt Lake City**
- **Central Valley Medical Center, Nephi**
- **Shriners Hospitals for Crippled Children, Intermountain Unit, Salt Lake City**
- **Utah State Hospital, Provo**

- **Uintah Basin Medical Center, Roosevelt**
- **Fort Duchesne Indian Health Center, Uintah**
- **U.S. Air Force Hospital, Hill Air Force Base**
- **Veterans Affairs Medical Center, Salt Lake City**

* In order to provide federal and foundation participants a "schematic" of the Utah health marketplace, NHPF compiled this listing from various sources, written and oral, and invited corrections. Not intended to include every provider organization in state, it was used as a reference for the site visit discussions.

Agenda

Tuesday, October 27, 1998

6:00 pm Reception/dinner with local participants [*DoubleTree Hotel, Salt Lake City—headquarters hotel*]

Wednesday, October 28, 1998

8:00 am Opening breakfast briefing [*Salon I, DoubleTree Hotel*]

ESSENTIAL COMMUNITY PROVIDERS: AN OVERVIEW OF
THE UTAH MARKET (WITH EMPHASIS ON FRONTIER AND RURAL SERVICES)

Gar Elison, *Deputy Director*, Utah Health Policy Commission

Richard B. Kinnersley, C.A.E., *President*, UHA, Utah Hospitals and Health Systems Association

Val J Bateman, M.B.A., M.H.A., *Deputy Executive Vice President*, Utah Medical Association

10:00 am Bus departure for West Wendover, Nevada (briefings en route)

10:45 am CHEMICAL AND NUCLEAR WASTE STORAGE:
ENVIRONMENTAL CONCERNS AND EMERGENCY PREPAREDNESS
(as the bus passes the Deseret Chemical Depot, a chemical weapons storage area)

Kari Sagers, C.E.M., *Director*, Emergency Management Department, Tooele County

Myron Lee, *Public Information Officer*, Emergency Management Department, Tooele County

11:30 am FROM PRIMARY CARE TO EMERGENCY MEDICAL SERVICES:
THE FRONTIER PATCHWORK

Susan E. Huether, R.N., Ph.D., *Associate Dean for Clinical Affairs*, College of Nursing,
University of Utah

1:00 pm Lunch [*Silversmith Convention Room*]

1:45 pm Bus tour and briefing on housing conditions of area population

Art Martines, Ph.D., *City Manager*, Wendover, Utah

2:00 pm Visit to University Wendover [Nursing] Clinic

DELIVERY OF CARE ON THE FRONTIER: THE ONLY GAME IN TOWN
(with a telemedicine demonstration)

Susan E. Huether, R.N., Ph.D. (see title above)

Becky J. Orr, R.N., *Coordinator of Patient Services*, University of Utah Wendover Clinic

Katherine S. Aoki, M.A., R.N., *Service Director* Community Outreach Clinics and Services,
University of Utah

3:30 pm Bus departure for DoubleTree Hotel, Salt Lake City (briefing en route)

- 4:00 pm CHIP: ADDING ANOTHER PIECE TO A PIECEMEAL SYSTEM
Chad J. Westover, Administrator, Children's Health Insurance Program, Utah Department of Health
- 6:30 pm Dinner for federal and foundation participants [*East Brunswick Room, Inn at Temple Square*]

Thursday, October 29, 1998

- 7:30 am Breakfast [*Salon I, DoubleTree Hotel*]
- 8:15 am Bus departure for Sandy
- 9:00 am Briefing and discussion, with snack [*Conference Rooms A and B, Alta View Hospital (an Intermountain Health Care, Inc., facility)*]

**PRIVATE-PUBLIC PARTNERSHIPS IN A RECONFIGURING HEALTH MARKETPLACE:
 SHORING UP THE SAFETY NET**

- Wes Thompson, M.B.A.**, Administrator and Chief Executive Officer, Alta View Hospital
Pamela J. Atkinson, Vice President of Mission Services, Intermountain Health Care, Inc.
The Hon. Tom Dolan, Mayor, Sandy City
Rhoda Gaufin, M.B.A., Executive Director, Mountainlands Community Health Center
M. Gordon Johnson, President, Legacy Management and Development Companies

