



Rural California

March 29–31, 2005

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Site Visit Report

Exploring California's Rural Health System: From the Redwood Forests to the Baja Border

THE GEORGE
WASHINGTON
UNIVERSITY
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National Health Policy Forum
Facilitating dialogue.
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2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]

Judith Miller Jones
Director

Sally Coberly
Deputy Director

Monique Martineau
Publications Director

Site Visit Managers

Eileen Salinsky
Principal Research Associate

Jessamy Taylor
Research Associate

Administrative Coordinator

Marcia Howard
Program Associate

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This site visit, “Exploring the California Rural Health System: From the Redwood Forests to the Baja Border,” was the first of two site visits made possible through generous support from the California Endowment. Twenty site visit participants and four National Health Policy Forum staff took a three-day tour of rural California and witnessed the geographic, economic, and demographic diversity of rural communities in the state. The participants learned that the challenges of maintaining quality health systems in rural communities as well as the innovative responses of rural Californians are varied.

The Forum is grateful to the rural health policy community in California. Many members received us warmly, spoke candidly, and gave freely of their time.

Special recognition and thanks go to several individuals who hosted us in their facilities in Sacramento, Lodi, San Andreas, Nevada City, and Downieville. Thanks to Jana Katz and her staff for providing excellent tours of the Telemedicine Learning Center and the telemedicine consult room and Pediatric Intensive Care Unit at the UC Davis Medical Center. Mike Kirkpatrick and Beth Butcher of Community Medical Centers, Inc., were gracious hosts in Lodi. We would like to thank Benjamin Gamez and his staff from El Concilio for their hard work in arranging for the group’s visit to a farmworker labor camp and to Jorge Eguiluz, the labor contractor. We appreciated Marcos Gallardo’s commentary on providing mental health services to farmworkers during our bus ride to “the islands.”

We are grateful to Mike Lawson for providing tours and meetings at Mark Twain St. Joseph’s Hospital. Thanks to Speranza Avram for welcoming us in Nevada City and for her assistance in planning the visit. Frank Lang and the Downieville community members were wonderful hosts, and we enjoyed visiting the unique frontier town.

We also want to thank the many distinguished speakers who so generously gave of their time to participate in our program: Barbara Masters, Herrmann Spetzler, Scott Christman, Jana Katz, Dr. Tom Nesbitt, Dr. Peter Yellowlees, Steve Viramontes, Barbara Johnston, Leona Butler, Judith Shaplin, Carol Mordhorst, Andy Anderson, Dr. Bill Davis, Mike Kirkpatrick, Beth Butcher, Benjamin Gamez, Ken Cohen, Dr. Guillermo Vicuna, Marcos Gallardo, Mike Lawson, John Deakyne, Kathy Yarbrough, Ray Hino, Sandra Shewry, Speranza Avram, Frank Lang, and members of the Downieville community. Thanks to Assemblyman Dave Cogdill, then-chairman of the California State Legislature Rural Caucus, for his remarks at the reception, and to Peggy Wheeler, policy analyst to the Caucus, whose participation greatly contributed to the site visit experience.



The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

Exploring California's Rural Health System: From the Redwood Forests to the Baja Border

BACKGROUND

California, the third largest state in the union by land mass and the largest by population, is known for its cities—from the glitz and glamour of Hollywood to the splendor of San Francisco and its Golden Gate Bridge to its capital, Sacramento, now home to actor-turned-governor Arnold Schwarzenegger. Despite its urban reputation, about 75 percent of the state's land mass is rural. California's rural areas are diverse in their geography and topography, spanning the redwood forests to the north, the agriculturally rich lands of the central valley, the deserts to the south, and the mountains to the east. In terms of race and ethnicity, income, education, and insurance status, rural residents vary both from one rural area to another and in comparison to urban residents. In general, rural Californians tend to be less educated, have lower incomes, and rely more heavily on public health insurance programs than urban Californians, although the differences can be moderate. A few rural areas are characterized by extreme poverty.

California often serves as a bellwether for the country, and perhaps it will in the changing dynamics of its rural communities as well. As of the 2000 Census, around 5 million people, or 15 percent of the state's population, lived in rural California, a 35 percent increase since 1990. As housing prices boom in urban areas, more and more people are seeking less expensive homes in rural areas but are commuting longer distances to their urban-based jobs. This migration has a significant impact on rural economies and health care systems. Similarly, with the ever-increasing price of land, rural economies are shifting away from agriculture, mining, and forestry to tourism.

Health Policy, California Style

From a health policy perspective, California provides a unique landscape from which to examine rural health care delivery. Any health policy discussion in the state happens in the context of the state's projected \$8 billion fiscal year 2005–2006 budget deficit. Medi-Cal, California's Medicaid program, is being examined closely because it consumes 14 percent of the state's general fund; expenditures for it have grown by 40 percent since 1999. As compared to other states, Medi-Cal has more generous eligibility levels—one in six Californians are covered by the program—but it has notably lower provider reimbursement rates, which affects

access to care. In response to the growing demand that Medi-Cal is placing on the state budget, the Schwarzenegger administration is proposing to redesign Medi-Cal in a number of ways, including expanding managed care for parents and children into 13 new counties, enrolling seniors and people with disabilities in managed care in 27 counties, and increasing beneficiary cost sharing.

The state's 58 counties bear much of the responsibility for health care. Counties participate in the financing of Medi-Cal; they determine Medi-Cal eligibility and are responsible for enrollment and recertification. They also provide public health services, services to medically indigent adults who do not qualify for Medi-Cal, and mental health and substance abuse services.

Over 50 percent of the Medi-Cal population is served through one of three county-level models of managed care; the remainder of the Medi-Cal population is served through fee-for-service. There is currently little Medi-Cal managed care penetration in rural areas, and the Medicare+Choice plans that ventured into rural areas have since withdrawn from those markets. Despite the state budget crisis, a number of California counties have been engaged in local initiatives to expand health insurance coverage to uninsured, low-income children who are ineligible for California's State Children's Health Insurance Program, "Healthy Families."

There are a number of recent state legislative efforts that have affected rural providers. California is the only state whose legislature has passed a law to mandate nurse-to-patient staffing ratios for medical/surgical units. Due to its propensity for earthquakes, over the next few years the state is phasing in tough seismic safety requirements for health care and other facilities. Ballot initiatives in California create a vehicle for voters to legislate directly on health care and other issues. In the most recent election, Californians voted to overturn a state law that mandated large and mid-size employers to provide health insurance to their employees and also voted to increase taxes by 1 percent on incomes over \$1 million to fund mental health services.

Rural Voices

Health care policy in California is dominated by urban constituencies, which constitute 85 percent of the population. In an effort to create a stronger voice for rural interests in the state legislature, the California State Legislature Rural Caucus was revitalized in January 2003. The California State Rural Health Association was founded six years ago to advocate for rural health issues. Within the California Health and Human Services Agency, the Rural Health Policy Council in the Office of Statewide Health Planning and Development was created in 1996, and the State Office of Rural Health in the Department of Health Services has served rural health interests even longer. The California Hospital Association has a Rural Healthcare Center that advocates on behalf of rural hospitals and provider-based rural health clinics. With the addition of these organizations, rural health advocacy continues to mature in California.

The Rural Health System

The status of the primary care system in the many rural communities of California is mixed. Rural primary care is increasingly dominated by models that benefit from cost-based reimbursements for Medi-Cal and Medicare, like federally qualified health centers (FQHCs) and rural health clinics (RHCs). Private physician practices do not appear to be as financially stable as FQHCs and RHCs. Mid-level providers, such as family nurse practitioners and physician assistants, provide a significant amount of primary care in rural areas.

On the inpatient side, many rural hospitals were built over 50 years ago with Hill-Burton funds and need to be renovated, but must do so in such a way as to comply with state seismic requirements, a capital-intensive effort. Most financially viable rural hospitals take advantage of federal designations that compensate for the difference in providing inpatient and outpatient care to Medicare beneficiaries in rural areas. Many rural hospitals receive cost-based reimbursement for outpatient and inpatient Medicare services because they become a critical access hospital or are designated as a sole community hospital. Some rural hospitals are finding financial opportunities in partnering with local prisons to provide care to inmates in their areas. Rural hospitals tend to be significant community employers and economic engines for rural economies.

Rural communities face significant challenges in financing care and in recruiting and retaining health professionals to provide emergency medical services, oral health services, and mental health and substance abuse services. Communities that are relatively close to urban centers find themselves in competition with employers that can offer more lucrative jobs to potential staff. Some rural areas in California experience seasonal population growth because of tourism and must adapt their health care systems to meet periodic additional need. Similarly, rural areas that are near one of the state's major urban areas struggle to prepare for a possible bioterrorist event, which could send a huge influx of people with acute and chronic health care needs their way.

PROGRAM

From March 29 through 31, 2005, a group of 20 site visit participants and four National Health Policy Forum staff explored the rural health system of California. Based in Sacramento, the program included panels at the headquarters hotel and excursions into rural areas located one to three hours away.

The program opened on Tuesday morning, March 29, with overviews of the special characteristics of California health policy. The first session provided an overview of rural communities in California by geography and demographics and explained the various state and federal definitions of rural areas, along with the funding streams that are tied to those definitions.

The next several sessions focused on telemedicine as a tool for expanding access to care in rural areas. To see telemedicine in action and to hear about related policy concerns, the group traveled to the University of California Davis's Center for Health and Technology and the UC Davis Medical Center. The afternoon of the first day

included a panel on managed care and its potential impact on rural areas, which was followed by a facilitated discussion on primary care delivery in rural California. A reception with welcoming remarks from Assemblyman Dave Cogdill, then-chairman of the California State Legislature Rural Caucus, ended the first day.

The morning of day two focused on the health status of and health care services available to the farmworker population in San Joaquin County, south of Sacramento. The group toured the Woodbridge Medical Group, Inc., in Lodi, one of ten sites that are part of a community and migrant health center network that has received expansion funding through President Bush's Health Centers Initiative. In addition to hearing from staff at this FQHC, the county's health services director spoke to participants about the challenges in serving this often undocumented, mostly Mexican population. Representatives from Su Salud and El Concilio, two community-based organizations that serve farmworkers, also spoke to the group. Next, the group drove southwest of Lodi to "the islands," so named because of the system of levees segmenting the agricultural land. There, site visit participants met with a farm labor contractor, ate lunch in a labor camp kitchen, and talked to farmworkers (through translators) about their lives and experiences accessing needed health care services.

