

1996
Program Authorization Review

Executive Summaries

Governor's Office of Strategic Planning and Budgeting
and
Joint Legislative Budget Committee Staff

November 1, 1995



STATE OF ARIZONA

PROGRAM AUTHORIZATION REVIEWS - COMPOSITE REPORT
1996 Legislative Session

TABLE OF CONTENTS

Page No.

Introduction.....INT-1

Program Authorization Reviews for each Program

Enterprise Network Services - JLBC/OSPB Executive Summary.....ADOA-1
Enterprise Network Services - Strategic Plan FY 1996 - FY 1998.....ADOA-5
Arizona Department of Administration - Comments on PAR.....ADOA-9

State Agriculture Laboratory - JLBC/OSPB Executive Summary.....ADA-1
State Agriculture Laboratory - Strategic Plan FY 1996 - FY 1998.....ADA-5
Department of Agriculture - Comments on PAR.....ADA-9

Complex Administration - JLBC/OSPB Executive Summary.....DOC-1
Complex Administration - Strategic Plan FY 1996 - FY 1998.....DOC-3
Department of Corrections - Comments on PAR.....DOC-5

Drop-Out Prevention - JLBC/OSPB Executive Summary.....ADE-1
Drop-Out Prevention - Strategic Plan FY 1996 - FY 1998.....ADE-5
Department of Education - Comments on PAR.....ADE-6

Underground Storage Tank - JLBC/OSPB Executive Summary.....DEQ-1
Underground Storage Tank - Strategic Plan FY 1996 - FY 1998.....DEQ-5
Department of Environmental Quality - Comments on PAR.....DEQ-7

Diagnostic Services - JLBC/OSPB Executive Summary.....DJC-1
Diagnostic Services - Strategic Plan FY 1996 - FY 1998.....DJC-5
Department of Juvenile Corrections - Comments on PAR.....DJC-7

Judicial Collection Enhancement Fund - JLBC/OSPB Executive Summary.....JUD-1
Judicial Collection Enhancement Fund - Strategic Plan FY 1996 - FY 1998.....JUD-5
Judicial System - Comments on PAR.....JUD-7

Rural Health Programs:

Overall Rural Health Executive Summary.....RH-1
University of Arizona Rural Health Office - Comments on Rural Health PAR.....RH-25
Department of Health Services - Comments on Rural Health PAR.....RH-28
Board of Medical Student Loans - Comments on Rural Health PAR.....RH-31

**PROGRAM AUTHORIZATION REVIEWS - COMPOSITE REPORT
1996 Legislative Session**

**TABLE OF CONTENTS
(continued)**

Rural Health Programs: (continued)

| | |
|--|--------|
| Arizona Health Education Centers - JLBC/OSPB Executive Summary..... | ABOR-1 |
| Arizona Health Education Centers - Strategic Plan FY 1996 - FY 1998..... | ABOR-5 |
| AzaAHEC - Comments on PAR..... | ABOR-7 |
| Medical Malpractice - JLBC/OSPB Executive Summary..... | DHS-1 |
| Medical Malpractice - Strategic Plan FY 1996 - FY 1998..... | DHS-5 |
| Primary Health Care - JLBC/OSPB Executive Summary..... | DHS-7 |
| Primary Health Care - Strategic Plan FY 1996 - FY 1998..... | DHS-9 |
| Loan Repayment - JLBC/OSPB Executive Summary | DHS-11 |
| Loan Repayment - Strategic Plan FY 1996 - FY 1998 | DHS-13 |
| Department of Health Services - Comments on PAR | DHS-15 |
| Medical Student Loan Program - JLBC/OSPB Executive Summary | MSLB-1 |
| Medical Student Loan Program - Strategic Plan FY 1996 - FY 1998..... | MSLB-5 |
| Board of Medical Student Loans - Comments on PAR | MSLB-7 |

INTRODUCTION

Overview - The Arizona Budget Reform legislation (Laws 1995, Chapter 283) established the process for Program Authorization Reviews (PAR). The PARs provide an opportunity for the Governor and Legislature to review State government programs. These program reviews are now part of the annual budget process and will result in decisions to retain, eliminate, or modify particular programs. Chapter 283 identified ten programs for the first cycle of reviews during the 1996 legislative session and fifteen for review in 1997. The first ten programs and subprograms are identified in Table 1.

The Joint Legislative Budget Committee (JLBC) staff and the Governor's Office of Strategic Planning and Budgeting (OSPB) have completed their review of these first ten programs, based upon self-assessments prepared by the agencies. This composite report summarizes the findings for all ten programs subject to PAR during the 1996 legislative session.

**Table 1: Programs Subject to PAR
1996 Legislative Session**

| Budget Unit Name | Program/Subprogram Name |
|-------------------------------------|--|
| Department of Administration | Enterprise Network Services |
| Department of Agriculture | State Agriculture Laboratory |
| Department of Corrections | Complex Administration |
| Department of Education | Drop-Out Prevention |
| Department of Environmental Quality | Underground Storage Tank |
| Department of Juvenile Corrections | Diagnostic Services |
| Judicial System | Judicial Collection Enhancement Fund |
| <u>Rural Health Programs</u> | |
| Board of Regents | Arizona Health Education Centers (Pass-through program) |
| Department of Health Services | Medical Malpractice, Primary Health Care, and Loan Repayment |
| Medical Student Loan Program | Entire Budget Unit |

PAR Process - The PAR process consists of three phases. The agency responsible for a program subject to PAR initiates the process by conducting a self-assessment of the program. This assessment answers specific questions in six categories: Background Information, Program Funding, Strategic Planning, Performance Measurement, Performance Results, and Other Issues posed by the Legislature, the Executive, or the Agency. The Agency Self-Assessment Checklist, which contains the specific questions the agencies were required to address, immediately follows this section.

Timeframes were very compressed for this first review cycle. The JLBC and OSPB staff issued PAR Guidelines to the agencies in April, 1995. The agencies then began to conduct their self-assessments. They were required to submit their written self-assessments to the JLBC and OSPB staff by July 1, 1995. In future years, the agencies will complete these self-assessments by April 1st.

In the second phase, the JLBC and OSPB staff jointly reviewed the agency self-assessment, and gathered additional information, as appropriate, to validate the agency's responses. Together, the two staffs then prepared a draft report of their findings for each of the ten programs. In mid-September, agencies were afforded an opportunity to review and comment on the draft reports. The JLBC and

OSPB staff made some revisions in response to additional information provided by the agencies. In October, each agency again reviewed the final product and prepared a formal response. These agency responses are included in the published reports. As required by law, the JLBC and OSPB staff published the final joint PAR reports on November 1, 1995. The two staffs also prepared this composite PAR document, which has been provided to each legislator, the Governor and the affected agencies. In future years, the JLBC/OSPB staff joint reports must be completed by October 1st.

In the third phase, the JLBC and OSPB staff will determine, as part of their ensuing budget recommendations, whether to retain, eliminate, or modify funding and related statutory references for the programs. Finally, these recommendations will be considered by the appropriate legislative committees during the legislative session.

Composite Report Organization - This Composite PAR Report is structured as follows: After this Introduction, summary information is provided on each of the ten programs. (Pages are numbered according to an abbreviation for each agency, as shown in Table 2 below). For each program, the following three items are included:

1. JLBC/OSPB Executive Summary (on lavender paper). This 2-3 page narrative summarizes the two offices' joint findings on the program based upon the agency self-assessment. Key conclusions are listed first in the Overview section, followed by a brief description of the program. The balance of the Executive Summary narrative addresses a standard set of questions:

- *How does the mission fit within the agency's overall mission and program's enabling authority?*
- *Do the historical performance measurements and the future performance targets adequately measure goals?*
- *Does the program perform efficiently and effectively, including comparisons with other jurisdictions?*
- *Are there other cost-effective alternative methods of accomplishing the program's mission?*
- *Are there other special issues of interest? (if applicable)*

JLBC/OSPB staff's responses to these questions, where especially important, appear in bold. These bolded statements constitute **findings**.

2. Program Strategic Plan for FY 1996 - FY 1998 (on white paper). The program strategic planning information is presented in a format adapted from the published *Master List of State Government Programs*. Included are the program (or subprogram) mission, description, funding formulas, goals, objectives, performance measures, performance data, funding, and FTE information. Many of the agencies have revised their strategic plans since the *Master List* was published, and this updated planning information has been incorporated, where available.

3. Agency Final Response to the Joint JLBC/OSPB PAR Report (on gray paper). Agencies were asked to limit their final, published responses to five pages.

Rural Health Programs - Three of the programs and subprograms selected for review in this first cycle address rural health issues. Chapter 283 prescribed that these programs be considered together in addressing the State's role in rural health. Therefore, the JLBC and OSPB staff prepared an Overall Rural Health Executive Summary, which appears only in this composite report along with the other three health-related programs. Since this overall document addresses broader rural health policy issues, it has a different format than the individual PAR executive summaries.

Individual PAR Reports - The JLBC/OSPB staff have also prepared individual reports for each of the ten programs subject to PAR. These documents contain much more detail about the program, and are available upon request. In addition to the information contained in this composite document, the individual reports include the agency's self-assessment and the JLBC/OSPB commentary on the agency's narrative.

Further Information - Copies of the individual PAR reports can be obtained by contacting Marge Cawley at the JLBC Staff office (542-5491) or Peggy O'Sullivan-Kachel at the OSPB office (542-5381). These two persons can also respond to general questions about the PAR process. For additional information about the specific programs subject to PAR, readers may want to contact the appropriate person from the agency, JLBC, and OSPB. These contacts are listed in Table 2.