- 11:00 am Departure for Nephi
- 1:15 pm Light lunch [*Conference Room, Central Valley Medical Center, Nephi*]
- 2:00 pm Brief tours of Central Valley Medical Center and adjacent clinic, followed by panel discussions [*Conference Room*]

- 2:15 pm **RURAL PROVIDERS IN TRANSITION: INPATIENT AND OUTPATIENT PROVIDERS**
 (featuring rural hospital, ambulatory care center, and rural health clinic issues)
Mark R. Stoddard, M.B.A., President, Rural Health Management Corporation
Michael C. Peterson, M.D., F.A.C.P., Chief of Staff, Central Valley Medical Center
Wain Allen, M.D., Owner, Coalville Health Center
Mark F. Dalley, M.P.A., Chief Executive Officer, Tooele Valley Healthcare System
Arda Morrell, Executive Director, Wayne County Medical Clinic, Inc.

- 3:30 pm **TARGETED SERVICES FOR NATIVE AMERICANS AND MIGRANT WORKERS**
 Native American Services:
Judy A. Edwards, R.N., M.P.H., Indian Health Liaison, Office of the Executive Director, Utah Department of Health
Betsy China, Chairwoman, Paiute Indian Tribe of Utah Health Committee
Carleen I. Kurip, Acting Education Director, Ute Tribal Health Board
P. Jane Powers, M.S., R.N., C.S., F.N.P., Clinical Administrator and Director, Northern Ute Native American Child Protection Telemedicine Program, Fort Duchesne Indian Health Center, U.S. Public Health Service
 Migrant Worker Services:
Saul Ramos, L.B.S.W., M.A., Director, Utah Farm Workers Health, Community Health Centers, Inc.

Scott Barlow, *Practice Administrator*, Mountain View Family Medicine
Antonio Guerra, *Medical Outreach Worker*, Utah Farm Workers Health,
Community Health Centers, Inc.

- 4:45 pm Departure for Sundance (near Provo)
6:15 pm Dinner [*Sundance*]
8:30 pm Bus departure for DoubleTree Hotel, Salt Lake City

Friday, October 30, 1998

- 8:00 am Hotel checkout, followed by breakfast [*Salon I, DoubleTree Hotel*]
8:45 am Bus departure for University of Utah, Salt Lake City
9:15 am Panel discussion [*Room 309, School of Medicine*]

THE FRONTIER WORKFORCE: TRAINING, RECRUITMENT, AND RETENTION PERSPECTIVES

F. Marian Bishop, Ph.D., M.S.P.H., *Professor and Chairman Emerita*, Department of Family and Preventive Medicine, School of Medicine, University of Utah

Michael K. Magill, M.D., *Chairman*, Department of Family and Preventive Medicine, School of Medicine, University of Utah

Peter I. Oppenheim, M.D., *Lead Clinician*, Copperview Community Health Center

Imogene Rigdon, Ph.D., A.P.R.N., *Associate Dean for Academic Affairs*, College of Nursing, University of Utah

- 10:30 am Wrap-up discussion [*Room 309, School of Medicine*]

ASSESSING FRONTIER SERVICES: LESSONS LEARNED

Edward G. Grossman, *Assistant Counsel, Legislative Counsel*, U.S. House of Representatives

Deborah Turner, R.N., B.S., *Senior Associate Director*, Utah Area Health Education Centers, Health Science Center, Salt Lake City

- 11:15 am Bus departure for airport

Federal Participants

Michael J. Bell

Staff Assistant
Office of Senator Hatch
U.S. Senate

Glenda C. Booth

Health Legislative Assistant
Office of Senator Feinstein
U.S. Senate

Fred Butler, Jr., M.P.H.

Public Health Analyst
Office of Data Evaluation, Analysis, and Research
Health Resources and Services Administration
Department of Health and Human Services

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Special Projects and Data Analysis Branch
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Specialist in Social Legislation
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Committee on Labor and Human Resources
U.S. Senate

Kim Lipsky, M.P.A.

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U.S. Senate

Stephanie Monroe

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Vice President for Health Policy
Public Sector Consultants, Inc., and
Program Evaluator

Biographical Sketches— Utah Participants

Wain Allen, M.D., is owner of two Utah health facilities northeast of Salt Lake City, the Coalville Health Center and the Kamas Health Center. Both centers, which he has operated since 1984, are designated as rural health clinics by the federal government. Since 1988, he has also served as a clinical professor at the University of Utah and as medical director of the Rocky Mountain Care Center. A graduate of the George Washington University School of Medicine, he is past president of the Utah Academy of Family Practice and has served on the board of directors of the Utah Medical Association since 1996.