Next, the group departed for Mark Twain St. Joseph's Hospital, about an hour and a half east in San Andreas, a town of fewer than 3,000 people in the foothills of the Sierra Nevada mountain range. After a tour of the facility, the hospital's chief executive officer and chief financial officer described their situation as a "house of cards" built by balancing state regulations, such as nurse staffing ratios and seismic requirements, low Medi-Cal payments, and cost-based Medicare reimbursements. The participants also heard from the chief executive officer of a critical access hospital in Kern County, who talked about the value of converting to that type of facility for the hospital's viability. The segment of the program on hospitals ended with a presentation from the executive director of the Rural Health Design Network, a San Andreas-based nonprofit that is implementing a community-based rural health system redesign process in a number of communities in the state.

The final day of the site visit began with a presentation by Sandra Shewry, director of the California Department of Health Services, which administers Medi-Cal, public health, and emergency preparedness programs, among others. Ms. Shewry discussed key state health policy concerns and placed them in the context of the state's significant budget deficit. Her discussion included the proposal to increase Medi-Cal cost sharing and expand Medi-Cal managed care in 13 new counties; emergency preparedness; the obesity epidemic; the proposed "California Rx" program; and the impact of the Medicare Modernization Act on the state, particularly the "clawback" provision. Although Ms. Shewry recognized the unique circumstances facing rural communities, she acknowledged that it is often challenging to address their special characteristics in state policies.

The group then traveled an hour northwest of Sacramento to Nevada City to learn about the role of networks in improving rural health systems from the executive director of the Northern Sierra Rural Health Network, Speranza Avram. From Nevada City, the group departed for Downieville, a frontier town of 350

residents located in Sierra County, the second-smallest county in the state with 3,500 residents, high in the Sierra Nevada Mountains. There the site visit participants toured the Western Sierra Medical Clinic, an FQHC “look-alike” (an FQHC that does not receive federal Section 330 grant funds) directed by nurse practitioner Frank Lang, and met with community members for a discussion about the challenges of maintaining access to health care services in a frontier setting. The discussion highlighted the difference between underserved and poor rural communities, and the need to have policies that recognize that difference. The critical importance of leadership in rural health, the challenges of providing emergency medical services, and the important role of federal programs like the National Health Service Corps and FQHC designation were also highlighted.

IMPRESSIONS

After the site visit, participants were asked to reflect on their experiences and observations. The following are key impressions participants took away from the presentations, as well as additional insights developed during a follow-up debriefing session.

Rural Diversity

Rural areas vary in significant ways.

Topographically, rural areas in California can be divided into four types: forest, mountain, valley, and desert. The economies, population characteristics, and proximity to urban areas for these different types of rural areas also vary, and that diversity makes directing resources to them problematic from a policy perspective. County-based methods for designating rurality can be a problem in California given the large size of many of its counties. The challenge for federal policymakers lies in designing programs and payments that encourage local solutions while maintaining accountability.

Rural Leadership

Despite efforts at the state level, there is limited rural voice in the health policymaking process in California.

The relative youth of the various rural health organizations working at the state level makes achieving sensitivity to rural needs in the statutory and regulatory processes a challenge.

At the rural community level, there are extraordinarily committed providers who are dedicated to the people they serve.

In many cases these individuals, whether physicians, mid-level practitioners, or administrators, make the difference between a community that has access to care locally and one that does not.

State Policy

Rural needs are not well integrated in state regulatory policies, and this can affect rural providers negatively.

Low Medi-Cal reimbursement rates permeate many rural health system problems and issues. In addition, the proposed expansion of a managed care delivery system for Medi-Cal in rural areas has bred uncertainty among rural providers. Other state-regulated processes, like hospital licensure, often do not take into account the differences in rural and urban hospital service mixes and their ability to access capital. For example, some rural hospitals that are going forward with new construction to become compliant with seismic safety standards face licensure requirements modeled on more urban service offerings like obstetrics. Nurse-to-patient staffing ratio regulations present a particular burden to rural facilities that often struggle to recruit and retain staff in areas with increasing costs of living.

Creating an Efficient Delivery System

Federal policy has a major impact on rural providers.

There is a perception by many at the federal level that significant funding is being directed to rural providers and that, in essence, rural providers “have been taken care of.” It is unclear, however, whether in reality these preferential payment provisions such as cost-based Medicaid and Medicare reimbursement for RHCs and cost-based Medicare reimbursement for inpatient and outpatient services in critical access hospitals are inadequate, adequate, or excessive, or whether they are creating more efficient rural health care systems. There are concerns that the bulk of this funding is flowing through inpatient reimbursement mechanisms and is therefore skewing the types of services offered.

Primary care in rural areas is dominated by a few models.

The FQHC is an extremely popular model for providing primary care services in rural areas. In general, cost-based clinics like FQHCs and RHCs appear to be more financially solvent than private physician practices in rural areas. The impact of the FQHC model on the viability of rural private practices in the same service area is unclear. Some argue that FQHCs are driving private physicians out of practice, whereas others believe that private physicians welcome the clinics because they have a mandate to treat the uninsured and receive enhanced reimbursements to do so. Whatever the case, these enhanced payments for primary care services are minor in comparison to federal payments for inpatient care provided in rural areas.

Rural hospitals are following the financial incentives established by the federal government to remain financially viable.

Current federal financing incentives encourage a health system focused on acute care as opposed to prevention and primary care. Although some rural hospitals provide outpatient services through rural health clinics, their ability to do so often depends on funds generated from more lucrative inpatient and diagnostic

IMPRESSIONS

procedures. The fiscal health of many rural hospitals depends on taking advantage of special rural hospital designations, such as critical access hospital status or sole community hospital status, which provide enhanced reimbursement for Medicare services. Some rural hospitals, however, may reap greater benefits from being designated “urban” for wage index purposes.

Some rural hospitals are undertaking a community-driven planning process that may create a better match between a community’s expectations for local access to health care services, their local utilization, and the hospital’s renewal.

These efforts were triggered by the state seismic safety regulations and rural hospitals’ efforts to raise capital to build new facilities. The planning process is extremely labor intensive and requires significant local leadership and, as a result, is happening in a limited number of rural communities. It is unclear the extent to which, beyond this particular process, rural hospitals in the state are thinking of community needs while developing their service offerings.

Telemedicine

Telemedicine is a tool for facilitating access to care for rural residents but does not solve the access problem.

Telemedicine is a promising tool but is fraught with many of the same challenges as the traditional face-to-face practice of medicine, such as low reimbursement from public insurance programs or no reimbursement from the uninsured and difficulty finding specialists for consultation. It does offer opportunities for rural-to-rural linkages that may help recruit and retain more specialists in rural areas.

Managed Care

Expanded managed care in rural areas has potential if safeguards are in place to protect access to care.

The proposed Medi-Cal managed care expansion into rural counties is perceived as a threat by rural providers, but rural communities may benefit from a managed care model if it is done thoughtfully with attention to access and managing care. Leadership plays a key role in designing and implementing a successful managed care model in rural areas. Rural health care organizations will have to be increasingly savvy as Medicare introduces a competitive bidding process through Medicare Advantage in 2006.

The California Rural Indian Health Board, Inc., is in the process of creating Turtle Health Plan, the first statewide health maintenance organization (HMO) created by and for American Indians. Turtle Health Plan should be operational in summer 2005 and will ultimately serve a target population of about 42,000 American Indians across 17 predominately rural counties. From their experience developing the HMO, key lessons for providing health care through managed care in rural areas include: dividing the state into regional service areas, not county-based service

IMPRESSIONS

areas; nonprofit status; building upon existing community health centers, tribal clinics, and rural health clinics; and creating a governance structure that is culturally and politically sensitive yet able to make quick, strategic decisions.

Rural Mental Health

The California mental health system appears to be inadequate.

The mental health system in rural California appears to be failing. After the policy decision to close inpatient institutions decades ago, there was little effort to finance community-based services in their place. During the site visit, speakers in every community raised this issue in terms of access problems and provider availability. The group saw examples of telepsychiatry applications, but these did not appear to alleviate the access problem substantially. Rural providers have high expectations for the impact of the Proposition 63 ballot initiative that voters passed in November 2004 to generate funds for mental health services by increasing taxes by 1 percent for incomes over \$1 million.

Farmworker Issues

Farmworkers tend to suffer from chronic conditions like diabetes and hypertension but face significant barriers to accessing care.

The agricultural areas of San Joaquin County rely on seasonal farmworkers to plant and harvest their crops. Many farmworkers have stopped migrating to other areas for work and instead are settling in the area and working in agriculture, construction, or other service sector work. Some farmworkers have undocumented immigration status and are ineligible for Medi-Cal; therefore, they must rely on the county-based and federally qualified clinic systems for health care. Although it is unclear the extent to which these services penetrate the various places farmworkers live and work, some care is available to them through community clinics. Community-based organizations are providing health education and health screenings and transportation to help farmworkers access health care services. By visiting a labor camp, albeit one on the more developed end of the spectrum, site visit participants learned the physically demanding nature of farmwork and saw the conditions in which many farmworkers live. Some site visit participants felt that the living conditions they witnessed clearly undermined the health status of this population, whereas others reacted more positively to their environment.

The delivery system for farmworkers is primarily geared to acute care, not prevention or primary care.

The San Joaquin County health system is focused on emergency and hospital services for this population. Providers noted that this approach does not promote optimal health nor necessarily result in lower health care expenditures, but it is the system that has political support. Some other counties with different political orientations target more resources to this population, including utilizing a more prevention-oriented approach.

IMPRESSIONS

Monday, March 28, 2005

Evening Arrival in Sacramento and check-in at headquarters hotel
[Hyatt Regency Sacramento, 1209 L Street, Sacramento]

Tuesday, March 29, 2005

7:15 am Breakfast available [Tahoe Room]

8:00 am Welcome and Introductions

8:15 am CALIFORNIA HEALTH POLICY 101

Barbara Masters, *Public Policy Director*, The California Endowment

- What is the extent of the state's commitment to public health and health financing programs? What portion of the state's health spending goes to support safety net and low income health programs? How is the current budget climate influencing health policy?
- How do the overall health expenditures and provider reimbursement levels for California's Medi-Cal program compare to those of other states?
- How are California's health programs organized and administered? What role do counties or other public entities play?
- What are some of the top priorities defined by Governor Schwarzenegger? Is the legislature likely to concur with these approaches?
- What is the history of The California Endowment? How do the Endowment and other health philanthropies fit into public policy activities and debates in the state?

8:45 am WHAT MAKES RURAL, RURAL? DEFINING RURAL CALIFORNIA

Herrmann Spetzler, *Executive Director*, Open Door Community Health Centers, Inc.

Scott Christman, *Enterprise GIS Coordinator*, California Office of Statewide Health Planning and Development

- Just how rural is California? In terms of land mass? Population?
- What are the different ways to define rural, and how do state and federal laws and policy relate to these definitions? How much variation is there across types of rural communities?