Table 2: Contact Persons for PAR Programs

| Agency Abbrev. | Program/Subprogram Name | Agency Contact | JLBC Analyst | OSPB Analyst |
|-----------------------|---|-----------------------|-------------------------|---------------------|
| ADOA | Enterprise Network Services | Tim Boncoskey | Lynne Smith / Phil Case | Tom Betlach |
| ADA | State Agriculture Laboratory | Dwight Harder | Karen Bock | Pam Scharon |
| DOC | Complex Administration | Don Horne | Lorenzo Martinez | Doug Tucker |
| ADE | Drop-Out Prevention | Trudy Rogers | Steve Schimpp | Rita Sauv |
| ADEQ | Underground Storage Tank | Wayne Aerni | Renee Bahl | Marcel Benberou |
| DJC | Diagnostic Services | Dave McCarroll | Karen Bock | John McCarthy |
| JUD | Judicial Collection Enhancement Fund | Agnes Felton | Brad Beranek | Mark DiNunzio |
| ABOR | Arizona Health Education Centers (Pass-through program) | Don Proulx | John Lee | Anne Barton |
| DHS | Medical Malpractice, Primary Health Care and Loan Repayment | Becky Derr | Jason Hall | Melodie Jones |
| MSLB | Medical Student Loan Board | Maggie Gumble | Bruce Groll | Melodie Jones |

For questions about the Overall Rural Health Executive Summary, contact Michael Bradley of JLBC, or Melodie Jones or Anne Barton of OSPB.

PROGRAM AUTHORIZATION REVIEW FACTORS AGENCY SELF-ASSESSMENT CHECKLIST

Program/Subprogram Name: _____

| Category | Factors | Questions ² | Addressed | |
|------------------------|-------------------------------|--|---------------------------|------------------------------------|
| | | | In Narrative ¹ | In Attached Materials ¹ |
| Background Information | A. Program Purpose | 1. What was the program originally designed to address? 2. What is the program's enabling authority/legal mandate? 3. What is the benefit to the taxpayers? 4. Provide a brief history of the program's development (i.e., date started, statutory changes, etc). | | |
| | B. Customers and Stakeholders | 1. Who are the customers of this program? 2. Who are the primary stakeholders? | | |
| | C. Primary Activities | 1. What are the primary activities of this program? 2. What major operational processes are associated with delivery of this program's services? | | |
| | D. Related Programs | 1. What are the related programs within and external to the agency? 2. What are the relationships to other programs and organizations? 3. How is the agency coordinating its program activities to avoid duplication or conflict with related programs? | | |

¹ For each question, note the page number in the self-assessment narrative or attached materials where this issue is addressed.

² These questions would also need to be addressed for subprograms, as appropriate.

| Category | Factors | Questions ² | Addressed | |
|-----------------|--------------------------------|--|---------------------------|------------------------------------|
| | | | In Narrative ¹ | In Attached Materials ¹ |
| Program Funding | A. Program Costs and Resources | <ol style="list-style-type: none"> 1. Identify all funding sources and amounts for the program. Describe any funding formulas or funding conventions. 2. Briefly summarize what resources are currently associated with the program, including human, capital, equipment, information, and technology resources. 3. Briefly describe any existing management information systems (automated and nonautomated) that are used to monitor program performance. 4. How are total costs for the program determined? 5. Does the total cost include administrative, information resource management or other indirect costs? (If costs are estimated, briefly describe. If there is a cost allocation plan, attach relevant portions.) | | |
| | B. Funding Implications | <ol style="list-style-type: none"> 1. Are current and future funding resources inadequate, adequate or excessive to achieve program mission, goals, objectives and performance targets? Explain. Include discussion of program benefits compared to costs. 2. Discuss trends in revenue sources. To what degree are funding levels expected to fluctuate over time? 3. Discuss approaches to reduce program's reliance on tax revenues. 4. If funding for the program were eliminated or reduced, what would be the consequences? What would be the benefits? Include: <ol style="list-style-type: none"> a. Impact on the public health, safety or welfare b. Impact on other programs. c. Direct and indirect cost savings (actual reduction in spending and reallocation of resources to other programs). | | |

¹ For each question, note the page number in the self-assessment narrative or attached materials where this issue is addressed.

² These questions would also need to be addressed for subprograms, as appropriate.

| Category | Factors | Questions ² | Addressed | |
|--------------------|---|---|---------------------------|------------------------------------|
| | | | In Narrative ¹ | In Attached Materials ¹ |
| Strategic Planning | A. Strategic Plan and Program List | <ol style="list-style-type: none"> 1. Provide program objectives, strategies, and action plans, if available. 2. How well does the mission of the program fit within the mission and goals of the agency as a whole? Discuss and include relevant portions of the agency strategic plan, if applicable. 3. How does the program mission correspond to the program's enabling authority? Explain any variances. 4. Discuss relationship of program's goals to its mission and primary activities. <p>(Note: <i>The criteria contained in the <u>Strategic Planning and Performance Measurement Handbook</u> and training materials will also be used to assess the appropriateness of strategic planning information.</i>)</p> | | |
| | B. Internal/External Assessment | <ol style="list-style-type: none"> 1. Provide a summary of strategic issues, opportunities and threats that were identified as part of the program's Internal/External Assessment, if available. 2. Identify factors which could affect future program performance, including: <ol style="list-style-type: none"> a. Expected changes in primary program customers and client populations. b. Proposed changes in federal or state laws that may impact performance. c. Other key trends or other significant factors that may affect the program. | | |
| | C. Service Delivery Alternatives Considered | Discuss the feasibility of alternative methods of accomplishing the program's mission, goals and objectives, such as competitive contracting, public/private partnerships, consolidation with other programs or consideration of other innovative approaches. (Be specific.) | | |

¹ For each question, note the page number in the self-assessment narrative or attached materials where this issue is addressed.

² These questions would also need to be addressed for subprograms, as appropriate.

| Category | Factors | Questions ² | Addressed | |
|----------------------|---|--|---------------------------|------------------------------------|
| | | | In Narrative ¹ | In Attached Materials ¹ |
| Performance Measures | A. Rationale for Selecting Performance Measures | <ol style="list-style-type: none"> 1. Attach completed Performance Measure Summary form for each performance measure selected for the program. 2. Has an appropriate set of performance measures been selected? <ol style="list-style-type: none"> a. How effective are they in measuring achievement of mission, goals and objectives? b. When taken together, do the measures represent an appropriate balance to gauge both program efficiency and effectiveness? c. Were other measures considered, but determined not to be feasible? Why? <p>(Note: <i>The criteria contained in the <u>Strategic Planning Handbook</u> and training materials will also be used to assess the appropriateness of performance measures.</i>)</p> <ol style="list-style-type: none"> 3. Are customer and stakeholder feedback solicited on a formal, regular basis? How is this information obtained and utilized? | | |
| | B. Performance Targets | <ol style="list-style-type: none"> 1. Discuss the use of benchmarking with other public and private sector organizations. 2. Identify any national or other standards, including any mandatory staffing levels or other performance requirements. | | |
| Performance Results | A. Performance History | <ol style="list-style-type: none"> 1. Provide information on unit costs and customer perceptions of the program. 2. Discuss any process changes that relate to the program, such as: <ol style="list-style-type: none"> a. Change in cycle times, rework, backlogs, workloads, etc. b. Change in customer satisfaction c. Change in employee productivity and morale 3. Discuss any overall change in program outcomes. 4. Provide any other information related to the efficiency and effectiveness of the program. | | |

¹ For each question, note the page number in the self-assessment narrative or attached materials where this issue is addressed.

² These questions would also need to be addressed for subprograms, as appropriate.

| Category | Factors | Questions ² | Addressed | |
|---------------------------------|------------------------------------|--|---------------------------|------------------------------------|
| | | | In Narrative ¹ | In Attached Materials ¹ |
| Performance Results (continued) | B. Performance Evaluation | <ol style="list-style-type: none"> 1. Discuss overall program performance and provide explanations for performance which exceeds or fails to meet targets. 2. Summarize any research on the efficiency and effectiveness of similar programs in other jurisdictions. 3. Summarize findings of relevant prior audits and management evaluations that relate to program efficiency and effectiveness, and explain progress in implementing recommendations. | | |
| Other Issues | A. Legislative or Executive Issues | Address any particular issues that are identified by the Legislature, Governor or evaluators at the onset of the PAR evaluation. (For example, a welfare program might be asked to assess actual and expected average duration of benefits and discuss the impacts of efforts to achieve self-sufficiency.) | | |
| | B. Agency Issues | <ol style="list-style-type: none"> 1. Identify any other issues that the agency seeks to bring to the attention of the evaluators (e.g., statutory issues, policy issues, etc.). 2. Discuss any proposed modifications to the program to improve efficiency and effectiveness (e.g., proposed consolidation, contracting, etc.). | | |

¹ For each question, note the page number in the self-assessment narrative or attached materials where this issue is addressed.

² These questions would also need to be addressed for subprograms, as appropriate.

ENTERPRISE NETWORK SERVICES
Arizona Department of Administration
JLBC/OSPB Executive Summary

Overview - The Enterprise Network Services (ENS) program is operated by the Information Services Division (ISD) of the Arizona Department of Administration (ADOA). The mission of the ENS program is to provide effective and efficient voice and data communications services to State agencies. The program is divided into two subprograms: Voice Communications and Data Communications. The Data Communications subprogram is further subdivided into Local Area Network (LAN) and Wide Area Network (WAN) lines of business. After reviewing the program, the JLBC/OSPB team reached the following conclusions:

- The Department should not have relied upon excess funds generated by the Voice Communications subprogram to establish and maintain the Data Communications subprogram.
- The Voice Communications subprogram appears largely successful, while the Data Communications subprogram has been a failure.
- Privatization is an option for all areas of ENS, but further research is required to determine which areas would be appropriate to privatize.
- A lack of strategic planning by the Department led to both a proliferation of non-compatible LANs and WANs throughout State government and the initial financial failure of the ADOA WAN.
- The Department needs to identify more useful performance measures that better detail the successes and failures of the program.