Katherine S. Aoki, M.A., R.N., is service director of community outreach clinics and services for the University of Utah Hospitals and Clinics, a post she has held since 1995. From 1992 until 1995, she was manager of the University of Utah's women's clinics; for the three previous years, she managed the organization's long-term home care services. She was a health care administrator in Maryland before she moved to Utah, first as coordinator of perinatal community education and then as manager of neonatal transport systems for the Maryland Institute of Emergency Medical Services Systems.

Pamela J. Atkinson, vice president of mission services for Intermountain Health Care, Inc., works with communities who manage and operate clinics for IHC for medically needy people. In addition, she is an advocate for homeless and low-income families and has a particular interest in helping low-income people access higher education. A member of the Utah State Board of Regents, she has held both teaching and hospital administration positions. Ms. Atkinson holds an R.N. degree from the University College Hospital in England, a B.S. from the University of California, and an M.A. from the University of Washington.

Scott Barlow was appointed practice administrator of Mountain View Family Medicine (MVFM) in May 1997. Since then, MVFM has grown from a small family practice group to a multi-specialty group offering family practice, obstetrics, pediatrics, and occupational medicine. Previously, Mr. Barlow was accounting manager and then associate director and chief operating officer for Community Health Centers, Inc. Before that, he worked for McKesson Drug Company as an accounting manager in three of its distribution centers.

Val J Bateman, M.B.A., M.H.A., is deputy executive vice president, responsible for government relations and other activities, at the Utah Medical Association. He was promoted to his current position in 1997, after having served as director of government relations. Prior to joining the association, he was a local health field coordinator at the Utah Department of Health, where he was first employed in 1987 as a policy analyst and planner. He gained prior experience with the military as hospital administrator for the U.S. Air Force Hospital/RAF Upper Heyford in the United Kingdom, director of human resources for the Office of Surgeon General Tactical Air Command, and associate administrator of the U.S. Air Force Academy Hospital. He also served as chief of the Medical Plans and Programs Division of the Office of the Air Force Inspector General and in various other positions, including six years in the Air Force Surgeon General's Office.

F. Marian Bishop, Ph.D., M.S.P.H., is professor and chairman emerita of the University of Utah School of Medicine's Department of Family and Preventive Medicine, which she chaired from 1984 to 1994 as the first woman director in the history of the university. She also is director of the school's graduate programs in public health. Prior to 1984, she was a professor and the chairman of the Department of Community Medicine and a professor of family medicine at the University of Alabama in Huntsville. Earlier, she held medical school faculty appointments at the University of Oklahoma and the University of Missouri, Columbia. Currently a member of the Health Resources and Services Administration's Council on Graduate Medical Education, she has served on other advisory boards for HRSA, as well as for the Agency for Health Care Policy and Research, in the U.S. Department of Health and Human Services.

Betsy China is chairwoman of the Paiute Indian Tribe of Utah Health Committee in Cedar City. She is also chairwoman of the Utah Indian Health Advisory Board in Salt Lake City. Member of the Shivwits Band, she is a secretary in the Paiute Indian Tribe of Utah's Environmental Resource Office. An advocate for better health services for the tribe, she is involved not only with health issues within the tribe but also with health policy concerns at the state and local levels. In the early 1990s, she was a member of the Utah Legal Service Board (Indian walk-in representative).

Mark F. Dalley, M.P.A., has been chief executive officer of the Tooele Valley Healthcare System since 1996. Previously, he served as administrator of Orem Community Hospital, chief operating officer of Dixie Regional Center, and administrator of Valley View Medical Center. He is associated with Rural Health Management Corporation.

The Hon. Tom Dolan is mayor of Sandy City, which is just south of Salt Lake City. Born in Washington, D.C., he graduated from the University of Utah in 1967 and has resided in Sandy since 1979. Earlier, he and his family lived in Colorado and Maryland. He served his first term as mayor from 1994 to 1997 and started his second term last year. He is first vice-president of the Utah League of Cities and Towns, vice-chair of Envision Utah, and co-chair of the Municipal County Coalition of Utah. He also serves on the EDCU Executive Committee, Wasatch Front Regional Council, Utah Tomorrow Committee, and the Trans-Jordan Board of Directors.