Agenda/continued ►

AGENDA

Tuesday, March 29, 2005 / continued

AGENDA

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| 8:45 am | <p>WHAT MAKES RURAL, RURAL?...continued</p> <ul style="list-style-type: none"> ■ To what extent does the “rural geography” of California depend on the definition of rural that is used? ■ What problems arise from the application of federal rules in California? ■ How is the state organized to work on rural health issues? |
| 10:00 am | <p>Bus Departure – University of California, Davis, Center for Health and Technology, Telemedicine Learning Center
[2450 48th Street, Sacramento]</p> |
| 10:30 am | <p>TELEMEDICINE: POTENTIAL, BARRIERS, AND LIMITATIONS</p> <p>Thomas Nesbitt, MD, MPH, <i>Associate Dean, Graduate Medical Education, Continuing Medical Education, and Outreach, and Director, Center for Health and Technology, UC Davis Health System</i></p> <p>Jana D. Katz, <i>Chief Administrative Officer, Center for Health and Technology, UC Davis Health System</i></p> <ul style="list-style-type: none"> ■ What is the history and purpose of the UC Davis Center for Health and Technology? ■ How has telemedicine been integrated into the UC Davis health care delivery mission? Teaching mission? Research mission? ■ To what extent does telemedicine improve access to care in rural communities? What are the potential benefits? What barriers have prevented telemedicine from achieving these benefits? ■ How widely have telemedicine applications been embraced by rural providers in California? What are the dominant models being used? |
| 11:30 am | <p>Lunch and Informal Discussion</p> <p>Barbara Johnston, <i>Executive Director, California Telemedicine & eHealth Center</i></p> |
| 12:15 pm | <p>SPECIALTY CARE VIA TELEMEDICINE: FILLING GAPS FOR RURAL PATIENTS</p> <p>Peter Yellowlees, MBBS, MD, <i>Professor of Psychiatry and Director of Academic Information Systems, UC Davis</i></p> <p>Steve Viramontes, <i>Telemedicine Coordinator, Round Valley Indian Health Center</i></p> |

Agenda/continued ►

Tuesday, March 29, 2005 / continued

AGENDA

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| 12:15 pm | <p>SPECIALTY CARE VIA TELEMEDICINE...continued</p> <ul style="list-style-type: none"> ■ What types of specialty care are most amenable to the use of telemedicine for enhancing health care? Which are most frequently used? ■ If specialty care were not available through telemedicine, what other options would be pursued? ■ What are the problems and limitations of using telemedicine for specialty care? How do these problems vary across specialties? ■ How do telemedicine consultation capabilities influence primary care workforce retention and recruitment? |
| 1:15 pm | <p>Bus Departure – UC Davis Medical Center
[2315 Stockton Boulevard, Sacramento]</p> |
| 1:30 pm | <p>Demonstration – Pediatric intensive care telemedicine application
Tour – Telemedicine consultation room</p> |
| 2:15 pm | <p>Bus Departure – Headquarters hotel</p> |
| 2:45 pm | <p>MANAGED CARE: RURAL FRIEND OR FOE? [Tahoe Room]</p> <p>Leona Butler, <i>Chief Executive Officer</i>, Santa Clara Family Health Plan</p> <p>Judith Shaplin, <i>Chief Executive Officer</i>, Mountain Health and Community Services</p> <p>Carol Mordhorst, <i>Director</i>, Mendocino County Department of Public Health, and <i>Chair</i>, County Medical Services Program Governing Board</p> <p>Ward “Andy” Anderson, <i>Chief Executive Officer</i>, Turtle Health Plan</p> <ul style="list-style-type: none"> ■ To what extent is managed care present in rural areas of California? Are there successful managed care programs in rural areas? In frontier areas? What made these efforts successful? What are the major impediments to expanded managed care in rural California? ■ How is the history of rural managed care tied to Medi-Cal? What are the implications of proposals for further expansion of managed care into rural communities under Medi-Cal redesign? |

Agenda/continued ►

Tuesday, March 29, 2005 / continued

- 2:45 pm **MANAGED CARE: RURAL FRIEND OR FOE?...continued**
- Have there been attempts to set up rural managed care programs for private or public sector beneficiaries? Were these attempts successful? Why or why not?
 - Is there experience with Medicare managed care in rural areas of California?
 - What types of managed care have been or would be most successful in rural California—closed panel, network, primary care case management, or other models?

- 4:15 pm **RURAL HEALTH ROUNDTABLE: PRIMARY CARE DELIVERY CHALLENGES**
- Speranza Avram**, *Executive Director*, Northern Sierra Rural Health Network
- William “Bill” Davis, MD**, *Private Practice Physician* in Winters, California, and *President of the Board*, California State Rural Health Association
- Herrmann Spetzler** (*see page 13*)
- Judith Shaplin** (*see page 15*)
- Carol Mordhorst** (*see page 15*)
- What are the primary challenges in delivering health care in rural areas of California? Are there major differences in the problems, issues, and solutions in rural versus frontier areas? What initiatives address these challenges?
 - What types of services are particularly difficult to access or are in high demand in rural areas? Behavioral health? Pharmacy?
 - To what extent can (or does) telemedicine address rural needs for primary care? For specialty care? In what ways are existing organizational models or technologies inadequate?
 - To what extent do county and local governments historically and presently have responsibility for financing, delivering, or administering health care in rural areas? How is this responsibility carried out?
 - How much care is funded by the Indian Health Service? Are American Indians cared for within the mainstream rural delivery systems in California, or do tribal services predominate?

Agenda / continued ►

AGENDA

Tuesday, March 29, 2005 / continued

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|---------|---|
| 4:15 pm | <p>RURAL HEALTH ROUNDTABLE...continued</p> <ul style="list-style-type: none"> ■ Are there attempts to measure quality of care delivered in rural practices and facilities? What types of pay-for-performance might be implemented in rural settings? ■ How are workforce shortages addressed in rural and frontier areas? What is the role of the National Health Service Corps and other federal programs in addressing these shortages? ■ How important is the enhanced Medicare payment in rural areas to the continued viability of providers? ■ Has the recent expansion of Section 330–funded health centers had a significant impact on access to care for California’s rural residents? |
| 5:30 pm | Adjournment |
| 6:00 pm | <p>Reception and Welcoming Remarks [Vines Restaurant – hotel lobby]</p> <p>Assemblyman Dave Cogdill, <i>Chair</i>, California State Legislature Rural Caucus</p> |
| 7:30 pm | Dinner on your own, if desired |

Wednesday, March 30, 2005

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|---------|--|
| 7:15 am | Breakfast available [Carmel Room] |
| 8:00 am | <p>Bus Departure – Woodbridge Medical Group, Lodi
[2401 West Turner Road, Suite 450, Lodi]</p> |
| 8:45 am | <p>THE CHANGING ROLE OF MIGRANT HEALTH CENTERS IN MEETING FARMWORKER HEALTH NEEDS</p> <p>Michael Kirkpatrick, <i>Chief Executive Officer</i>, Community Medical Centers, Inc.</p> <p>Beth Butcher, <i>Clinic Manager</i>, Woodbridge Medical Group</p> <p>Presentation and Tour – Woodbridge Medical Group</p> <ul style="list-style-type: none"> ■ What is the Community Medical Centers’s history of delivering health services? How many sites exist? Where are they located? What types of population does each serve? |

Agenda / continued ►

AGENDA

Wednesday, March 30, 2005 / continued

AGENDA

8:45 am THE CHANGING ROLE OF MIGRANT HEALTH CENTERS...continued

- Where does the Woodbridge Clinic fit in the overall operation of Community Medical Centers? Within the overall safety net in San Joaquin County?
- What are Woodbridge Clinic patients like? What are their health needs?
- What percentage of clients are farmworkers? How many of the clients are documented versus undocumented? How does inability to pay or immigration status influence care-seeking behaviors and access to services?
- How have changes in worker migration patterns and employment options influenced the mission and operations of the Community Medical Centers's clinics?
- Are farmworkers participating in the Woodbridge Clinic's diabetes disease management efforts? What are the special challenges of managing care for these patients? To what extent has federal leadership from HRSA (the Health Resources and Services Administration) affected the success of these efforts?
- What is the biggest challenge to the continued viability of Woodbridge and its sister clinics?
- How has the funding of the clinic expansion changed the capacity or service offerings of Woodbridge?

9:45 am FARMWORKER HEALTH: IS AN OUNCE OF PREVENTION WORTH A POUND OF CURE?

Ben Gamez, *Executive Director*, El Concilio

Kenneth Cohen, *Director*, San Joaquin County Health Care Services

Guillermo Vicuna, DDS, *President of the Board*, Su Salud

- What are the greatest needs of farmworkers? What are their primary health problems, and what are the greatest challenges in meeting their health needs?
- How do the needs of farmworkers compare with the needs of their families? Are a significant proportion of children in San Joaquin County from farmworker families? How does this affect the schools and social services in the county?
- Are farmworker health needs and those of their families met by community providers? Is the health care safety net primarily oriented toward the needs of this population?

Agenda/continued ►

Wednesday, March 30, 2005 / continued

AGENDA

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|----------|---|
| 9:45 am | <p>FARMWORKER HEALTH...continued</p> <ul style="list-style-type: none"> ■ What role do growers and labor contractors play in the life of farmworkers? ■ How is the farmworker population changing? How do these changes influence health services? What other vulnerable populations are living in the county? ■ What role do outreach workers play? What sorts of community groups work with farmworker families? |
| 11:00 am | <p>Bus Departure – The Islands, an agricultural area west of Stockton</p> |
| 11:45 am | <p>Lunch and Tour of the fields</p> <p>Led by Ben Gamez, El Concilio</p> |
| 1:00 pm | <p>Bus Departure – San Andreas</p> |
| 2:30 pm | <p>Tour – Mark Twain St. Joseph's Hospital
[768 Mountain Ranch Road, San Andreas]</p> <p>Michael P. Lawson, FACHE, <i>President</i>,
Mark Twain St. Joseph's Hospital</p> <p>John R. Deakyne, <i>Chief Financial Officer</i>,
Mark Twain St. Joseph's Hospital</p> |
| 3:00 pm | <p>MAPPING THE "FAULT" LINES FOR RURAL HOSPITALS</p> <p>Michael P. Lawson, FACHE (<i>see above</i>)</p> <p>John R. Deakyne (<i>see above</i>)</p> <ul style="list-style-type: none"> ■ What is the primary service area of the hospital? What are the demographics and geography of the service area? What other health care providers exist in this or nearby communities? ■ What services are offered? How does the hospital balance its inpatient and primary care services? How does the hospital address services that are needed by patients but unavailable in San Andreas? ■ What are the hospital's primary sources of revenue and primary cost drivers? What role does enhanced Medicare funding play in the financial viability of the hospital? ■ To what extent does profitability vary across service types? Are the hospital's rural health clinics financially viable? Does this viability depend on existing Medicare payment rules? |