The Department completed a separate Self-Assessment for each of the three lines of business contained within the ENS program. This approach, which was beyond the official requirements for the Self-Assessment, allowed the JLBC and OSPB team to better evaluate the program. Overall, the content and detail contained within the Self-Assessment are adequate. However, the report does not sufficiently address funding and lacks a strategic planning focus. ADOA is currently developing a "business plan" for ENS, which reportedly will address some strategic issues not adequately covered in the Self-Assessment, such as industry performance benchmarks and planned operational changes.

Program Description - The services provided by the ENS program are based on statutory mandates and trends in technology. Statutorily, ADOA is mandated to provide a centralized telephone system to all State agencies. The Department provides local telephone service through a combination of public and privately-owned equipment and contracts with private vendors for intrastate and interstate long distance calls. All State agencies are required to utilize ADOA's telephone system. ADOA provides other telephone-related services such as systems design, systems repair, and Capitol Mall switchboard operations.

The Department also has the broad statutory mandate to coordinate, develop and implement statewide automation and data communications systems. This mandate and trends in technology have led ADOA to offer local area network (LAN) and wide area network (WAN) services to State agencies. A LAN is a

system of personal computers linked together to share software, storage space, and data. A WAN is a system of LANs linked together to enhance communications and the sharing of data.

The Department currently provides LAN services to the Office of the Governor and ADOA itself. WAN services are provided to several agencies through the Multi-Agency Governmental Network (MAGNET). The Department plans to expand its LAN and WAN customer base in future years to serve more agencies.

How does the mission fit within the Agency's overall mission and the program's enabling authority?

The program mission, "To provide consulting, design, installation, training, maintenance, and support services for voice and data communications to all State agencies," fits within the program's enabling authority and within the Department's mission to provide support services to State agencies. However, in the case of ENS, it is also useful to examine the individual subprogram missions.

The Voice Communications subprogram's mission is: "To provide telecommunication services to all State agencies to improve compatibility and minimize overall cost to the State." It appears the Department has implemented the subprogram in a manner that fits the program's mission and that meets the intent of the enabling authority (A.R.S. § 41-798 through § 41-802).

The Department's statutory authority to provide data communication services is implicit rather than explicit. In A.R.S. § 41-712, ADOA is given the explicit mandate to coordinate and implement State automation. The statute does not specifically mention LAN or WAN services; but in today's technology environment, these services logically should be construed as part of the Department's State automation mandate. The Data Communications subprogram's mission is: "To provide installation and maintenance of data communications equipment and transmission media to improve communications compatibility, reduce duplication and cost for State agencies." This fits the program's mission, but the Department has not implemented the subprogram mission successfully. As detailed in the Agency Self-Assessment, **a lack of strategic planning by the Department has led to both a proliferation of non-compatible LANs and WANs throughout State government and the initial financial failure of the ADOA WAN.**

Do the historical performance measurements and the future performance targets adequately measure goals?

The Department does not have adequate performance measures. Generally, the Department has developed measures designed to address the effective provision of services. However, with the exception of some measures in the Voice Communications subprogram, there is a lack of efficiency measures and of benchmarks against which to compare performance. **The Department needs to identify more useful performance measures that better detail the successes and failures of the program.**

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

The lack of existing performance measures hinders our ability to address this question. Based on the available evidence, however, **the Voice Communications subprogram appears largely successful,**

while the Data Communications subprogram has been a failure. As detailed in the Agency Self-Assessment, the Voice Communications subprogram's successes include substantial savings resulting from the purchase and installation of the Capitol Mall phone switch, an improved connection rate for first call-attempts, and potential savings associated with re-bidding of the intrastate long distance contract.

The failures of the Data Communications subprogram include considerable annual losses for the subprogram and failure to provide information and alternatives to the Legislature and the Governor on the financial viability of the subprogram. In addition, **the Department should not have relied upon excess funds generated by the Voice Communications subprogram to establish and maintain the Data Communications subprogram.** The Telecommunications Revolving Fund, as established in A.R.S. § 41-802, is restricted and is not an appropriate funding source for the purchase of equipment needed to maintain and operate a LAN or WAN. The Department maintains that the fund is an appropriate funding source, based upon their interpretation of the statute.

Historically, ENS services have been funded from the non-appropriated Telecommunications Revolving Fund (TRF) and the Automation Revolving Fund (ARF), which has been appropriated since FY 1994. The TRF receives fees from State agencies for the provision of telephone services, LAN services, and WAN services. The ARF receives fees for LAN services, but also receives fees from other automation services (such as mainframe computing and computer courses) which are beyond the scope of this PAR. The following table shows the annual profits and losses for ENS.

Table 1: Annual ENS Profits/(Losses)
(Represents all Funds)

| Line of Business | Actual FY 1993 | Actual FY 1994 | Estimated FY 1995 | Expected FY 1996 | Expected FY 1997 |
|-------------------------|-----------------------|-----------------------|--------------------------|-------------------------|-------------------------|
| Voice | \$1,572,102 | \$948,695 | \$602,625 | \$755,912 | \$703,201 |
| LAN | (112,840) | (604,647) | (386,096) | (686,213) | (349,725) |
| WAN | (242,028) | (954,385) | (921,949) | (954,901) | (644,146) |
| TOTAL | \$1,217,234 | \$(610,337) | \$(705,420) | \$(885,202) | \$(290,670) |

Are there cost-effective alternative methods of accomplishing the program's mission?

Privatization is an option for all areas of ENS, but further research is required to determine which areas would be appropriate to privatize. Voice communications, LAN services, and WAN services already are privatized to a significant extent through the leasing of private sector telephone lines and use of computer consultant services. As part of the business plan, the Department should address additional privatization opportunities.



**ENTERPRISE NETWORK SERVICES
STRATEGIC PLAN FY 1996 - FY 1998**

PROGRAM SUMMARY

ENTERPRISE NETWORK SERVICES

A.R.S. §§ 41-702, 41-712, 41-713, 41-802

Contact: John McDowell, Assistant Director 542-2340
Information Services Division ADA22.PRO

Program Mission: *To provide consulting, design, installation, training, maintenance and support services for voice and data communications to all state agencies.*

Program Description: The Enterprise Network Services unit is responsible for the overall installation and management of common voice and data communications services and equipment. The unit is specifically chartered for the Capitol Mall and Tucson State Office complex in addition to other state locations. Standard telecommunications products and services are available; however, designing and consulting services are available for unique agency solutions at a fee-for-service charge.

Program Statutory Funding Formula: Not applicable.

Subprograms: Data Communications and Voice Communications

Funding Source and FTE Amounts: (Thousands)*

| Source | FY 1995 | FY 1996 | FY 1997 |
|------------------------------|------------------------|------------------------|------------------------|
| | <u>\$ Actual</u> | <u>\$ Estimate</u> | <u>\$ Request</u> |
| General Fund | 298.6 | 321.4 | 0.0 |
| Other Appropriated Funds | 1,274.0 | 669.2 | 540.8 |
| Other Non-appropriated Funds | <u>14,389.8</u> | <u>14,777.3</u> | <u>16,562.7</u> |
| Program Total | <u>15,962.4</u> | <u>15,767.9</u> | <u>17,107.5</u> |

FTE Positions 67.4 70.0 82.0

* Includes depreciation expenses

SUBPROGRAM SUMMARY Data Communications

Subprogram Mission: *To provide installation and maintenance of data communications equipment and transmission media to improve communications compatibility, reduce duplication and cost for state agencies.*

Subprogram Description: Data communications services are provided through a centrally managed wide area network and local area networks. These include the fiber optic network on the Capitol Mall and leased facilities to major Arizona cities. Various line speeds and communications technologies are used depending on the agency requirements. A central help desk is available for inquiries from the agencies seeking new service or having questions concerning installed services.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals, Objectives, and Performance Measures:

◆ **Goal 1 -** To provide effective and efficient intra-state Wide-Area-Network and Local-Area-Networks to support the data communications.

→Objective #1: By June 30, 1996, expand the statewide backbone from the current 75 to 114 locations.

→Objective #2: During FY 1996, connect agencies, with agency-purchased equipment, on and off the Phoenix and Tucson Malls to the state backbone within 7 days from notification of equipment delivery request and all others within 30 days of receipt of the written request.

→Objective #3: During FY 1996, ensure that the state backbone is available at least 98 percent of the time during each 24 hour period, 365 days per year in Phoenix and at least 90 percent of the time in Tucson.

→Objective #4: By November 30, 1995, define resource-shared LAN requirements projections and build a plan for implementation, consistent with funding and staff resources.

| Type | Performance Measures | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|---------|--|---------------|-----------------|-----------------|-----------------|
| | | <u>Actual</u> | <u>Expected</u> | <u>Expected</u> | <u>Expected</u> |
| Outcome | Percent of customer satisfied with services | N/A | 85 | 95 | 98 |
| Output | Percent of time action taken on reported problems within 15 minutes during normal business hours | N/A | 90 | 95 | 98 |
| Output | Percent of time action taken on reported problems within 30 minutes after normal business hours | N/A | 90 | 95 | 98 |
| Outcome | Percent of time resolution of identified problem is completed within agreed upon timeframe | N/A | 90 | 95 | 98 |

◆ **Goal 2 -** To provide efficient and effective support services for the data communications networks.