Judy A. Edwards, R.N., M.P.H., is liaison for Indian health for the Utah Department of Health. Focused on state health policy and interaction with tribal governments, she has a developmental and coordination role for the department's executive director and the Governor's Office. Among other duties, she works with tribal leaders and tribal health boards to develop health improvement strategies and to facilitate and initiate dialogue with local health departments. Before assuming her current post in 1993, she was program coordinator for perinatal mortality review for the department. Earlier, she was coordinator of the University Employee Quit Smoking Program at the University of Alabama at Birmingham and coordinator of Prevent Prematurity, a low-birthweight project in Bozeman, Montana. A DHHS grant reviewer, she also has been active in American College of Obstetricians and Gynecologists and community fetal and infant mortality initiatives.

Gar Elison is deputy director of the Utah Health Policy Commission and director of the Medical Education Council. His other positions include Executive Board member of the National Academy for State Health Policy and member of the academy's Access for the Uninsured Steering Committee as well as member of the Board of Directors of the Frontier Education Center. Mr. Elison has taught in the Management Certificate Program at the University of Utah since 1985 and, before that, held faculty appointments at Idaho State University and the University of New Mexico medical school.

Rhoda Gaufin, M.B.A., is executive director of the Mountainlands Community Health Center. Ms. Gaufin has more than 20 years of management experience. Before joining Mountainlands in 1995, she worked for the City of

New York, holding, among other positions, the posts of director of the Health Management Division of the Department of Correction and deputy director of the Medical Division of the Department of Sanitation. She is the recipient of a Robert Wood Johnson Foundation Local Funding Partners Initiative exploring ways to extend health care access to low-income and ethnic populations through coordinated volunteerism, community development, and education.

Antonio Guerra has been a medical outreach worker for Utah Farm Workers Health, Community Health Centers, Inc., since 1995. In addition to his work at Utah County migrant stations, Mr. Guerra has for the past five years been an American Red Cross volunteer in the Salt Lake City chapter.

Susan E. Huether, R.N., Ph.D., is associate dean for clinical affairs at the University of Utah College of Nursing. She has been associate dean since 1995; before that she was the college's associate dean for academic affairs, a division director, and a program director. The college offers B.S., M.S., and Ph.D. degree programs and has several initiatives under way, including a nursing clinic in Wendover, Nevada, which is linked to the university's telemedicine program, and a Gerontology Center, which offers a master of science degree in gerontology as well as undergraduate and graduate certificate programs.

M. Gordon Johnson is president of Legacy Management and Development Companies in Salt Lake City. His current volunteer positions include chairman of the board of Intermountain Health Care's Urban Central Region (Alta View, Cottonwood, and LDS Hospitals), chairperson of the Healthy Sandy Partnership, and trustee of the Cottonwood-Alta View Health Care Foundation. Before becoming a real estate developer, Mr. Johnson served for ten years as an executive and program producer of domestic and international broadcasting for Bonneville International Corporation.

Richard B. Kinnersley, C.A.E., is president of UHA, Utah Hospitals and Health Systems Association. After having headed the organization from 1978 to 1986, he became president and chief executive officer of U-Care, a health maintenance organization, for two years. He returned to the association as executive vice-president in 1989 and became president in 1990. While heading U-Care, he also was director of regional services for the University of Utah Hospital.

Carleen I. Kurip, a member of the Ute Indian Tribe, has been acting education director of the Ute Tribal Health Board since 1997 and is a member of the Utah State

Health Advisory Board, Utah State/Ute Tribe Child Development Team, and Utah State Ethnic Mental Health Board. Previously, she worked on tax issues, served as public relations director as well as editor of the *Ute Bulletin*, and was involved in Ute tribal education. She also has served as staff auditor of Minerals Management Royalty, an account supervisor for the Bureau of Indian Affairs, and a counselor for the Uintah School District.

Myron Lee has been public information officer of the Emergency Management Department, Tooele County, for the past six years. Prior to that, he was a reporter for the *Tooele Transcript-Bulletin*.