Agenda/continued ►

Wednesday, March 30, 2005 / continued

AGENDA

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|---------|---|
| 3:00 pm | <p>MAPPING THE “FAULT” LINES...continued</p> <ul style="list-style-type: none"> ■ How was it possible to build the new facility in San Andreas to meet the new state seismic requirements, given limited funds and the size of the community? ■ Does the hospital have trouble with workforce recruitment and retention? ■ Is there managed care in the San Andreas area? How does this affect the hospital? What impact would Medi-Cal redesign likely have on the hospital? |
| 3:45 pm | <p>RURAL HOSPITALS: PAST, PRESENT, AND FUTURE</p> <p>Kathy Yarbrough, <i>Executive Director</i>, Rural Health Design Network</p> <p>Raymond Hino, <i>Chief Executive Officer</i>, Tehachapi Hospital</p> <ul style="list-style-type: none"> ■ What are the biggest problems and challenges for California rural hospitals? ■ What is a rural hospital network? What is the history of designing hospital networks in San Andreas and other rural communities of California? ■ How important is the engagement of local communities in ensuring the viability of rural hospitals? ■ Can high-quality care be delivered in very small rural or frontier communities? Are there special ways to address quality in smaller geographic settings? ■ How can small hospitals afford information technology and electronic medical records? ■ What considerations are crucial in converting a hospital to critical access hospital status? How does this designation influence hospital operations? Financial performance? |
| 5:00 pm | Bus Departure – Sloughhouse Inn |
| 6:00 pm | <p>Dinner – Sloughhouse Inn</p> <p>[12700 Meiss Road, Sloughhouse]</p> |
| 7:30 pm | Bus Departure – Headquarters hotel |

Agenda/continued ►

Thursday, March 31, 2005

AGENDA

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| 7:15 am | Breakfast available [Carmel Room] |
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| 8:00 am | <p>REALIGNING STATE HEALTH POLICY: MEDI-CAL AND MORE</p> <p>Sandra Shewry, <i>Director</i>, California Department of Health Services</p> <ul style="list-style-type: none"> ■ How is the Department of Health Services (DHS) structured, and what are its key functions? How does DHS relate to the California Health and Human Services Agency? ■ What are Governor Schwarzenegger's priorities for DHS? ■ How does the state regulate and monitor rural hospitals and other health care providers? Do California's large urban areas overshadow problems of small rural and frontier areas? How might proposed organizational changes improve the performance of state government in this respect? ■ How do state regulatory processes influence rural providers' willingness and ability to participate in federal programs? ■ What are the primary goals of the Medi-Cal redesign proposals? How would they change the current Medi-Cal program? What problems are driving the proposal? ■ How are all of these plans likely to affect rural communities? |
| <hr/> | |
| 9:15 am | <p>Bus Departure – Nevada City</p> <p>[138 New Mohawk Road, Suite 100, Nevada City]</p> |
| <hr/> | |
| 10:30 am | <p>NORTHERN SIERRA RURAL HEALTH NETWORK:
NETWORKING FOR RURAL HEALTH</p> <p>Speranza Avram (<i>see page 16</i>)</p> <ul style="list-style-type: none"> ■ What are the goals and priorities of the Northern Sierra Rural Health Network? How is the network funded? Who are members of the network and how do they relate to one another? ■ To what extent is telemedicine used among network members? For clinical uses? For administrative uses? ■ What kinds of efficiencies and quality enhancements are sought through collaboration in this network? ■ How does the network reconcile different priorities of the variety of provider types within its membership? |

Agenda/continued ►

Thursday, March 31, 2005 / continued

11:30 am	Lunch
Noon	Bus Departure – Western Sierra Medical Clinic, Downieville
1:30 pm	<p>Tour – Western Sierra Medical Clinic [209 Nevada Street, Downieville]</p> <p>Frank J. Lang, NP, <i>Executive Director</i>, Western Sierra Medical Clinic</p>
2:00 pm	<p>THE FRONTIER HEALTH CARE EXPERIENCE [100 Courthouse Square]</p> <p>Frank J. Lang, NP (<i>see above</i>)</p> <p>Arnold Gutman, <i>Supervisor for District 1</i>, Sierra County Board of Supervisors</p> <p>Peter Huebner, <i>Board Member</i>, Western Sierra Medical Clinic, and <i>Supervisor for District 2</i>, Sierra County Board of Supervisors</p> <ul style="list-style-type: none"> ■ What is the population and what geographic areas are served by the Western Sierra Medical Clinic in Downieville? ■ What type of county and/or community support and infrastructure exists in Downieville to complement or supplement the clinic: emergency medical services, fire departments, police, other community structures? ■ How does care delivery in frontier locations differ from that provided in less remote rural sites? ■ What is the history of the clinic? How well is the clinic integrated into the community's social fabric? ■ On what sources of revenue does the clinic rely? How does the clinic's federally qualified health center look-alike status affect the viability of the clinic? ■ How close, in proximity, are other medical facilities or providers? ■ How do Mr. Lang and clinic staff interact with other area (or the nearest other) hospitals and providers? ■ How difficult is it to attract and retain clinic staff? How important has the National Health Service Corps been in securing health professionals? ■ What measures are taken to maintain and improve quality of care?

Agenda/continued ►

AGENDA

Thursday, March 31, 2005 / continued

3:15 pm	Free time in Downieville
4:00 pm	Bus Departure – Nevada City
5:15 pm	Free time on Broad Street, Nevada City
6:00 pm	Dinner – Citronee Bistro and Wine Bar [320 Broad Street, Nevada City]
7:30 pm	Bus Departure – Headquarters hotel

Friday, April 1, 2005

Morning	Check-out from headquarters hotel and departure to Sacramento International Airport
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AGENDA

Federal and Foundation Participants

Johanna Barraza-Cannon

Technical Director

Division of State Children's
Health Insurance
Center for Medicaid and
State Operations
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Christine Brudevold, PhD

Assistant Director

Medicare Payments Team
Government Accountability Office

Jennifer Bryning

Legislative Analyst

Office of the Assistant Secretary
for Legislation
Department of Health and
Human Services

Matt Cutler

Senior Policy Analyst

Office of the Assistant Secretary for
Budget, Technology, and Finance
Department of Health and
Human Services

Sam duPont

Legislative Assistant

Office of Rep. Wayne T. Gilchrest (R-MD)
U.S. House of Representatives

Michael Fiore

Director

Division of Managed Care Policy
Medicare Plan Policy Group
Center for Beneficiary Choices
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Suzanne Hassett

Policy Coordinator

Office of the Secretary
Department of Health and
Human Services

Thomas W. Hertz, PhD

Senior Policy Analyst

Office of Health Policy
Office of the Assistant Secretary for
Planning and Evaluation
Department of Health and
Human Services

Leah Kegler

Special Assistant

Office of the Administrator
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Christopher W. Loftis, PhD

Congressional Fellow

Committee on Health, Education,
Labor, and Pensions
U.S. Senate

Barbara Masters

Public Policy Director

The California Endowment

James Miller

Legislative Assistant

Office of Rep. J. Gresham Barrett (R-SC)
U.S. House of Representatives

Heather Mizeur

Director of Domestic Policy

Office of Sen. John F. Kerry (D-MA)
U.S. Senate

Participants / continued ►

Federal and Foundation Participants / continued

Tom Morris

Deputy Director
Office of Rural Health Policy
Health Resources and
Services Administration
Department of Health and
Human Services

Lori Neal

Legislative Assistant
Office of Sen. Blanche Lincoln (D-AR)
U.S. Senate

Frank Szefflinski

Senior Health Insurance Specialist
Division of Managed Care Policy
Medicare Plan Policy Group
Center for Beneficiary Choices
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Sibyl Tilson

Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Deborah Veres

Professional Staff Member (D)
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Peggy Broussard Wheeler

Rural Policy Analyst
California State Legislature
Rural Caucus

Deborah Williams

Professional Staff Member (R)
Committee on Ways and Means
U.S. House of Representatives

PARTICIPANTS

NHPF Staff

Judith D. Moore

Senior Fellow

Eileen Salinsky

Principal Research Associate

Jessamy Taylor

Research Associate

Marcia Howard

Program Associate

Biographical Sketches

Federal and Foundation Participants

Johanna Barraza-Cannon is the technical director in the Division of State Children's Health Insurance in the Centers for Medicare & Medicaid Services. As part of her work, she provides technical assistance to both internal and external constituents on SCHIP (State Children's Health Insurance Program) policy, rules, and regulations. Ms. Barraza-Cannon also provides assistance to states on state plan amendments, section 1115 demonstrations, quality and performance measurement, reporting requirements, and program implementation and operation issues. Her areas of interest include barriers to care for minority populations, including migrant farm workers. She worked as a consultant on Medicaid and other health care issues for three years with Tucker Alan, Inc., and worked as an analyst in the Illinois State Legislature, Majority House Research and Appropriations staff. She has a master's degree from the University of Chicago.

Christine Brudevold, PhD, has more than 25 years of health care experience, both domestic and international. She joined the Government Accountability Office (GAO) as an assistant director on the Medicare Payments Team in 2002, and has been focusing on various Medicare and private sector health care finance issues. Prior to working at the GAO, Ms. Brudevold spent several years doing health care reform and independent consulting work throughout Asia. Her experience includes managing a Blue Cross Blue Shield HMO in Massachusetts and directing research activities for the Group Health Association of America. Ms. Brudevold has a PhD degree from the University of Hong Kong and an MPH degree from the University of Rochester.

Jennifer Bryning is a legislative analyst at the Department of Health and Human Services (DHHS) in the Office of the Assistant Secretary for Legislation, where she is responsible for congressional legislation, hearings, and inquiries related to health information technology, the uninsured, and all programs administered by the Health Resources and Services Administration (HRSA). Ms. Bryning joined the federal government as a presidential management fellow in 2001 and has worked in the DHHS budget office and the HRSA Community Health Centers program. Before joining the federal government, she worked for several nonprofit social services organizations in Southern California. She has a master of public policy degree from the UCLA School of Public Affairs and a bachelor's degree from Whittier College.

Matt Cutler is a senior policy analyst in the Office of the Assistant Secretary for Budget, Technology, and Finance in the Department of Health and Human Services. He has seven years of experience working on Medicare hospital payment issues and is his office's team leader on Medicare rural health and quality of care issues. Mr. Cutler has a bachelor's degree in history from the University of

Minnesota and a master's degree in public policy from the La Follette Institute of Public Affairs at the University of Wisconsin, Madison.

Sam duPont is a legislative assistant for Rep. Wayne T. Gilchrest (R-MD). In addition to health care, he follows education, social security, telecommunications, small business, and financial issues for the Congressman. Before beginning work with Rep. Gilchrest in 2003, he was an intern for Rep. Katherine Harris (R-FL). Mr. duPont earned a BA degree in political science in 2003 from Davidson College, where he was a member of the student government and was active with Habitat for Humanity and the Davidson College Republicans.