→Objective #1: During FY 1996, complete all large data communications projects accurately and within 60 days after receipt of a customer approved order.

→Objective #2: By March 31, 1996, provide a Phoenix Operations Center from 6 A.M. to 10 P.M., six days per week, and all other times provide an Automatic on-call service.

→Objective #3: By March 31, 1996, provide ADOA Field Support for metropolitan Phoenix and Tucson, Monday through Friday, 8 A.M. to 5 P.M. and on a call-out basis all other times.

**ENTERPRISE NETWORK SERVICES
STRATEGIC PLAN FY 1996 - FY 1998**

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|-------------------|---------------------|---------------------|---------------------|
| Outcome | Percent of agency customers rating data communications services as satisfactory or better | N/A | 85 | 95 | 98 |
| Outcome | Percent of questions received at help desk answered within 24 hours | N/A | 90 | 92 | 94 |
| Output | Percent of orders completed within 60 days after approval | N/A | 80 | 85 | 90 |

◆ Goal 3 - To evaluate and implement new technology that will improve communications services.

→Objective #1: By May 31, 1996, evaluate outside resources to provide network management and site maintenance for the state backbone.

→Objective #2: By May 31, 1996, evaluate ATM as a possible technology for migration.

→Objective #3: By June 30, 1996, investigate the technology available to provide usage based billing.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|-------------------|---------------------|---------------------|---------------------|
| Outcome | Percent of customers satisfied with MAGNET services | N/A | 85 | 95 | 98 |
| Output | New customer services provided to customers | N/A | 2 | 2 | 2 |
| Input | New services requests received | 3 | 4 | 5 | 5 |

Funding Source and FTE Amounts: (Thousands)*

| Source | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
|--|----------------------|------------------------|-----------------------|
| General Fund | 298.6 | 321.4 | 0.0 |
| Other Appropriated Funds - Automation Revolving Fund | 1,274.0 | 669.2 | 544.8 |
| Other Non-appropriated Funds - Telecommunications Revolving Fund | 2,315.7 | 3,615.8 | 5,555.0 |
| Subprogram Total | 3,888.3 | 4,606.4 | 6,099.8 |
| FTE Positions | 27.6 | 29.5 | 43.0 |

* Includes depreciation expenses

SUBPROGRAM SUMMARY: Voice Communications

Subprogram Mission: To provide telecommunication services to all state agencies to improve compatibility and minimize overall cost to the State.

Subprogram Description: The voice communications unit provides telephone services through a central system located on the Capitol Mall and the Tucson Office complex. Intra and inter-

state long distance services are provided through contracts with various communication vendors. Installation and maintenance of communications equipment and a central switchboard information center is available to assist state employees, the legislature and the public. This unit also provides consulting, planning support, and user training services for the agencies. New applications, such as voice mail, automated attendant and integrated voice response services, are supported and available to agencies. An annual telephone directory is compiled and provided to all state employees.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals, Objectives, and Performance Measures:

◆ Goal 1 - To provide a quality central telephone system in a cost-effective manner.

→Objective #1: During FY 1996, conduct two semi-annual traffic engineering studies to determine level of network trunking required to meet service goals (First study completion date is October 1, 1995 and the second is April 1, 1996).

→Objective #2: By December 31, 1995, install US West self-healing alternate route protection (SHARPS) to provide redundant feed for all capitol mall lines and Tucson office complex

→Objective #3: By February 28, 1996, establish annual extended service plan (ESP) for on-line support from Northern Telecom to resolve critical service problems (reducing down time.)

→Objective #4: By June 30, 1996, implement new statewide long distance calling service for intra and inter state activity.

→Objective #5: By June 30, 1996, investigate and recommend acquisition of Northern Telecom new hardware and software offerings to improve capability of statewide networking, i.e., ATM, SONNET, etc.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|-------------------|---------------------|---------------------|---------------------|
| Output | Percent of calls not completed on first attempt | N/A | 3.0 | 3.0 | 3.0 |
| Output | Percent of time (24 hours per day 365 days per year) that telephone system is available | 99.8 | 99.8 | 99.9 | 99.95 |
| Outcome | Percent of customer cost less than average commercial costs | | | | |
| | basic installation | 60.0 | 60.0 | 60.0 | 70.0 |
| | line costs | 12.0 | 12.0 | 12.0 | 12.0 |

◆ Goal 2 - To provide efficient and effective voice communications services.

→Objective #1: By June 30, 1996, implement new usage based long distance service at reduced costs providing calling detail for agency chargeback requirements.

→Objective #2: By September 30, 1995, upgrade OCTEL voice processing system in Phoenix and Tucson.

**ENTERPRISE NETWORK SERVICES
STRATEGIC PLAN FY 1996 - FY 1998**

→Objective #3: By June 30, 1996, replace service center system management software, increasing response capability to customer agencies. (This is possible if funds are available and a position is filled to increase service center staff level.)

| <u>Type</u> | <u>Performance Measures</u> | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|-------------|---|---------------|-----------------|-----------------|-----------------|
| | | <u>Actual</u> | <u>Expected</u> | <u>Expected</u> | <u>Expected</u> |
| Output | Percent of requests for service completed within 5 work days | 94.8 | 95.0 | 95.0 | 98.0 |
| Outcome | Percent of customers with above average satisfaction rating based on ISD semi-annual survey | 72.0 | 80.0 | 85.0 | 90.0 |
| Output | Percent of calls answered in three rings | 97.9 | 99.0 | 99.0 | 99.0 |
| Output | Percent of repair requests completed within four hours | 99.9 | 95.0 | 95.0 | 95.0 |

◆ Goal 3 - To develop and implement specialized voice services.

→Objective #1: By may 1, 1996, implement six new agency Automated Call Distributor (ACD) systems.

→Objective #2: By June 30, 1996, install five new agency Automated Attendant (AA) systems.

→Objective #3: By June 30, 1996, develop six new agency Integrated Voice Response (IVR) applications.

→Objective #4: By June 30, 1996, develop and implement a marketing plan for increasing agency voice mail service use.

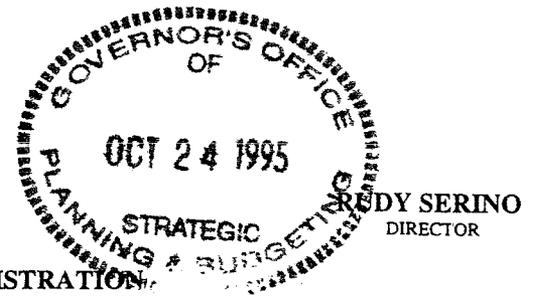
| <u>Type</u> | <u>Performance Measures</u> | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|-------------|-----------------------------|---------------|-----------------|-----------------|-----------------|
| | | <u>Actual</u> | <u>Expected</u> | <u>Expected</u> | <u>Expected</u> |
| Output | ACD systems installed | N/A | N/A | N/A | N/A |
| Output | AA systems installed | N/A | N/A | N/A | N/A |
| Output | IVR Applications developed | N/A | N/A | N/A | N/A |

Funding Source and FTE Amounts: (Thousands)*

| <u>Source</u> | FY 1995 | FY 1996 | FY 1997 |
|---|------------------|--------------------|-------------------|
| | <u>\$ Actual</u> | <u>\$ Estimate</u> | <u>\$ Request</u> |
| Other Non-appropriated Funds - Telecommunications Revolving Fund | <u>12,074.1</u> | <u>11,161.5</u> | <u>11,007.7</u> |
| FTE Positions | <u>39.8</u> | <u>40.6</u> | <u>39.0</u> |

* Includes depreciation expenses

FIFE SYMINGTON
GOVERNOR



ARIZONA DEPARTMENT OF ADMINISTRATION
INFORMATION SERVICES DIVISION
1616 W. ADAMS
PHOENIX, ARIZONA 85007

October 23, 1995

Mr. Peter Burns, Executive Director
Governor's Office of Strategic Planning and Budgeting
1700 W. Washington, 5th Floor
Phoenix, AZ 85007

Mr. Ted A. Ferris, Staff Director
Joint Legislative Budget Committee
1716 W. Adams
Phoenix, AZ 85007

Dear Sirs:

Attached is the ADOA final commentary on the Program Authorization Review (PAR) of the Enterprise Network Services (ENS) program.

It is my understanding that these comments will be placed in both the PAR Composite Report and the individual agency PAR report.

The attachment reflects the structure requested in your memorandum of October 18, 1995. The ADOA commentary is in response to the findings in the JLBC/OSPB Executive Summary.

My staff and I will be prepared to work with you during Phase III of the PAR process. Please advise on how we can be of assistance.

Sincerely,

A handwritten signature in cursive script that reads "John McDowell".

John McDowell
Deputy Director

JMcD:ds

Attach.

ENTERPRISE NETWORK SERVICES
Arizona Department of Administration
Agency Comments on JLBC/OSPB PAR Analysis and Findings

EXECUTIVE SUMMARY

Overview

The Department acknowledges the description of the Enterprise Network Systems (ENS) program as correct, but does not concur with all of the findings listed by the JLBC/OSPB analysts. Specific comments are provided below with each finding.

Question 1: How does the mission fit within the Agency's overall mission and the program's enabling authority?