Michael K. Magill, M.D., is professor and chairman of the Department of Family and Preventive Medicine, University of Utah School of Medicine. He became chairman in 1995, after having been director of the Utah Area Health Education Centers and director of the Educational Outreach Programs in the university's Office of the Vice President for Health Sciences. Previously, he was senior vice president of the Tallahassee Memorial Regional Medical Center, following a stint as director of the center's Family Practice Residency Program. He also was assistant professor and director of faculty development for the University of Arizona in Tucson.

Art Martines, Ph.D., is city manager of the City of Wendover, Utah, a position he has held since 1996. Previously, he was president of the School Board of Notre Dame Regional School for 4 years; president of Carbon School District in Price, Utah, for 8 years; and, for 12 years, mayor of Price.

Arda Morrell is executive director of Wayne County Medical Clinic, Inc., in Bicknell, Utah, a position she has held since 1978. Positions on the numerous committees on which she has served in the state include member, Health Advisory Council, Utah Department of Health, 1985 to 1991; all offices of the Board of Directors, Association for Utah Community Health, 1984 to the present; member of the State Rural Health Advisory Committee; member of the NACHC Legislative, Rural Health, and Credentials Committees; and vice president and secretary of the Community Health Association of Mountain and Plains States.

Peter I. Oppenheim, M.D., is lead clinician at Copperview Community Health Center, Community Health Centers, Inc., as well as a member of Community Health Centers' Medical Management and Compensation Committees. He is also an assistant professor in the University of Utah Department of Family and Preventive Medicine. Before joining Copperview in 1996, he was a health policy analyst with the Physician Payment Review Commission.

Becky J. Orr, R.N., is coordinator of patient services, University of Utah Wendover Clinic in Wendover, Nevada. She has worked at the clinic for less than a year. A long-time resident of Wendover, she also is a case manager for Tooele Valley Home Health, an organization she joined in 1997.

Michael C. Peterson, M.D., F.A.C.P., is chief of staff at Central Valley Medical Center in Nephi. He has held this position since 1996, two years after joining the center as a staff physician. In addition, he is medical director of the Canyon Hills Nursing Home in Nephi and a volunteer clinical faculty member in the Division of General Internal Medicine, University of Utah School of Medicine, Salt Lake City.

P. Jane Powers, M.S., R.N., C.S., F.N.P., is clinical administrator as well as director of the Northern Ute Native American Child Protection Telemedicine Program at Fort Duchesne (Utah) Indian Health Center, U.S. Public Health Service. She has been at the center since 1993. From late 1988 to mid-1993, she was a family nurse practitioner and clinical director at Nimkee Memorial Wellness Center, Isabella Indian Reservation, Mt. Pleasant, Michigan, where she had done similar work from 1980 to 1984. She also held several posts in Colorado, including associate administrator and director of nursing at Routt Memorial Hospital in Steamboat Springs, assistant administrator and director of nursing at Kremmling Memorial Hospital in Kremmling, and family nurse practitioner in Akron. A recipient of PHS and other nursing awards and citations, she has been involved in several special advocacy projects focused on children and has established a pilot telemedicine program featuring child and adult abuse and neglect examinations by leading experts.

Saul Ramos, L.B.S.W., M.A., is director of Utah Farm Workers Health, Community Health Centers, Inc. He has been with the organization since 1995. Among his other positions are migrant coordinator, Community Health Association of Mountain and Plains States; migrant farm worker representative, Utah Department of Health Ethnic Health Committee; member of the Farm Worker Committee, National Association of Community Health Centers; and board member, Association for Utah Community Health.

Imogene Rigdon, Ph.D., A.P.R.N., is associate dean for academic affairs and associate professor, University of Utah College of Nursing. Before accepting her current position at the university in 1996, she held teaching positions at the College of Nursing and was professor and dean of St. Mark's-Westminster School of Nursing and Health Science, Westminster College, in Salt Lake City.

Her teaching and clinical nursing experience spans more than 35 years.

Kari Sagers, C.E.M., serves as Tooele County's emergency management director. She has been director since 1991, after having been an emergency response planner and a program planner in the county's Emergency Management Department. She received her certified emergency manager credentials in 1995. Ms. Sagers is a member of the Chemical Stockpile Emergency Preparedness Program National Exercise Integrated Process Team, which was established by the Department of the Army and Federal Emergency Management Agency and is staffed nationally with local, state, and federal emergency management representatives. She also has been actively involved in planning and developing the Utah Communications Agency Network, a statewide radio system, and was recognized by the former governor as the state's first "Outstanding County Emergency Management Director."