Mike Fiore is the director of the Division of Managed Care Policy within the Center for Beneficiary Choices, Medicare Plan Policy Group. He is responsible for directing the policy related to the Medicare Advantage program, including issues related to benefits and beneficiary protections, quality improvement, and payment. Previously, Mr. Fiore was the director of the division responsible for Medicaid managed care policies and health care reform demonstrations. He has also worked in other parts of the Centers for Medicare & Medicaid Services, including its policy, regulations, and research offices. He has a BS degree in behavioral health and social work and an MBA degree.

Suzanne Hassett is a policy coordinator in the Office of the Secretary, Department of Health and Human Services, where she is responsible for coordinating policy information regarding the Medicaid program and State Children's Health Insurance Program (SCHIP). Before coming to the secretary's office in 2003, Ms. Hassett worked in the Office of the Administrator of the Health Care Financing Administration (now known as the Centers for Medicare & Medicaid Services), primarily on Medicaid and SCHIP issues. She also spent five years working in the Office of Sen. Jack Reed (D-RI).

Thomas W. Hertz, PhD, has worked for the Department of Health and Human Services (DHHS) since 1978, most of that time in the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the principal advisor to the secretary of DHHS on policy issues. Dr. Hertz is the ASPE policy analyst for Indian health issues. He also has focused on a variety of other public health and health financing policy issues, including health promotion and disease prevention, racial and ethnic disparities in health, rural health, telemedicine, Medicare reimbursement for home health agencies, health professions, and health care reform. He was a member of the team that developed the HIPAA (the Health Insurance Portability and Accountability Act of 1996) privacy regulations. Before joining ASPE, he worked in the Administration on Children, Youth and Families within DHHS, with a special interest in Head Start issues. Prior to that, he was a senior scientist in the Social Research Group, George Washington University, and an assistant professor in the Department of Human Development and Family Studies at Cornell University. He has a BA degree from Stanford University and a PhD degree in experimental child psychology from the University of Minnesota.

Leah Kegler serves as a special assistant to the director of Medicare outreach at the Centers for Medicare & Medicaid Services. She was previously a health policy

BIOGRAPHICAL SKETCHES

Participants

advisor to the majority staff of the Senate Committee on Finance during the writing and negotiating of the Medicare Modernization Act of 2003. Her work with the Committee focused on the low-income Medicare drug benefit, the Medicaid program, and Social Security Act child welfare programs. Before joining the panel, she worked for the Center for the Study of Human Resources in Austin, TX. Ms. Kegler earned a master's degree in public affairs from the LBJ School of Public Affairs at the University of Texas.

Christopher W. Loftis, PhD, is an American Association for the Advancement of Science congressional fellow in the Health Policy office of the Senate Committee on Health, Education, Labor, and Pensions, where he is responsible for issues pertaining to child health (including school-based health), the Substance Abuse and Mental Health Services Administration, infectious diseases, bioterrorism, medical marijuana, international AIDS, Medicaid and the State Children's Health Insurance Program, and many conditions with a strong behavioral health component (such as diabetes and obesity). Dr. Loftis holds a bachelor's degree from University of California, San Diego, and a doctorate in clinical psychology with a specialization in pediatric neuropsychology from the University of Florida. He completed a clinical internship at the Kennedy Krieger Institute at Johns Hopkins in Baltimore, Maryland, where he worked with children with traumatic injuries, developmental disabilities, and chronic illnesses.

Barbara Masters is the public policy director at The California Endowment. In that capacity, she helps the Endowment develop strategies to bring about long-term policy change in support of its mission. The Endowment strives to expand access to affordable, quality health care to the state's underserved individuals and communities and to improve the health status of all Californians. Ms. Masters most recently served as director of intergovernmental relations for the Los Angeles County Department of Health Services. There, she was responsible for developing and directing a comprehensive approach to state and federal governmental relations in support of the safety net and to improve access to health care for low-income populations. Prior to that, Ms. Masters spent six years as the vice president of the California Association of Public Hospitals and Health Systems. She previously worked for the Contra Costa County Health Services Department as special assistant to the director for policy, and as the executive assistant to the Hazardous Materials Commission. She began her career in health policy in Washington, DC, serving for six years as the legislative assistant for health for former Sen. Alan Cranston (D-CA). Ms. Masters received her bachelor's degree in molecular biology from the University of California, Berkeley, and her master's degree in molecular, cellular, and developmental biology from the University of Colorado, Boulder. She also completed the graduate certificate program for science communication at the University of California, Santa Cruz.

James Miller is a legislative assistant for Rep. J. Gresham Barrett (R-SC). He monitors issues including health, environment, family, telecommunications, and gun control policy. The Congressman represents the 3rd district of South Carolina, which includes Mr. Miller's hometown. Rep. Barrett has been in Congress since 2003 and serves on the House Committees on Financial Services, Budget, and

BIOGRAPHICAL SKETCHES

Participants

International Relations. Mr. Miller graduated in the spring of 2003 from Davidson College with a degree in political science.

Heather Mizeur is the director of domestic policy for Sen. John F. Kerry (D-MA), advising him on legislative strategy for all health and social policy issues. In addition to her Senate responsibilities, she worked with Sen. Kerry to write the health care reform plan and disabilities platform for his 2004 Presidential campaign. She took a leave of absence from the Senate in August of 2004 to be the Maryland state director for the Kerry-Edwards campaign. Ms. Mizeur joined Sen. Kerry's staff in April 2003 after spending over five years as the director of state affairs for the National Association of Community Health Centers, where she worked to promote laws, policies, and regulations to assist health centers and the low-income and uninsured patients they serve across the country. In the fall of 2002, Ms. Mizeur took a leave of absence from NACHC to serve as policy director for Maryland Lt. Governor Kathleen Kennedy Townsend's gubernatorial campaign. Prior to joining NACHC, Ms. Mizeur worked for several years in the U.S. House of Representatives, where she was legislative director to retired Congressman Joseph P. Kennedy II (D-MA) after working as a legislative assistant for Rep. Sheila Jackson Lee (D-TX) and former Rep. Marjorie Margolies-Mezvinsky (D-PA). Before moving to Washington, DC, Ms. Mizeur worked for two state legislators in Springfield, Illinois. In November 2003, she was elected to represent Ward 2 on the City Council for Takoma Park, Maryland.

Tom Morris is the deputy director for the Office of Rural Health Policy, where he coordinates budget and program activities for the office's seven grant programs. Mr. Morris also manages the office's response on policy issues with a particular emphasis on the rural implications of Medicare and Medicaid regulations, as well as other ongoing policy issues related to health workforce and service delivery. In addition, he serves as executive secretary for the National Advisory Committee on Rural Health and Human Services, which advises the secretary of the department of health and human services on issues affecting rural communities. Prior to assuming the acting deputy position, he served for four years as the office's policy coordinator. In that position, he served as the office's primary liaison with the Centers for Medicare & Medicaid Services (CMS). Mr. Morris has previous work experience as a fellow on the staff of Sen. Kent Conrad (D-ND) and with the CMS Office of Legislation. Prior to joining the government, he was a newspaper reporter and editor covering health care and other issues at two daily newspapers in North Carolina. Mr. Morris has an undergraduate degree in journalism from the University of North Carolina at Chapel Hill and a master's degree in public administration with a concentration in community health from East Carolina University.

Lori Neal has been a legislative assistant for Sen. Blanche Lincoln (D-AR) since July of 2003 and handles Social Security, Medicaid, Temporary Assistance for Needy Families (TANF), education, and other social policy issues. Prior to her current role, she served as legislative correspondent for Sen. Lincoln. Ms. Neal graduated from the University of Oklahoma in 1997 with a bachelor of science degree in education and earned a master of public administration degree from Columbia University in 2002.

BIOGRAPHICAL SKETCHES

Participants

Frank Szefflinski has worked for the federal government for nearly 30 years and is currently lead policy analyst for Medicare managed care access to care at the Centers for Medicare & Medicaid Services (CMS). He was the principle author of subpart C, Benefits and Beneficiary Protections, of the recently published Medicare Advantage regulation “CMS-4069-F.”

Sibyl Tilson, a specialist in social legislation, has been with the Congressional Research Service for five years. Her current position was preceded by employment with the General Accounting Office (now known as the Government Accountability Office), Coopers and Lybrand, the Massachusetts Medicaid program, and the Massachusetts Rate Setting Commission. Ms. Tilson has a BA degree in economics from Yale University and a master’s degree in city planning from the Kennedy School of Government at Harvard University.

Deborah Veres serves as minority professional staff for the House Committee on Ways and Means, Subcommittee on Health. In this position, Ms. Veres provides expert advice on all matters related to health policy, particularly initiatives to expand coverage. Previously Ms. Veres was the legislative assistant for health policy for Sen. Jay Rockefeller (D-WV) and the director of public policy for Ascension Health, the nation’s largest nonprofit health system. Ms. Veres received her undergraduate degree in government from the University of Alaska, Southeast. While completing this degree, she served in various capacities with the Alaska State Legislature. Ms. Veres later received a master of health administration degree from the University of Washington. She was awarded the David A. Winston national health policy fellowship, which brought her to Washington, DC, in 1998. She fulfilled her fellowship with the Subcommittee on Health by staffing the deliberations of the National Bipartisan Commission on the Future of Medicare.

Peggy Broussard Wheeler was hired as the policy analyst for the California State Legislature Rural Caucus in April 2004. In this capacity, she assists all members of the Rural Caucus by conducting research and providing analyses of relevant issues that affect individuals, families, and communities in rural California. In the course of a diverse 22-year career, Ms. Wheeler has gained a wealth of experience in the implementation and management of health care programs. In a position as program director for the National Health Service Corps (NHSC) project in the Arizona Rural Health Office (RHO), she conducted outreach and liaison activities to health care professionals serving in these communities, collecting input and feedback from NHSC constituents critical to developing future recruitment and retention strategies. The RHO assisted in the coordination of resources to help strengthen rural health care entities’ infrastructure and helped create a foundation for the retention of physicians and other health care professionals. Ms. Wheeler holds an MPH degree in program and clinic administration from the University of California, Berkeley, and a bachelor of science degree from the University of California, Davis.

Deborah Williams has worked on health care payment and technology coverage issues for the U.S. Congress and its advisors, the federal government, and the national hospital association. She currently serves as majority professional staff for the House Committee on Ways and Means, which oversees Medicare, taxes, trade, Social Security, and welfare. For the Committee, she has worked on a broad

BIOGRAPHICAL SKETCHES

Participants

array of Medicare national payment and coverage policy issues. Specifically, she was a lead staff member on provider payment issues, except physicians, during the negotiations on the Medicare Modernization Act, passed in 2003. She is currently examining the issues around tax exemption. She was also a senior analyst on the Medicare Payment Advisory Commission, which advises Congress on Medicare payment. For six years, Ms. Williams was responsible for Medicare hospital inpatient and outpatient issues for the American Hospital Association, working with government agencies, the Congress, hospital executives, and chief financial officers. In the early 1990s, Ms. Williams served as senior analyst for the Prospective Payment Assessment Commission, the original commission that advised Congress on how to implement and maintain the national payment systems. From 1986 to 1989, Ms. Williams worked as an economist for the Health Care Financing Administration, earning awards for her research. Ms. Williams worked on the development of the national fee schedule for physicians, focusing on geographic payment issues. Ms. Williams was trained as an economist.