JLBC/OSPB Finding - Data Communications subprogram mission fits the program's mission, but the Department has not implemented the program submission successfully...**a lack of strategic planning by the Department has led to both a proliferation of non-compatible LANs and WANs throughout State government and the initial financial failure of the ADOA WAN.**

ADOA IRMG Response - It is agreed that the Statewide Planning function must be strengthened. It is a separate program, performed by a different section, and therefore, beyond the scope of this PAR. It is acknowledged that weaknesses in the planning activity have impaired the execution of the service provision for the Data Communications subprogram. However, it could be argued from the JLBC/OSPB analysis that the WAN program may have stopped medium to small agencies from developing their own networks. This is brought out in the analysis, but not included in the Executive Summary Commentary.

The issue of the appropriate use of the Telecommunications Revolving Fund for the Data Communications subprogram is a matter of interpretation of the enabling statutes. It is true that at the time the original statute was written in 1972 that the explicit intent of the legislature was for telephone services. However, the term "telecommunications" referred to in both the title and wording of 41-798, 41-801 and 41-802 has long had a standard interpretation in the industry to mean the transmission of both voice and data. Use of this fund to assist in the statewide communication of data has been a common practice by the Department for a number of years. The present trend in telecommunications technology is to use common lines for the transmission of both data and voice in all of its forms to reduce cost and enhance the ability of organizations to communicate effectively. The deployment of both LAN and WAN technology for the state and its interaction with, and joint use of, voice system apparatus results in it being an enhancement to the statewide telecommunication system. The system is in a state of transition from purely voice functionality to FAX on demand, interactive voice response mechanisms for computer access from telephone instruments and voice messaging interfaces to LAN connected PCs. With these changes in technology, the same wire or fiber transmitting the voice traffic is used for data traffic as well.

The migration of voice and data has already taken place in the private sector. Companies such as AT&T and US West are providing both voice and data services to their customers. Cable companies are already positioning themselves to provide these services as well. If Arizona government is not going to follow this trend, the Department suggests the statutes be updated accordingly with explicit language indicating that data communication is not included in the definition of telecommunication.

Question 2: Do the historical performance measurements and the future performance targets adequately measure goals?

JLBC/OSPB Findings - The Department needs to identify more useful performance measures that better detail the successes and failures of the program.

ADOA IRMG Response

The Department agrees that additional performance measurements are needed. It is committed to using benchmarks, surveys and subscriptions to establish more meaningful measurements that promote greater accountability and effective tracking of service levels provided and the associated value added. The expanded measurements will focus on monitoring the variables of quality, efficiency and output units. Nationwide standards developed by LAN service providers have emerged slowly to serve as guidelines in the industry because of the complexity of the variables involved. Best practices by other government entities that are recognized to possess effective telecommunication services will be studied further. During FY 1996 emphasis will be placed on measurement of system availability, average network response time, percent of problems resolved within specified time limits, and customer satisfaction with services provided.

Question 3: Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

JLBC/OSPB Finding 1 - the Voice Communications subprogram appears largely successful while the Data Communications subprogram has been a failure

ADOA IRMG Response

The Department does not agree with JLBC/OSPB findings that the Data Communication subprogram is a failure. First, the LAN subprogram provides full services to a base of 670 customers. The services include LAN management and administration; physical moves and configuration control; security; backup and recovery; help desk; application support for e-mail, Microsoft Office, FoxPro database management system, Visio- graphics package; and virus scanning and removal. In addition, PC hardware and software services are provided for an additional 200 users in Risk Management, Personnel, General Services and Procurement for ADOA with their individual LAN support. This is accomplished with a direct staff of twelve people.

The definition of a LAN as contained in the analysis, "... a system of personal computers linked together to share software, storage space, and data," does not adequately define the current structure of the ADOA LAN. The ADOA LAN encompasses several buildings with different protocols, hardware, wiring schemes, software applications and even operating systems. This hybrid system is more akin to the definition of a MAN (i.e., a Metro Area Network with a six-mile radius with multiple servers) or the WAN definition in the report. This is well within the ratio of support staff to users published as reasonable ranges by the Gartner Group for a MAN with this level of complexity and breadth of services.

Second, analysis performed during the Auditor General Sunset Review, carried out during the same period the PAR was conducted, includes the following for the WAN Services. Network availability statistics shows that MAGNET is consistently up 99.5 percent of the time. The MAGNET connects 76 different buildings and stretches from Flagstaff to Nogales. This network is maintained with 4.25 FTEs, 24 hours a day, 365 days a year with extremely limited vendor support. ADOA cannot find any private or public sector entities to date that can meet that type of performance to FTE ratio. Only one customer has ever disconnected from MAGNET; and within the following month, the same customer wanted to reconnect. There is a definite value added for agencies utilizing this service. It is providing an effective means to connect agencies and communicate data. Furthermore, it provides a strong alternative and basis for eliminating the redundancy of current individual agency networks.

Third, the PAR analysis itself even says, "...numerous agencies have taken advantage of the services offered by ADOA.... This connectivity through the WAN has provided agencies with the opportunity to increase communication abilities with geographically dispersed offices within their organizations. It has also led to opportunities to improve communications between agencies." Therefore, the subprogram should not be classified as a failure when credit is given in the analysis phase of the report to the contrary.

The issue of expanding ADOA LAN support services to additional agencies is one that must be discussed further. By its very nature, some functions are best administered locally.

JLBC/OSPB Finding 2 - the Department should not have relied upon excess funds generated by the Voice Communications subprogram to establish and maintain the Data Communications subprogram.

ADOA IRMG Response

As indicated in the analysis of the PAR self assessment, the Data Communications subprogram is funded from three different sources: General Fund, Automation Revolving Fund and the Telecommunications Revolving Fund. It is agreed that the funding for the program should receive further review and adjustment. A balance must be achieved between the cost of services provided, the value added and the recovery mechanism.

The JLBC/OSPB funding commentary on the Data Communications WAN raises many important funding issues that need to be addressed as part of the Fiscal Year 1997 budget process. It specifically states: "For example, if the statute for the Telecommunications Revolving Fund were modified, would it be appropriate to subsidize the Wide Area Network with excess revenues generated through the voice program? How does the State establish or fund capital investment in infrastructure required for projects like the Wide Area Network? If the program should not be subsidized, how will agencies afford the rate increases necessary to make the WAN break even financially?"

The Department would like to assist the OSPB/JLBC in their quest to answer the very important questions outlined above.

In addition, how will the State finance the construction of a single unified voice and data network? It has been recognized in many earlier studies of the telecommunications function that the State should be able to save dollars through consolidation of the individual diverse agency data networks.

Question 4: Are there cost-effective alternative methods of accomplishing the program's mission?

JLBC/OSPB Finding - Privatization is an option for all areas of ENS, but further research is required to determine which areas would be appropriate to privatize.

ADOA IRMG Response

The Department agrees. Certain LAN support functions have already been privatized. An example is the hardware support for PCs and other LAN components. This is accomplished through contract to the private sector. There are other opportunities available. There is a commitment within ADOA IRMG to evaluate all products and services provided through Enterprise Network Services. Decisions to make or buy will be based on business need, costs, ability to provide the service and other key factors. Help from JLBC and OSPB is welcomed in balancing the need to control Information Resource Management costs and the quality of the services required to meet needs.

Question 5 : Are there other special areas of interest?

JLBC/OSPB Finding - No commentary is given

ADOA IRMG Response

It can be seen from the work involved in this PAR that there is a strong relationship and dependency between all the programs that make up the Information Resource Management Group. The inter-relationships must be considered in making changes to improve the efficiency and effectiveness of any individual program and/or subprogram. The Department welcomes the opportunity to work with JLBC and OSPB in strengthening the contribution and effectiveness of IRMG on a statewide basis.

STATE AGRICULTURAL LABORATORY PROGRAM
Arizona Department of Agriculture
JLBC/OSPB Executive Summary

Overview - The State Agricultural Laboratory (SAL) effectively provides analytical services to the regulatory programs it supports. Results from a comparison with other state laboratories across the nation and with private-sector labs show that:

- SAL performs within the range of other states' performance, especially in terms of quality assurance, rush cycle time (i.e., time taken to provide results for samples marked "rush"), and violation rates (i.e., percentage of samples analyzed that violate applicable standards).
- SAL is relatively cost-effective compared to other states and to private sector labs.
- Privatization of the entire lab would probably not result in cost savings, although some cost savings and other benefits might be possible if certain subsections were privatized. Further research is required.

The Arizona Department of Agriculture (ADA) committed significant effort to the PAR process. The self-assessment included substantial consideration of service-delivery options, a nation-wide benchmark survey of state government laboratories, carefully developed unit-cost analysis, and a description of the several layers of regulatory authority under which the lab and Department operate. The PAR has helped the Department to enhance ongoing efforts to evaluate its processes and to plan for improved coordination of its field and laboratory support activities.

Program Description - The State Agricultural Laboratory analyzes food products, animal feed products, agricultural chemicals, and a variety of biological specimens in order to protect the public food supply to ensure that agricultural products meet quality guarantees, and to protect agricultural industries from pest infestation. ADA field staff collect the samples and submit them to the lab for testing. The field staff then pursue enforcement using SAL's test results. (Evaluating the effectiveness of enforcement is beyond the scope of this PAR.) The SAL's four subprograms are: Animal/Animal Products; Biological Identification; Chemical Residue Analysis; and Formulations. Within these are 12 subsections, or functional areas, known as Mycotoxin, Pesticide Residue, Pesticide Formulations, Feed Formulations, Fertilizer Formulations, Meat, Brucellosis, Microbiology (Dairy), Dairy Chemistry, Entomology, Plant Pathology, and Seed. The lab's direct customers include the ADA regulatory divisions (Animal Services, Plant Industries, Chemicals/Environmental Services), the Structural Pest Control Commission, the Department of Environmental Quality, and certain Indian tribes, while stakeholders include consumers and producers of foods and agricultural products. The State Agricultural Laboratory receives almost all of its funding from the General Fund. It also has contracts with other agencies and political subdivisions, and collects fees for certain limited services.