Mark R. Stoddard, M.B.A., is president of Rural Health Management Corporation, which leases or manages five rural hospitals, five home health agencies, and three long-term-care facilities. He also is president of Central Valley Medical Center and the Rural Health Care Foundation. He received his M.B.A. degree from Brigham Young University. He is active in numerous professional associations: he is a board member of the Utah Association of HealthCare Providers and served on the board of the Utah Medical Association, as well as the Utah Hospital Association, of which he also was president and council chairman for rural hospitals. He was a governing board member for small or rural hospitals and a regional policy board delegate for the American Hospital Association. He currently chairs the board of trustees of Snow College and is a trustee of Sutherland Institute.

Wes Thompson, M.B.A., is administrator and chief executive officer of Alta View Hospital, an Intermountain Health Care facility in Sandy, Utah. Before assuming this post in 1991, he served as assistant administrator. He previously was director of the Utah Small Employer Health Plan. Earlier, he served as vice president of ambulatory surgery and director of planning and marketing for Intermountain.

Deborah Turner, R.N., B.S., is senior associate director of the Utah Area Health Education Centers, University of Utah Health Science Center, in Salt Lake City. Before assuming the post in 1995, she was director of the State of Utah's Washington Office for three years; administrative assistant for intergovernmental affairs and community relations for the Utah Department of Health for four years; and, from 1980 to 1985, a staff member both in the U.S.

Senate office of Sen. Orrin Hatch (R-Utah) and of the Senate Labor and Human Resources Committee. She served on the board of Utah Issues and as a commissioner on the Governor's Commission on Women and Families.

Chad J. Westover is administrator of the Utah Children's Health Insurance Program. Before accepting that position this year, he was for four years a senior policy consultant with the Utah Health Policy Commission. His previous experience includes stints as national marketing executive with Utah Economic Development, national finance director of the 1993 Hatch Election Committee, senior legislative assistant to Rep. Michael Huffington (R-Calif.), and research assistant in the office of the ranking minority member on the U.S. Senate Labor and Human Resources Committee between 1991 and 1993.

Biographical Sketches— Federal Participants

Michael J. Bell has served as staff assistant in the Health Policy Office of Sen. Orrin Hatch (R-Utah) since 1997. Before that, he was staff assistant for the Senate Judiciary Committee.

Glenda C. Booth is health legislative assistant to Sen. Dianne Feinstein (D-Calif.). Past congressional staff positions include deputy staff director of the Subcommittee on Commerce of the House Commerce Committee and legislative director for Reps. Doug Walgren (D-Pa.) and Peter Hoagland (D-Neb.).

Fred Butler, Jr., M.P.H., is public health analyst in the Office of Data Evaluation, Analysis, and Research in the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS)—a position he has held since 1998. Previously, he served as a research associate at George Washington University Hospital, a senior research associate at the National Institutes of Health, D.C. Initiative, and as a public health administration academic fellow at the Centers for Disease Control.

F. Lawrence Clare, M.D., M.P.H., is deputy chief in the Special Projects and Data Analysis Branch of the Deputy Executive Secretary, Council on Graduate Medical Education, Division of Medicine, HRSA, DHHS. Prior to 1995, when he assumed his current position, he was chief of the Data Analysis Section, Special Projects and Data Analysis Branch. Between 1978 and 1982, he was assistant to the director in the Office of Demonstrations and Evaluations in the Health Care Financing Administration's Office of Research and Policy. He also served as New York regional program director in the Professional Standards Review Organization Program from 1974 to 1978. Before that, he served as New York regional program representative and director in the HMO program.

Kenneth R. Cohen, M.H.S.A., M.P.P., has served as minority staff director and chief minority investigator for the Senate Special Committee on Aging since 1997. Other positions on the committee include professional staff member, acting minority staff director, and fellow. From 1992 to 1994, he served as health policy analyst for the Physician Payment Review Commission. He began his

health care career in 1988 as public health advisor for the Centers for Disease Control and Prevention.

Karen Davenport has been health legislative assistant for Sen. Robert Kerrey (D-Neb.) since 1996. From 1991 to 1996, she was a social science research analyst with the Office of Legislation, HCFA, DHHS. For the two previous years, she was administrative assistant for the Henry M. Jackson Foundation.