BIOGRAPHICAL SKETCHES

Participants

Biographical Sketches

Speakers

Ward “Andy” Anderson has been the chief executive officer of Turtle Health Plan since July 2002. Turtle Health Plan will be the first American Indian Medicaid managed health care organization in the nation and will represent the first time in California Indian health history that 19 separate, independent, and distinct Indian health organizations have joined the same organization. Operations are estimated to start in June 2005 with about 20,000 enrollees within the first year. Prior to becoming the CEO of Turtle Health Plan, Mr. Anderson was the associate director of managed care and the deputy director of the California Rural Indian Health Board (CRIHB) in Sacramento, California. He joined that organization in 1999. CRIHB is a statewide, voluntary membership, advocacy association of Indian-controlled outpatient clinics, a quasi-federal agency, a technical assistance firm, and an Indian congress. From 1991 to 1999, he served as the executive director of Family Health Centers, Okanogan, Washington. Mr. Anderson began his experience in Indian health by directing the Toiyabe Indian Health Project in Bishop, California, from 1978 to 1991. There he was responsible for the entire administration, medical, dental, public health, mental health, and home health care services at three outpatient clinics. Mr. Anderson was a Peace Corps volunteer in southern Chile and also served as a recruiter and trainer for the Peace Corps. He has an MPH degree from the University of Southern California, Los Angeles.

Speranza Avram serves as the executive director for the Northern Sierra Rural Health Network, a nonprofit corporation based in Nevada City and Redding that is working to strengthen rural health services in the northeastern corner of California. The Network’s membership consists of over 40 rural clinics, rural hospitals, public health departments, and other health care providers located in nine counties in the northern part of the state. The Network is actively involved in managing a regional telemedicine network, providing technical assistance and technology services to the region’s rural health providers, and working to integrate mental health services into rural primary care practices in the region. Before joining the Network in 1995, Ms. Avram served as clinic manager at the Western Sierra Medical Clinic in Downieville. She has also worked as a consultant to bring increased resources for health services into rural communities throughout Northern California. Her clients included health care foundations, rural hospitals, rural clinics, public health departments, and other rural health organizations. She is the author of *Building Healthy Rural Communities in Northern California* as well as *Guide to Telecommunications Discount Programs for State and Federal Programs*. She has a BA degree in community studies from the University of California, Santa Cruz, and a master in public administration degree from the University of San Francisco.

Beth Butcher is the clinic manager and director of staff development for the Woodbridge Medical Group in Lodi, California, one of 10 clinic sites that constitute the Community Medical Centers, Inc. She moved to California three and a half years ago from Windsor, Ontario, Canada, where she worked as a hospital-based nurse for 28 years. Ms. Butcher spent much of that time working in an emergency room with a trauma unit that served a large area that was both urban and rural. She also worked in the intensive care and critical care units. During the last few years, she worked in an outpatient department at the hospital. At the Woodbridge clinic, Ms. Butcher has been particularly interested in improving care for patients with chronic conditions such as diabetes. The Woodbridge clinic has been an enthusiastic participant in the diabetes health disparities collaborative coordinated by the Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services. In her role as director of staff development, she is developing a staff education program to help the entire organization provide better care and education to their patient population.

Leona Butler is the chief executive officer of the Santa Clara Family Health Plan, the local health plan established by the Santa Clara County Board of Supervisors to provide managed care for the Medi-Cal population under the state's "Two Plan Model." Ms. Butler is responsible for developing and administering Santa Clara's Healthy Kids Program, the first program in the country to use local funds to cover uninsured children who are ineligible for other publicly funded programs such as Medi-Cal and California's State Children's Health Insurance Program, called Healthy Families. She is a major participant in the Children's Health Initiative (CHI), the overall effort to achieve health insurance coverage for 100% of Santa Clara's children through outreach in partnership with the county's Valley Health and Hospital System, as well as community clinics, schools, churches, and community-based organizations. Previously, Ms. Butler served as the chief executive officer of the Health Plan of San Joaquin, where she was responsible for designing the health plan, obtaining its Knox-Keene license, contracting with the Department of Health Services, and implementing all aspects of the Health Plan of San Joaquin, which had a membership of over 48,000. As vice president for provider affairs at Blue Cross of California, Ms. Butler was responsible for the conception, design, and implementation of the Prudent Buyer plan, the first large preferred provider organization in the state, and for designing and administering provider contracting for California Care. Ms. Butler spent three years with the California legislature as the chief staff person on the Medi-Cal program during a time of major Medi-Cal reform, and she organized and administered a large medical group in San Francisco, now known as the California Pacific Medical Group. Her health care experience started at the University of California San Francisco Medical Center, where she held a variety of positions, starting as an analyst for the chancellor and culminating as principal investigator for a grant to investigate ways to educate the public via television news.

Scott Christman came to the Office of Statewide Health Planning and Development (OSHPD) in 2001, where he has since coordinated the implementation of geographic information systems (GIS) technology. Currently, Mr. Christman is responsible for all aspects of the office-wide enterprise GIS program, serving as

BIOGRAPHICAL SKETCHES

Speakers

both project manager and technical coordinator. Prior to his work at OSHPD, Mr. Christman worked as a labor market analyst for the California Employment Development Department (EDD), where he applied GIS technology to expand and enhance labor market research and economic analysis for the department. He also served as a GIS Specialist for the EDD's Facilities Management group and later for the governor's Office of Emergency Services (OES). Mr. Christman earned a bachelor of economics degree from Sacramento State University. In May, he will graduate from the University of Southern California with a master of planning and development studies degree, focusing on the application of GIS in support of public policy and planning.

Kenneth Cohen is the director the San Joaquin County Health Care Services Agency and the chief executive officer of San Joaquin General Hospital. He has worked for San Joaquin County since October 2003, managing a \$500 million annual budget and nearly 3,000 employees. The Health Care Services Agency encompasses San Joaquin General Hospital and the Departments of Public Health, Behavioral Health, and Substance Abuse as well as the Public Guardian and Conservator Office. Before joining San Joaquin County, Mr. Cohen was the chief executive officer of the Alameda County Medical Center in Alameda, California, for two years. Prior to that, he spent 15 years in Riverside, California, initially as the hospital administrator at Riverside General Hospital University Medical Center, then as the director of Riverside County Health Services Agency, and finally as the director and chief executive officer of the Riverside County Health Services Agency and the Riverside County Regional Medical Center. He administered two hospitals in Hollywood, Florida, before moving to California. He serves on the boards of a number of community, state, and national organizations, including the Health Plan of San Joaquin, the California Association of Public Hospitals, and the National Association of Public Hospitals. He has received a number of professional and community recognition awards. Mr. Cohen was a 1998 senior policy fellow with the Robert Wood Johnson Foundation and the National Association of Public Hospitals. He received a bachelor of science degree from Ithaca College and a master of arts degree in health care administration from the George Washington University.

Dave Cogdill serves as the California State Assembly representative for the 25th district and chair of the California State Legislature Rural Caucus. He was first elected to this position in November 2000. He is a 22-year resident of Modesto where he owns his own real estate appraisal business. He began public service in 1975 when he was elected to the board of directors of the Bridgeport Fire Protection District in Mono County. Since then he has remained involved, serving on the Bridgeport School PTA, the Stanislaus County YMCA Board of Directors, the Modesto Chamber of Commerce Board of Directors, and captain of the Volunteer Fire Department. In 1991 he was elected to the Modesto City Council. In 1995, Assemblyman Cogdill received the Hispanic Chamber of Commerce's "Friend of the Year Award." He was also awarded the President's Award by the Stanislaus County YMCA in 1998. Although he did not seek a second term in the next election, he was appointed to the Council once again in 1996, from which he assumed his seat in the Assembly. He brings to Sacramento his

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commitment to improving schools, protecting property rights, increasing employment in the Valley, and lowering crime.

William “Bill” Davis, MD, is a family physician who practices medicine in the rural community of Winters, California, where he also resides. Dr. Davis is currently the president of the California Rural Health Association. Five years ago, Dr. Davis and community leaders in Winters received national attention when he became exasperated with the administrative demands associated with managed care systems. Health maintenance organizations and the medical association with which he was affiliated had rigid requirements for reimbursement that did not recognize the special needs of rural patients. He was ready to quit his practice all together. However, the 6,000 residents of Winters appreciated Dr. Davis’s personal style of medicine, which still includes house calls. They held a town meeting, gathered donated cash and materials, and transformed a one-time shoe repair shop into the Winters Healthcare Foundation. Through his work with the California Rural Health Association, Dr. Davis has joined with other rural clinics in California to advocate for rural health services.

John R. Deakyne is the chief financial officer for Mark Twain St. Joseph’s Hospital located in San Andreas, California, an affiliate of Catholic Healthcare West. Before this position he was the finance manager for the Maniilaq Health Center, a tribally run hospital located in the Northwest Arctic Borough of Alaska. He also has experience as the chief financial officer for a physical rehabilitation hospital in rural southeastern West Virginia and as the controller for a psychiatric hospital in Maine. Mr. Deakyne received a bachelor of business administration degree from Pace University and a master of business administration from New Hampshire College. He is a long-standing member of the Healthcare Financial Management Association.

Ben Gamez was born in Sacramento, California, into a farmworking family. Growing up he split his time between Mexico and the United States. Typically he lived in Mexico and attended school there three months a year and spent the other nine months each year in the United States going to school and learning English. Through the support of his wife and three children, he worked in the agricultural fields and went to school at the same time. Currently, he is working on a bachelor’s degree and will begin working toward a master’s degree in business administration in 2006. Since 2003 he has been working with El Concilio, where he started as a migrant outreach worker and worked his way up to become a program coordinator in the health department. He finds nothing more gratifying than helping vulnerable populations obtain health insurance, health-related education, and other resources. Through his work at El Concilio, he enjoys being a voice for the Hispanic community and serving as a bridge between the Spanish-speaking community and the health and social service programs that are available in San Joaquin County.

Arnold Gutman is the supervisor for district 1 for the Sierra County Board of Supervisors. He was elected to his third term in January 2005 and began his service on the Board in 1997. He also serves on the Sierra County Planning Commission to which he was appointed in 1995. He worked for Stauffer Chemical

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Company in Richmond, California, from 1962 to 1991 when he retired. He served in various capacities in the company, including inventing new agrochemicals, for which he was granted 103 U.S. patents and over 400 foreign patents, and coordinating the development of new research products.