How does the program mission fit with the Agency's overall mission and the program's enabling authority?

The State Agricultural Laboratory mission "to ensure the provision of timely and efficient laboratory support services" for the regulatory programs it serves aligns well with ADA's twofold mission "to ensure wholesome food and fiber for the consuming public and to promote and enhance the vitality of the Arizona agricultural community in an environmentally sound manner." Laboratory support services are necessary for the Department to fulfill its regulatory mission.

Do the historical performance measurements and the future performance targets adequately measure goals?

The performance measurements historically used measure activity but do not effectively measure program success. Historical measures were simple input and output measurements and did not measure program success. As a result of the PAR, ADA is revising SAL's program goals and will be developing new measurements accordingly. These measures should address five key areas: accuracy and court-defensibility of analysis; responsiveness (regarding regular and emergency work); cost-effectiveness; retaining Federal certification or recognition; and customer satisfaction. The formal goals and objectives must be measurable and must relate to the lab's primary mission.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

SAL performs comfortably within the range of other state laboratories, especially in terms of quality assurance, rush cycle time, and violation rates. The Department surveyed all other state laboratories, as well as other government laboratories to determine benchmarks against which to measure the performance of each of the 12 subsections. The measurements used in the survey are the only ones currently available for comparative measurements of SAL's performance, and they raise further questions about department-wide operations. In the future, ADA should develop the ability to measure whether the lab meets Arizona's needs: whether the lab's direct customer needs are met, whether lab analyses hold up in court, cost-effectiveness, and—ultimately whether ADA regulatory programs protect Arizona citizens.

The survey results must be interpreted cautiously due to inconsistencies among respondents' regulatory programs, and among their interpretations of the survey questions. The survey data on "rush cycle time" show that SAL analyzes and provides reports expeditiously compared to other states for samples marked "rush." (A plurality of samples are marked rush, and ADA is reviewing its policy on designating samples "normal," "rush," or "priority.") Compared to other reporting labs, SAL took less than the average number of days to produce "rush" analysis results in 8 of its 12 subsections. "Normal" cycle time was also acceptable. The survey data on violation rates show that SAL's violation rates are above average for eight of nine comparable subsections. For some subsections this indicates that ADA field staff effectively target violators by following up on complaints and other leads. But it may also indicate a need for more random sampling in some areas. ADA is reconsidering its strategies of sampling and enforcement in order to increase both efficiency and effectiveness. Lab records show that SAL's subprograms meet 95% to 100% of nationally accepted quality assurance standards.

Are there other cost-effective alternative methods of accomplishing the program's mission?

SAL unit costs appear to be below private-sector average prices for several subsections, so privatization of the entire state agricultural laboratory would probably not result in cost savings. Further research is required to evaluate privatizing certain subsections. The PAR self-assessment and follow-up research suggest that privatization might be a cost-effective alternative for a few subsections, such as feed and fertilizer formulations. Privatization of some or all of the SAL's functions should be considered if there is a potential for cost savings without offsetting administrative problems.

Unit cost is largely a function of personnel, capital equipment, supplies, and other operating costs. According to ADA's calculations, SAL's unit costs are mostly at or below the average private-sector cost for the various subsections, but no factor for equipment was included in these calculations. When the unit cost is adjusted to include capital equipment (amortization), five subsections are below the private-sector average cost, while four subsections are at or above. (Three subsections had no private-sector counterpart, so could not be compared). Lower state personnel costs help keep costs low for subsections that do not have heavy capital equipment needs. These comparison of unit costs to private-sector prices must be viewed cautiously because the functions of the state regulatory laboratory are not exactly the same as private agricultural or environmental labs. In addition, the ADA's unit cost calculations do not include all statewide overhead costs.

Additional funding for laboratory equipment may also enhance efficiency and effectiveness. The self-assessment states that certain available analytical equipment can handle many times the volume of the older models currently used at the lab. This would enable the lab to increase sampling volume and/or to free up staff time for technical support or for analysis not currently possible. The Department may provide specific details in its next budget request.

ADA collects a variety of fees. Existing law would seem to permit that some of these be used to help support the laboratory analysis. This would raise questions about equity given that some agricultural sectors pay registration or regulatory fees while others receive special benefits from ADA activity but pay no direct fees. Also, several political subdivisions or other agencies contract with the SAL for laboratory analysis. The Department did not provide cost or revenue figures to demonstrate that such contracts in fact pay for themselves. If such contracts are "subsidized" by the General Fund for indirect or overhead costs, price modification may be warranted.

STATE AGRICULTURAL LABORATORY
STRATEGIC PLAN FY 1996 - FY 1998

PROGRAM SUMMARY

STATE AGRICULTURAL LABORATORY

A.R.S. § 3-141, et. seq.

Contact: Dwight Harder, Assistant Director 407-2833
State Agricultural Laboratory AHA09.PRO

Program Mission: *To ensure the provision of timely and efficient laboratory support services for the Department's regulatory enforcement, ancillary scientific programs and other agencies.*

Program Description: This program provides the scientific analysis, sample collection, training and laboratory certification services related to agricultural food products such as dairy, detection and identification of residue level contaminants, identification of pests, analysis of seed purity and assessment of compliance with agricultural product label specification and formulation requirements.

Subprograms:

- Animal/Animal Products Control
- Biological Identification
- Chemical Residue Analysis
- Formulations

| Source | (Thousands) | | |
|---------------|----------------------|------------------------|-----------------------|
| | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
| General Fund | <u>1,169.6</u> | <u>1,226.7</u> | <u>1,433.9</u> |
| FTE Positions | <u>20.0</u> | <u>20.0</u> | <u>20.0</u> |

SUBPROGRAM SUMMARY

Animal/Animal Products Control

Subprogram Mission: *To ensure the provision of timely and efficient laboratory support services for Department regulatory enforcement in the area of animal/animal products.*

Subprogram Description: This program provides the scientific testing and analysis for agricultural food products, such as dairy and animal disease control.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ Goal 1 - To maintain, monitor and evaluate a timely, efficient and cost-effective sample analysis and identification system to support regulatory enforcement activities, and to protect the public health and safety by achieving the highest compliance with federal standards of certification of both personnel and processes.

→Objective #1: INFORMATION NOT PROVIDED

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|--|-------------------|---------------------|---------------------|---------------------|
| Output | Compliance issues resolved | Yes | Yes | Yes | N/A |
| Output | Training sessions | 12 | 8 | 6 | N/A |
| Outcome | Average performance rating achieved | 98 | 94 | 96 | N/A |
| Outcome | Percent of samples done in a timely manner | 89 | 92 | 92 | N/A |

| Source | (Thousands) | | |
|---------------|----------------------|------------------------|-----------------------|
| | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
| General Fund | <u>286.1</u> | <u>341.7</u> | <u>341.7</u> |
| FTE Positions | <u>5.8</u> | <u>5.8</u> | <u>5.8</u> |

SUBPROGRAM SUMMARY Biological Identification

Subprogram Mission: *To ensure the provision of timely and efficient laboratory support services for Department enforcement in the areas of Malacology, Plant Pathology, Seed Technology, Entomology, Nematology, and Botany.*

Subprogram Description: This program provides the scientific testing and analysis of seed purity and quality and for the authoritative identification of pests, such as the africanized honey bee.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ Goal 1 - To maintain, monitor and evaluate a timely, efficient and cost-effective sample analysis and identification system to support regulatory enforcement activities, and to protect the public health and safety by ensuring the highest compliance with regulations governing seed purity and quality, and agricultural pest identifications through the design and implementation of a sample collection and analysis plan.

→Objective #1: INFORMATION NOT PROVIDED

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|--|-------------------|---------------------|---------------------|---------------------|
| Output | Samples analyzed | 5,028 | 7,000 | 7,000 | 7,000 |
| Output | Average turnaround time for sample testing | 9.8 | 8.0 | N/A | N/A |
| Outcome | Violations | 2,575 | 1,800 | N/A | N/A |
| Outcome | Percent of samples done in a timely manner | 68 | 78 | 85 | 85 |

**STATE AGRICULTURAL LABORATORY
STRATEGIC PLAN FY 1996 - FY 1998**

| Funding Source and FTE Amounts: | (Thousands) | | |
|---|--------------|--------------|--------------|
| | FY 1995 | FY 1996 | FY 1997 |
| | \$ Actual | \$ Estimate | \$ Request |
| Source | | | |
| General Fund | 353.8 | 420.7 | 420.7 |
| Other Non-appropriated Funds - Phytosanitary Funds | <u>3.1</u> | <u>3.1</u> | <u>3.1</u> |
| Subprogram Total | <u>356.9</u> | <u>423.8</u> | <u>423.8</u> |
| FTE Positions | <u>6.8</u> | <u>6.8</u> | <u>6.8</u> |

| Funding Source and FTE Amounts: | (Thousands) | | |
|--|--------------|--------------|--------------|
| | FY 1995 | FY 1996 | FY 1997 |
| | \$ Actual | \$ Estimate | \$ Request |
| Source | | | |
| General Fund | 314.6 | 388.4 | 388.4 |
| Other Non-appropriated Funds - Inter-Governmental Agreement with the Structural Pest Control Commission; Pesticide Fund | <u>86.1</u> | <u>86.1</u> | <u>86.1</u> |
| Program Total | <u>400.7</u> | <u>474.5</u> | <u>474.5</u> |
| FTE Positions | <u>5.7</u> | <u>5.7</u> | <u>5.7</u> |

SUBPROGRAM SUMMARY Chemical Residue Analysis

Subprogram Mission: *To provide quality pesticide and mycotoxin residue analysis and service for the Department regulatory monitoring and enforcement activities in an accurate, timely, safe and cost-effective manner.*

Subprogram Description: This program provides the scientific analysis, sample collection, training and lab certification services related to the detection and identification of residue level contaminants for enforcement agencies charged with protecting the public and/or the environment.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ Goal 1 - To produce court defendable data in the most efficient manner, to maintain a high degree of professionalism and education, and to provide superior training and lab certification services by ensuring the provision of improved services to our customers through the implementation of an expanded sample analysis plan.