Anne Dievler, Ph.D., began serving as senior policy analyst in the Health, Education and Human Services Division of the General Accounting Office in 1998. Most recently, she was a faculty member at the Johns Hopkins University School of Hygiene and Public Health. From 1990 to 1995, she was a doctoral student in the school and, from 1984 to 1990, she was a policy analyst with the Massachusetts Department of Public Health.

Lorraine M. Fishback, M.A., is policy coordinator in the Executive Secretariat in the Office of the Secretary, DHHS—a position she has held since 1994. Also in DHHS, she served as deputy director in the Division of Policy Analysis, Office of Health Planning and Evaluation, Public Health Service.

George Greenberg is senior advisor in the Office of Health Policy, Assistant Secretary for Planning and Evaluation, DHHS.

Edward G. Grossman is assistant counsel in the Office of the Legislative Counsel, House of Representatives—a position he has held since 1975. Most recently, he coordinated and drafted significant parts of the Medicare, Medicaid, and child health provisions of the Balanced Budget Act of 1997 and the non-tax provisions of the Health Insurance Portability and Accountability Act of 1996.

Hope Ann Hegstrom has been a professional health staff member of the Senate Special Committee on Aging since 1997. From 1993 to 1997 she served as a legislative assistant in the office of Sen. Charles Grassley (R-Iowa).

Elicia J. Herz, Ph.D., is specialist in social legislation in the Health Section, Education and Public Welfare Division of

the Congressional Research Service, Library of Congress. From 1988 to 1998 she was associate director in the Health Care Organization and Policy Division of the MEDSTAT Group. She was also an analyst in the Office of Technology Assessment, U.S. Congress, from 1985 to 1987.

David Larson is a professional staff member of the Subcommittee on Public Health and Safety, Senate Committee on Labor and Human Resources. Prior to 1996, he was a professional staff member for the committee's Disability Subcommittee and a legislative associate for Duncan and Associates.

Kim Lipsky, M.P.A., is a professional staff member on the Senate Committee on Veterans' Affairs. In this capacity, she works for committee ranking minority member Sen. Jay Rockefeller (D-W.Va.) and is responsible for legislation and oversight related to the Veterans Health Administration. She also worked for Sen. Rockefeller while he served as chairman of the committee and as a staff member of a nonprofit health care reform organization he founded. Previously, she was a health care management consultant, assisting hospitals with marketing and revenue generation efforts, conducting focus groups, and developing mechanisms to improve the delivery of health services.

Stephanie Monroe is staff director and majority and chief counsel of the Subcommittee on Children and Families, Senate Committee on Labor and Human Resources.

George Morey is a policy analyst in the Division of Acute Care, Center for Health Plans and Providers, HCFA, DHHS. He has worked for over 25 years in the areas of hospital certification, coverage, and payment and has prepared implementing regulations for both the previous Rural Primary Care Hospital program and the current Critical Access Hospital program.

Tracey M. Orloff, M.P.H., is senior policy analyst/project manager of health policy studies within the National Governors' Association's Center for Best Practices. She has extensive experience in Medicaid, managed care, primary care delivery systems, rural health, quality of care, and maternal and child health. Previously, she worked as senior health associate for the Children's Defense Fund; senior research analyst for Systemetrics/McGraw-Hill, Inc.; director of federal affairs for the American Public Health Association; and program director for the National Women's Health Network.

Marlon L. Priest, M.D., is a health policy fellow in the Office of Sen. Orrin Hatch (R-Utah). He also holds the position of professor of emergency medicine and associate dean at the University of Alabama Birmingham (UAB).

Most recently at UAB, he led the startups of the multi-campus Department of Emergency Medicine and a regional student development program. His academic responsibilities have included serving as residency training program director, chair of the school's clinical curriculum committee, and director of medical center student development. He has served as the president and national councillor of the Alabama chapter of the American College of Emergency Physicians, as scholar in academic administration and health policy with the Association of Academic Health Centers, and on the board of directors of the Sisters of Charity of Nazareth Health System.

Marcia Starbecker, R.N., M.S.N., is nurse consultant in the Special Projects Grants Branch, Division of Nursing, HRSA, DHHS.

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