Peter Huebner serves as a member of the board of directors for the Western Sierra Medical Clinic, is a volunteer with the Sierra City Fire Department, and is the supervisor for district 2 on the Sierra County Board of Supervisors. From 1971 to 1985, he owned and ran Scandinavian furniture stores in Walnut Creek and San Ramon, California. He retired from business in 1985 and has since served in a number of volunteer capacities.

Raymond Hino has served as the chief executive officer of Tehachapi Hospital since 1998. In 2001, the hospital achieved designation as California's third critical access hospital. During his career in hospital administration, he has worked in a variety of hospital settings, including proprietary, nonprofit, and governmental hospitals, and in hospitals ranging in size from 24 to 429 beds. Mr. Hino was a fellow in the National Association of Public Hospitals Management Fellowship Program in 1991. He is a diplomate in the American College of Healthcare Executives. He served two terms on the board of directors for the Montana Hospital Association and he is currently serving on the board of directors for the California Healthcare Association (CHA). He has been a member of the board of directors for the CHA Rural Healthcare Center since 1999. In 2003, he was elected chairman of the CHA Rural Healthcare Center. He graduated cum laude from the University of Southern California (USC) with a bachelor of science degree in public administration in 1976. In 1978, he received his master's degree in public administration (in the Health Services Administration Program), also from USC.

Barbara Johnston is the executive director of the California Telemedicine & eHealth Center (CTEC). She has been working in eHealth since 1995 and has undertaken both program development and research regarding clinical outcomes and cost effectiveness. Her current work at CTEC is focused on expanding health care access for rural and underserved populations by fostering the utilization of telemedicine technologies, telecommunications resources development, and direct funding for eHealth networks expansion throughout California. Previously, Ms. Johnston developed eMental Health programs in the United States and in Australia, where she served as an advisor to its Commonwealth Scientific and Industrial Research Organization. She was the chief operations officer for HealthShare, an internet-based virtual private network in Australia allowing rural communities to access otherwise unavailable mental health services. Prior to that position, Ms. Johnston worked within Kaiser Permanente's Division of Research as an eHealth manager, where she played a key role in developing an online program designed to treat patients with depression and bipolar disorders. Additionally, she was the research manager for Kaiser Permanente's benchmark study on the effectiveness of Telehomecare. Ms. Johnston has a master of nursing science, management and leadership degree.

Jana D. Katz has been working with the University of California, Davis, Health System since August of 1995, where she serves as the chief administrative officer

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for the Center for Health and Technology (CHT). The CHT oversees programs designed to enhance health care through the use of advanced telecommunications and information technology. Ms. Katz is responsible for the development and implementation of a number of initiatives using diverse technologies. At UC Davis, the CHT operates the Telemedicine Learning Center and uses video-based telemedicine, remote monitoring, distance education, medical informatics. Beyond her work with the CHT, for nine years she has reported directly to the chief executive officer of the UC Davis Health System as lead analyst and negotiator of a \$25 million yearly contract with Sacramento County, which includes all emergency and specialty care for County-responsible indigent patient and jail inmates. Prior to her role at UC Davis, Ms. Katz was with Stanford Health System, where she began with the Cardiovascular Service Line and later became the project manager for the Stanford Telemedicine Program. Ms. Katz is a nationally recognized speaker on telemedicine and has provided expert testimony to the California State Legislature. She is also a board member of the Center for Telehealth Law. After completing her undergraduate degree in Genetics from the University of California at Davis, Ms. Katz received a master in public health degree with an emphasis in health policy and administration from the University of California, Berkeley.

Michael Kirkpatrick has been, since 1977, the chief executive officer of Community Medical Centers, Inc., a community and migrant health center program serving four counties through ten clinic locations. He is a former president and a current member of the California Primary Care Association Board. Prior to joining Community Medical Centers, Inc., Mr. Kirkpatrick managed a number of primary care clinics in San Mateo and Santa Clara Counties. He serves on a number of additional state and community boards. Mr. Kirkpatrick received a BA degree in political science from the University of Alabama, attended the MBA program at the University of Alabama, and completed coursework for the MPA program at the University of San Francisco. He served in the Peace Corps in Latin America.

Frank J. Lang has been the executive director of the Western Sierra Medical Clinic since 1976. He received a BS degree in nursing from the University of Northern Colorado in 1970, a joint MS and NP degree from the University of Colorado in 1973, and a family nurse practitioner degree from the University of California, Davis, School of Medicine in 1976. He joined the Western Sierra Medical Clinic in 1976 as a member of the National Health Service Corps, U.S. Public Health Service. He is currently a second-year law student in the Executive Juris Doctorate Program at Concord University School of Law. He is involved in a number of community organizations in the Downieville, California, area.

Michael P. Lawson, FACHE, is the president of Mark Twain St. Joseph's Hospital in San Andreas, California, an affiliate of Catholic Healthcare West. Prior to this position he was president and chief executive officer of Brookside Hospital in San Pablo, California, and Sunnyside Community Hospital in Sunnyside, Washington. He has held senior positions at both community and academic medical centers. He is an active preceptor and lecturer for several universities and is on the faculty at St. Mary's College in Moraga, California. Mr. Lawson has served as

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regent for the American College of Healthcare Executives and as former president of the Healthcare Executives of Northern California. Mr. Lawson is an elected member of the Governing Council for Small and Rural Hospitals, American Hospital Association. He is active on many national and statewide professional and community organizations. Mr. Lawson received his master in health administration degree from Baylor University and attended the University of California at Berkeley for postgraduate studies.

Barbara Masters is the public policy director at The California Endowment. In that capacity, she helps the Endowment develop strategies to bring about long-term policy change in support of its mission. The Endowment strives to expand access to affordable, quality health care to the state's underserved individuals and communities and to improve the health status of all Californians. Ms. Masters most recently served as director of intergovernmental relations for the Los Angeles County Department of Health Services. There, she was responsible for developing and directing a comprehensive approach to state and federal governmental relations in support of the safety net and to improve access to health care for low-income populations. Prior to that, Ms. Masters spent six years as the vice president of the California Association of Public Hospitals and Health Systems. She previously worked for the Contra Costa County Health Services Department as special assistant to the director for policy, and as the executive assistant to the Hazardous Materials Commission. She began her career in health policy in Washington, DC, serving for six years as the legislative assistant for health for Sen. Alan Cranston (D-CA). Ms. Masters received her bachelor's degree in molecular biology from the University of California, Berkeley, and her master's degree in molecular, cellular, and developmental biology from the University of Colorado, Boulder. She also completed the graduate certificate program for science communication at the University of California, Santa Cruz.

Carol Mordhorst is the public health director for Mendocino County in Northern California. She has held this position for the past 14 years. Prior to this position, Ms. Mordhorst was the director of the Cochise County Public Health Department in Arizona. She has over 30 years of experience in the health and human services field. In addition to her positions with county public health, she has managed a community health center and worked in the developmental disabilities field. Ms. Mordhorst focuses on public health from the rural perspective. She is also interested in issues of access to care for rural residents. She serves as chairperson of the County Medical Services Program, which is made up of 34 small counties to provide services for medically needy indigent adults in rural areas of California. She is also a member of the California Small County Health Executives Committee and the California State Rural Health Association. Ms. Mordhorst has also been a leader in community mobilization for population health improvement. Currently, she manages several grants that focus on community health improvement. She has a bachelor's degree in business administration.

Thomas Nesbitt, MD, MPH, serves as the associate dean for graduate medical education, continuing medical education, and outreach and has been with the University of California, Davis, School of Medicine for 16 years. Dr. Nesbitt received his

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medical degree from the University of California, Davis; completed his residency training through the Spokane Family of Medicine Residency Program, an affiliate of the University of Washington School of Medicine; and obtained his master of public health degree at the University of Washington's School of Public Health. He is a member of the Alpha Omega Alpha Honor Society. Dr. Nesbitt is currently a tenured professor at the UC Davis Department of Family and Community Medicine. Under the long-term leadership of Dr. Nesbitt, the UC Davis Health System (UCDHS) has developed one of the nation's leading telehealth programs, now under the umbrella of the Center for Health and Technology (CHT). The Telemedicine Program, founded by Dr. Nesbitt, includes a variety of applications, such as video-based consultations, store-and-forward services, emergency room and intensive care unit monitoring, radiology, and home health. The program provides over 80 clinic and hospital sites with access to more than 30 medical specialties. In addition to clinical services, UCDHS established the UCD Telemedicine Learning Center in 1999 and has since provided an intensive three-day telemedicine training program to over 600 health care professionals, including physicians, clinic coordinators, business executives, and technicians.

Judith Shaplin has been working with Mountain Health & Community Services (MHCS) since 1985. Under her leadership, services have increased beyond primary care, moving toward comprehensive health care including x-ray, mental health, and health education. In 1998, when no other community organization was able to provide the necessary infrastructure, she accepted the responsibility of operations at Mt. Empire Community Center, located in Campo, California. This community center houses the Mountain Empire Senior Nutrition Center, which offers senior meals at five community sites and meal delivery to the homebound, a computer learning center, and a family literacy program and also hosts community forums and events. Ms. Shaplin believes that the inclusion of community services enhances medical services and benefits communities. Increasing visibility of rural San Diego County and its many unaddressed issues has been Ms. Shaplin's focus. She works to ensure a "safety net" of services for our isolated communities. She has taken a leadership position in bringing together the disconnected communities of the region through collaboration. Her efforts include work with the Back County Revitalization, the Mt. Empire Collaborative, the annual Heart of the Mountain Awards, the Rural Emergency Preparedness Group, the San Diego Council of Community Clinics, the Southern California Rural Health Roundtable. She also has an active membership role with the California State Rural Health Association (CSRHA).

Herrmann Spetzler has been the chief executive officer and executive director of Open Door Community Health Centers, Inc., since 1977. He is a co-founder of the California Primary Care Association and currently serves on its board of directors. He founded the California State Rural Health Association in 1995 and also served as the president of its board. He is actively involved in a number of other rural health and human services-related organizations in his community and in the state. Prior to joining Open Door Community Health Centers, Inc., Mr. Spetzler worked for the Sierra Council on Alcoholism and Alcohol Abuse and the Orange County Department of Mental Health. He holds a BS degree from California State

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University and an MA degree from Humboldt State University, and he has completed MIS graduate seminars at Stanford University.