→Objective #1: INFORMATION NOT PROVIDED

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|-------------------|---------------------|---------------------|---------------------|
| Output | Analytes | 1,008 | 1,400 | N/A | N/A |
| Outcome | Samples analyzed and reported in a timely and accurate manner | 83 | 79 | N/A | N/A |
| Outcome | Percent of analytical sets which met all Quality Assurance criteria | 99 | 99 | N/A | N/A |
| Outcome | Average time to process samples | 34 | 50 | N/A | N/A |

SUBPROGRAM SUMMARY Formulations

Subprogram Mission: *To ensure the provision of timely and efficient laboratory support services for Department regulatory monitoring and enforcement in the area of formulations testing.*

Subprogram Description: This program provides the scientific testing and analysis for agricultural products to ensure compliance with appropriate levels of chemical concentrations, label specifications, etc.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ Goal 1 - To maintain, monitor and evaluate a timely, efficient and cost-effective sample analysis and identification system to support regulatory monitoring and enforcement activities, and to protect the public health and safety by ensuring the highest compliance with regulations governing feed, fertilizer and pesticide labels and formulations through the design and implementation of a sample collection and testing plan.

→Objective #1: INFORMATION NOT PROVIDED

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|--|-------------------|---------------------|---------------------|---------------------|
| Output | Samples submitted in accordance with sampling plan | N/A | N/A | N/A | N/A |
| Output | Total analyses per category: | | | | |
| | Feed | 698 | 763 | 700 | 1,000 |
| | Fert | 1,161 | 864 | 900 | 1,500 |
| | Pest | 293 | 206 | 200 | 250 |
| | Meat | N/A | 60 | 100 | 100 |
| Output | Range of sample turnaround time | 1-175 | 1-164 | N/A | N/A |
| Outcome | Samples analyzed in a timely and accurate manner | 81 | 76 | 85 | 90 |
| Outcome | Violations identified and reported timely | 55 | 64 | 75 | 80 |

STATE AGRICULTURAL LABORATORY
STRATEGIC PLAN FY 1996 - FY 1998

| <u>Source</u> | (Thousands) | | |
|--|----------------------|------------------------|-----------------------|
| | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
| General Fund | 246.0 | 300.9 | 300.9 |
| Other Non-appropriated Funds - Feed and Fertilizer Fund; Southwest Boll Weevil Program | <u>35.8</u> | <u>35.8</u> | <u>35.8</u> |
| Subprogram Total | <u>281.8</u> | <u>336.7</u> | <u>336.7</u> |
| FTE Positions | <u>4.7</u> | <u>4.7</u> | <u>4.7</u> |

KEITH KELLY
Director



DWIGHT HARDER
Assistant Director

Arizona Department of Agriculture

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STATE AGRICULTURAL LABORATORY

October 23, 1995

Ms. Karen Bock
Senior Budget Analyst
Joint Legislative Budget Committee Staff

HAND DELIVERED

Dear Ms. Bock,

We appreciate the opportunity to respond to the 10/19/95 joint JLBC/OSPB analysis of the State Agricultural Laboratory program authorization review self-assessment study. Our hope is that the attached comments will provide appropriate clarification for the issues we have addressed.

Sincerely,

A handwritten signature in cursive script that reads "Dwight Harder for Keith Kelly".

Keith Kelly
Director, Arizona Department of Agriculture

cc: Peggy O'Sullivan-Kachel, OSPB
Pam Scharon, OSPB

THE ARIZONA DEPARTMENT OF AGRICULTURE'S COMMENTS

IN RESPONSE TO

THE 10/19/95 JOINT JLBC/OSPB PAR ANALYSIS

OF

THE STATE AGRICULTURAL LABORATORY

PROGRAM AUTHORIZATION REVIEW SELF-ASSESSMENT STUDY

Thank you for this opportunity to comment on your analysis of State Agricultural Laboratory's program authorization review (PAR) self-assessment. We especially appreciate your stating that our laboratory effectively provides analytical services to the regulatory programs it serves, and that it is comfortably within the performance range of other states, and is cost-effective compared to other states and to the private sector laboratories.

We value JLBC/OSPB's astuteness in recognizing the laboratory's primary mission to provide support services necessary for the Department to fulfill its direct statutory mandates to regulate the agricultural community and protect the health of the consumer from contaminated foodstuffs. Of the statutes listed in the JLBC/OSPB statutory summary table, three expressly describe the laboratory functions while the remainder are statutes requiring some type of testing to be done by a state lab thereby limiting the service delivery options.

We are pleased to have this opportunity to further define the following critical points addressed in your commentary: **1) privatization; 2) unit costs; and 3) performance measurements.**

A number of factors need serious consideration when exploring the privatization of any of the State Agricultural Laboratory's (SAL) functions. Some potential for savings for the State may be possible for some tests through privatization if one looks only at SAL's unit costs compared to private laboratory prices. It is important to remember, however, that any test done by the private sector must be performed by laboratories that are certified, monitored and their results verified by the State Agricultural Laboratory. These additional costs when combined with the expense of specialized quality assurance and administrative overhead would result in higher unit costs than if SAL were to perform the same analyses.

SAL's survey of government and private laboratories was quite comprehensive - 83 state and federal laboratories and 60 private laboratories. Its survey response rate was approximately 50 percent. Prior to the survey, SAL's staff found very little

published laboratory performance data available on a national basis. Consequently, the information developed from the surveys was very useful, even though state laboratories, except for one, had not previously computed unit costs. Although many states had considered privatization, few concluded that an in depth study was warranted. The Oregon Department of Agriculture conducted a six-month study to determine if privatization would be a feasible cost alternative for their laboratory services. Results showed that by transferring all analytical work to private labs, while maintaining control over the quality, it would cost 45% more than the cost of operating Oregon's current laboratory. (see PAR appendix Q). Furthermore, one of the state labs surveyed showed additional charges for quality assurance at 30% of its lab analyses fees. Although data is not currently available to develop cost figures for quality assurance for the specific analyses performed by SAL, it can be safely assumed that such costs would further increase private laboratories unit costs. Most of SAL's testing follows protocol and official analytical procedures not normally used by private laboratories. **The specialized testing activities SAL performs are often as different from a private lab's as the work a heart surgeon does compared with what a paramedic does on an emergency call.**

SAL has a modern, high tech, state-of-the-art laboratory facility with excess analytical space. This situation eliminates a cost factor from privatization consideration, so future unit costs do not have to be affected by amortization of a costly new building. The SAL building was designed to accommodate 45 to 50 staff members. It currently has a staff of 22 FTE's. With minimal cost, the State Agricultural Laboratory is especially suited to accommodate additional work in chemistry, such as environmental testing for pesticides and toxic metals in soil and water.

Several other factors need due consideration in a privatization study. Conflicts of interest are a potential problem. **If privatization of SAL activities were to occur, a private lab might not be discrete about the Department's test results if it also does the same types of testing for industry clients.** In addition, when comparing unit costs, the extra cost a private laboratory would need for additional liability insurance would be on top of the cost in the PAR tables. Private labs may incur considerable **liability** if their sample analyses are used for the basis of the Department's regulatory actions. Private laboratories also have beneficial tax advantages, which the SAL does not have to reduce costs. Furthermore, since we know of no studies on how private laboratories develop unit cost, questions about administrative staffing level would need to be evaluated to determine a private laboratory's average administrative overhead charge.

When comparing SAL unit costs with the costs of using private labs, it is important to understand the type of testing performed at the lab. For example, the SAL residue program primarily provides

unique testing for pesticides in agriculturally related matrices. These types of samples vary anywhere from food, to plant materials, to clothing, to soils, to air, to water, etc. The two most common matrices are foliage and surface swabs from properties adjacent to agricultural fields. The pesticides analyzed in these samples are numerous and very diverse. In order to reach SAL's level of testing, it takes **many years to develop** the required specialized expertise and appropriate laboratory operations/documentation support system (standard operating procedures, chain of custody, quality assurance, analytical procedures development and verification). Private laboratories typically do not possess the versatility nor the expertise nor the cost incentive to devote a significant portion of their resources to develop specialize methodologies for small sample volumes and multiple pesticides. SAL activities require more stringent quality control requirements and method development activities than found in private laboratories focusing on environmental testing. This fundamental difference is not reflected by the price comparisons in the PAR unit cost tables. The private labs surveyed primarily provide environmental testing. Environmental testing, for the most part, consists of routine testing of soil and water matrices using very specific and well-defined methodology. This approach reduces costs. Only a small number of samples submitted to the SAL are of this routine nature. Of the 524 pesticide residue analyses performed at the SAL during FY 94, only 28 (5%) had matrix/analyte combinations which were represented by the private lab cost survey. And of these, 20 were submitted by agencies which had contracted with SAL to provide the analysis. In addition to the analysis cost comparison, other critical factors, such as conflict of interest, high risk of liability, and increased lab responsibilities (to provide certification), combine to make privatization of the pesticide residue functions questionably cost-effective.