Sandra Shewry is the director of California's State Department of Health Services (DHS), one of the largest state departments with a budget of \$32 billion and 6,000 employees. Ms. Shewry administers public health, education, disease prevention, and health protection programs for 35 million Californians. She administers the state's Medicaid Program (Medi-Cal) providing health care services to more than six million individuals annually. Prior to joining DHS in 2004, she was the director of health at the National Governor's Association's Center for Best Practices, where she directed research, analysis, technical assistance, and resource development on a broad range of health financing, service delivery, and policy issues. Ms. Shewry also served as the executive director of the California Managed Risk Medical Insurance Board and was responsible for development and implementation of California's high risk pool, a subsidized pregnancy coverage program, a small employer purchasing cooperative, and the state's Children's Health Insurance Program, called Healthy Families. Ms. Shewry has over 20 years' experience in California state government. She began her state career with DHS as a health planning analyst and later served as an assistant secretary at the Health and Welfare Agency. Her interests and expertise are in the areas of health care financing, insurance markets, public private partnerships, and health care purchasing. Ms. Shewry earned graduate degrees in public health and social welfare from the University of California, Berkeley.

Guillermo Vicuna, DDS, practiced dentistry for 30 years and is a co-founder and president of the board of Su Salud, a Stockton, California, based nonprofit organization. Su Salud focuses on disease prevention through health education for the underserved, uninsured working poor and is an entirely volunteer organization. He graduated from the University of Buenos Aires, Argentina, School of Dentistry and completed a postdoctoral fellowship in preventive dentistry at the University of California, San Francisco, School of Dentistry. He was appointed adjunct clinical professor in restorative dentistry by the University of the Pacific, School of Dentistry and became clinical director for dental services at the San Joaquin General Hospital in Stockton in 1999. In recognition of his leadership and continuing efforts to improve the health of others, he has received an impressive list of distinguished honors from a variety of individuals and organizations. He was the recipient of a "1000 Points of Light" award by former President George Bush.

Steve Viramontes has worked as a public health nurse for the last 18 years. He has spent 12 of those years working for Indian Health clinics. A majority of his experience was gained as the director of outreach at both Consolidated Tribal Health in Ukiah, California, and Round Valley Indian Health Center in Covelo, California. Recently he has worked as a diabetes project specialist for the California Area Indian Health Service, and currently he is the telemedicine coordinator for the Round Valley Indian Health Center and the California Area Indian Health Service.

Kathy Yarbrough is the executive director of the Rural Health Design Network. She has over 35 years of demonstrated leadership experience in both the operation of nonprofit, rural, public and district health care systems, and in the development

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of rural health networks with an emphasis on community-based health planning and strategic development. Her other areas of expertise include the development and implementation of continuous quality improvement programs; marketing and public relations programs; partnership and affiliation processes; development of community specific physician recruitment and retention programs; organizational and financial restructuring; ambulatory and in-patient service development; community based clinic development; capital campaign development; and new facility planning, development, and opening. Ms. Yarbrough has been recognized for her leadership and contributions to rural health in California. She has served in leadership positions for a number of health and hospital related organizations, including the California Healthcare Association and its Rural Health Advisory Board; the California Healthcare Collaborative; the Hospital Council of Northern and Central California; the California Association of Hospitals and Health Systems and its Political Action Committee; the American Hospital Association; the California State Rural Health Association; and First Five of Calaveras County.

Peter Yellowlees, MBBS, MD, is a professor of psychiatry and the director of academic information systems at the University of California, Davis. He recently moved to California from Australia, where he worked for 20 years after undertaking his medical training in London. He has an international reputation in telemedicine and long-distance health and education delivery and is an experienced speaker who has given over 100 presentations in 20 countries in the last five years. He has a number of research interests and is presently working on projects involving robotic surgery, electronic record implementation, data mining and disease management protocols, internet e-mail and video consultation services, and electronic death record certification processes. Dr. Yellowlees is a psychiatrist who has worked in public and private sectors, in academia, and in rural settings. He has published three books and approximately 100 scientific articles and book chapters, and he has been regularly involved in media presentations. He has been a consultant to governments and private sector companies in several countries and has received about \$5 million in research grants. His main interests are in improving access to health and education services using information technologies.

BIOGRAPHICAL SKETCHES

Speakers

Rural California Speaker Contacts

Ward “Andy” Anderson

Chief Executive Officer

Turtle Health Plan

2033 Howe Avenue, Suite 160

Sacramento, CA 95825

Phone: 916/286-7215

Fax: 916/679-6383

E-mail: aanderson@turtlehealth.org

Speranza Avram

Executive Director

Northern Sierra Rural Health Network

700 Zion Street, Suite E

Nevada City, CA 95959

Phone: 530/470-9091

Fax: 530/470-9094

E-mail: speranza@nsrhn.org

Beth Butcher

Clinical Manager

Woodbridge Medical Group

2401 W. Turner Road, #450

Lodi, CA 95242-2185

Phone: 209/370-1700

Fax: 209/370-1737

E-mail: bbutcher@communitymedicalcenters.org

Leona Butler

Chief Executive Officer

Santa Clara Family Health Plan

210 E. Hacienda Avenue

Campbell, CA 95008

Phone: 408/874-1702

E-mail: lbutler@scfhp.com

Scott Christman

Enterprise GIS Coordinator

CA Office of Statewide Health

Planning and Development

818 K Street, Room 300

Sacramento, CA 95814

Phone: 916/323-1414

Fax: 916/322-1693

E-mail: schristm@oshpd.state.ca.us

Kenneth Cohen

Director

San Joaquin County Health

Care Services

500 West Hospital Road

French Camp, CA 95231

Phone: 209/468-6600

Fax: 209/468-6136

E-mail: k.cohen@sjgh.hs.co.san-joaquin.ca.us

Assemblyman Dave Cogdill

Chair

California State Legislature Rural Caucus

State Capitol, Room 4117

Sacramento, CA 95814

Phone: 916/319-2025

Fax: 916/319-2125

William “Bill” Davis, MD

President

California State Rural Health Association

23 Main Street

Winters, CA 95694

Phone: 530/795-4377

E-mail: wbdavismd@sbcglobal.net

John R. Deakyne

Chief Financial Officer

Mark Twain St. Joseph’s Hospital

768 Mountain Ranch Road

San Andreas, CA 95249

Phone: 209/754-2515

Fax: 209/754-2626

E-mail: jdeakyne@chw.edu

Benjamin Gamez

Program Coordinator

Salud Primero

807 N. San Joaquin Street

2nd floor

Stockton, CA 95202

Phone: 209/547-2855

Fax: 209/468-9683

E-mail: bgam@elconcilio.org

Speaker Contacts / continued ►

Rural California Speaker Contacts / continued

Arnold Gutman

Supervisor for District 1
Sierra County Board of Supervisors
PO Box 484
Downieville, CA 95936
Phone: 530/289-3423

Peter Huebner

Board Member
Western Sierra Medical Clinic
PO Box 349
Sierra City, CA 96125
Phone: 530/862-1004
E-mail: pwhziggy@cwo.com

Raymond Hino

Chief Executive Officer
Tehachapi Hospital
PO Box 1900
Tehachapi, CA 93581
Phone: 661/823-3001
E-mail: ceo@tvhd.org

Barbara Johnston

Executive Director
California Telemedicine & eHealth Center
1215 K Street, Suite 800
Sacramento, CA 95814
Phone: 916/552-7679
E-mail: bjohnston@calhealth.org

Jana D. Katz

Chief Administrative Officer
Center for Health and Technology
UC Davis Medical Center
2315 Stockton Boulevard
Sherman Way Building
Sacramento, CA 95817
Phone: 916/734-1361
Fax: 916/734-1366
E-mail: jana.katz-bell@ucdmc.ucdavis.edu

Michael Kirkpatrick

Chief Executive Officer
Community Medical Centers, Inc.
701 E. Channel Street
Stockton, CA 95202
Phone: 209/944-4705
E-mail: mkirkpatrick@communitymedicalcenters.org

Frank J. Lang

Executive Director
Western Sierra Medical Clinic
PO Box 286
Downieville, CA 95936
Phone: 530/289-3298
Fax: 530/289-3159
E-mail: FrankJLang@wsmcmed.org

Michael P. Lawson, FACHE

President
Mark Twain St. Joseph's Hospital
768 Mountain Ranch Road
San Andreas, CA 95249
Phone: 209/754-2515
Fax: 209/754-2626
E-mail: mlawson@chw.edu

Barbara Masters

Public Policy Director
The California Endowment
21650 Oxnard Street, Suite 1200
Woodland Hills, CA 91367
Phone: 818/593-6600
Fax: 818/703-4193
E-mail: bmasters@calendow.org

Carol Mordhorst

Chair
County Medical Services Program
Governing Board
1120 S. Dora Street
Uria, CA 95482
Phone: 707/472-2777
E-mail: mordhorc@co.mendocino.ca.us

Thomas Nesbitt, MD, MPH

Associate Dean, GME, CME, and Outreach Director
Center for Health and Technology
UC Davis Health System
2315 Stockton Boulevard
Sherman Way Building, Room 3160
Sacramento, CA 95817
Phone: 916/734-5675
E-mail: thomas.nesbitt@ucdmc.ucdavis.edu

Speaker Contacts / continued ►

CONTACTS

Rural California Speaker Contacts / continued**Judith Shaplin**

Chief Executive Officer
Mountain Health and Community
Services
31115 Highway 94
Campo, CA 91906
Phone: 619/478-5254 Ext. 28
E-mail: jshaplin@mtnhealth.org

Herrmann Spetzler

Executive Director
Open Door Community Health
Centers, Inc.
785 18th Street
Arcata, CA 95521
Phone: 707/826-8633 x124
Fax: 707/826-8638
E-mail: hspetzler@
opendoorhealth.com

Sandra Shewry

Director
California Department of
Health Services
1000 G Street, Suite 450
Sacramento, CA 95814
Phone: 916/324-4695
E-mail: sshewry@dhs.ca.gov

Guillermo Vicuna, DDS

President of the Board
Su Salud
6069 Huntingdale Circle
Stockton, CA 95219
Phone: 209/473-1714
E-mail: gcvicuna@sbcglobal.net

Steve Viramontes

Telemedicine Coordinator
Round Valley Indian Health Center
PO Box 247
Corelo, CA 95428
Phone: 707/983-6404 x136
Cell: 707/367-0520
E-mail: stevev@california.ihs.gov

Kathy Yarbrough

Executive Director
Rural Health Design Network
40 A. North Main, PO Box 1542
San Andreas, CA 95249
Phone: 209/754-4181
Home: 209/754-4171
E-mail: kathyarborough@msn.com

Peter Yellowlees, MBBS, MD

Professor of Psychiatry
Director of Academic Information Systems
UC Davis
2315 Stockton Boulevard
Sacramento, CA 95817
Phone: 916/734-8581
E-mail: peter.yellowlees@
ucdmc.ucdavis.edu

CONTACTS

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National Health Policy Forum

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2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390

202/862-9837 [fax]

nhpf@gwu.edu [e-mail]

www.nhpf.org [web]