JLBC/OSPB raised a question as to why SAL did not include capital equipment in its original unit cost figures. SAL used actual FY 94 expenses and no money was appropriated for capital equipment during that fiscal year. A **very important consideration** is that additional equipment can reduce unit costs. For example, this year's planned purchase of a \$40,000 nitrogen analyzer (amortized over 11 years), will enable SAL to expect a reduction in unit costs for feed from \$55.33 to \$29.10 and for fertilizers from \$50.32 to \$26.02 (see PAR determination of unit costs table). These analyses will be competitive with private laboratories due to shortened analytical times with this more automated technology which will approximately double the number of analyses for the same total cost. Moreover, considerably less chemical and hazardous waste disposal costs are required with this equipment compared to the SAL's current equipment which significantly recaptures capital investment amortization.

SAL provides added benefits of strict quality control, advisory support to regulatory staff, and responsiveness to

emergency demands which is already included in its unit cost figures. To provide these added benefits, private labs would charge more, therefore their unit costs would increase. One critical factor that deserves attention is SAL's quick response to emergency demands. If a private laboratory, with a broad customer base, were contracted to do SAL's current activities in areas such as residue analyses, it would be hard-pressed to duplicate SAL's history of rapid, quality responses, such as the analyses of watermelons for Aldicarb. Private labs would probably lose customer base if they had to shift 70 to 80% of their staff to handle emergency sample demands for up to 6 weeks for one customer. SAL's use of strategic planning to set specific goals and measurements to ascertain a better picture of effectiveness will place it at the forefront among government labs. The process of revising the lab's performance measurements is continuing and is included in the Department's 3-year plan, wherein it is the primary goal of the lab to meet the needs of the Department's regulatory divisions and other agencies, using surveys as the measurement of its effectiveness. The survey is to be developed during the current fiscal year and distributed on a quarterly basis. Some national standards, such as the Pasteurized Milk Ordinance and Good Laboratory Practices, will continue to be utilized by the lab. Performance measurements related to such standards will be developed and expanded.

SAL works in an integrated manner with the Department's regulatory divisions. For example, a new, comprehensive sampling plan will be developed for the Environmental Services Division (ESD) of the Department by January 1996. This plan is being developed by a total-quality-management team, including lab staff. The plan will specify a schedule for the type of products to be sampled and the analytes to be determined. Consequently, the laboratory will be able to reduce cycle time and increase analysis output, because more incoming samples will be received and analyzed in batches, rather than individually. The plan will also ensure that the sampling of feeds, fertilizer, and pesticide formulations, as well as mycotoxin monitoring samples, are statistically random and of sufficient size for ESD to make valid judgements about product quality and safety. It will also enable ESD to better utilize its investigators in order to meet its divisional strategic plan's goals and objectives. While the lab provides a wide variety of information and technical support, the regulatory divisions and agencies it serves make all final decisions on sample submission. The laboratory has no direct control of the number or types of samples it receives.

The performance measurements used by most state laboratories are input/output models (numbers of samples received and tests performed) and do not provide a complete picture of a lab's effectiveness. As stated in the JLBC/OSPB Commentary, these measurements do not measure accuracy, court-defensibility, responsiveness, cost-effectiveness and performance satisfaction,

even though these items are a very important part of our services. The single use of unit cost measurements for regulatory labs may not be appropriate. We will continue working on methods to develop parameters which will better inform us of our effectiveness and how well we satisfy the needs of those we serve.

COMPLEX ADMINISTRATION
Arizona Department of Corrections
OSP/OLBC Executive Summary

Overview - The mission of the Complex Administration Subprogram is to provide consistency in the implementation of departmental policies and procedures within the several prison units. The achievement of this mission is measured primarily by analyzing cost per inmate data and the results of regular inspections of complex files that detail actions taken and procedures followed in the areas of personnel, inmate records management, facility maintenance, and fiscal services. Conclusions that have been reached after reviewing this program are as follows:

- In view of the complicated nature of this subprogram, which combines a variety of operational responsibilities and authority with several overhead staff functions, the Department may wish to consider incorporating the functions of this Complex Administration Subprogram into more appropriate program categories. The current definition of this subprogram overlaps many other programs related to service delivery and agency administration.
- The established goals of achieving consistent operation in all prison units and general cost efficiency rely heavily on evaluating performance and expenditure data on a complex-by-complex basis and comparing them against established standards. However, such data were not available to the OLBC/OSP Staff during the course of this program review. Subsequent submissions of more detailed performance measurement data will help establish benchmarks and identify areas of variance between complexes.

Program Description - Complex Administration evolved over time as the State prison system expanded to various locations throughout Arizona. Currently, there are 42 individual prison units located all over the State. The 8 complex administrations provide overhead staff services to the individual prison units and enforce the authority of the Department's Director; as an organizational form, it provides a manageable span of control over field operations for the Adult Institutions Division. This subprogram was not explicitly created in statute nor through a specific budget appropriation; its authority is derived from the general duties and powers of the Department's Director to organize and administer the Agency. However, there has been at least a repeated tacit endorsement of Complex Administration through the approval of construction plans for new prison facilities that have included the capital infrastructure for this subprogram and approval of operational appropriations that have included complex staff.

How does the mission fit within the Agency's overall mission and the program's enabling authority?

This subprogram's resources and functions should be re-allocated among an administrative program and a prison operations program. Striving to establish and maintain consistent policies and procedures throughout the State prison system is consonant with the Agency's mission and the enabling authority for the Department. A.R.S. § 41-1604 gives the Director broad authority to organize the Department and implement programs and policies necessary to carry out the Agency's mission. However, this subprogram was never enacted in statute nor explicitly created through budget appropriations; it evolved over time as an internal management response to the growth and

expansion of the State prison system. As such, it overlaps many other programs related to service delivery and agency administration, making a clear analysis and evaluation difficult.

Do the historical performance measures and the future performance targets adequately measure goals?

It is not possible to measure the cost effectiveness of this subprogram because too many other factors, such as prison overcrowding, impinge upon the utility of the available expenditure data. Consistency could be illustrated if the Agency submits data that compares performance measures among the several complexes and clearly establishes acceptable ranges of variations for each measurement; future program progress could be measured by the reduction of variations.

The Department submitted the results of these measures in aggregate form and did not provide comparisons between the several complexes. It is impossible to determine whether consistency across the State prison system is being achieved unless the components (complexes) within that system are compared. Composite reporting can tend to mute both the effectiveness of outstanding programs and mask the ineffectiveness of poor ones. The Agency has agreed to submit these data by complex.

In addition, the Agency should specify the amount of variation among complexes that can be reasonably tolerated (given the unique factors that will obviously affect each complex due to location, size and other special, individual situations) and how future performance measures would indicate progress in reducing variations and increasing consistency.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

It is impossible to ascertain the effectiveness and efficiency of this subprogram. Insufficient evidence is presented to substantiate the Agency claims that the subprogram is not funded adequately or that the subprogram is responsible for the low cost per inmate. There are no industry standards available to compare the Complex Administration management model against. Arizona does have a relatively low cost per inmate, compared with other states. However, it is impossible to determine to what extent this subprogram contributes to this result since Complex Administration does not manage all the resources within the Department.

Are there other cost-effective alternative methods of accomplishing the program's mission?

Complex Administration is the most applicable management model for the manner in which Arizona has chosen to build prisons. The alternative would be to shift the functions to the prison units, which would require duplicate staff and higher costs. (These administrative functions do not lend themselves to complete centralization in Phoenix).

Arizona Department of Corrections



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SAMUEL A. LEWIS
DIRECTOR



October 23, 1995

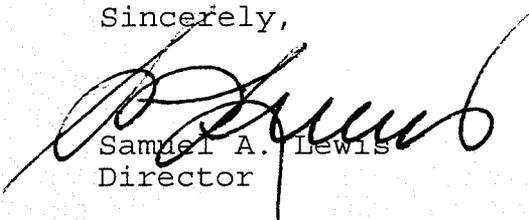
Ted A. Ferris, Director
Joint Legislative Budget Committee
1716 West Adams
Phoenix, Arizona 85007

Peter Burns, Executive Director
Governor's Office of Strategic Planning & Budgeting
1700 West Washington, Room 500
Phoenix, Arizona 85007

Dear Mr. Ferris and Mr. Burns:

Enclosed you will find comments to your analysis of the program authorization review (PAR). Also included is the requested funding information for Fiscal Year 1997 for the complex administration program.

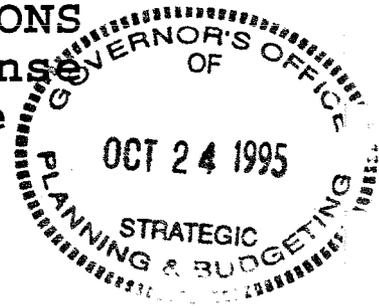
Sincerely,


Samuel A. Lewis
Director

SAL\TLS\cz

Enclosures

ARIZONA DEPARTMENT OF CORRECTIONS
PAR Comments Submitted in Response
to OSPB/JLBC Analysis of the
Complex Administration
Sub-program



Overview -

- ADC Response:
1. Complex administration is responsible for both operations and administrative activities at the prison complex, it necessarily must overlap many programs related to service delivery and agency administration. It may not be possible to develop programs that adhere to a strict cleavage between operations and administration at the institutional level. Normally in program budgeting that separation is not of significant concern.
 2. Information on a complex-by-complex basis was provided to the Governor's Office of Strategic Planning and Budgeting on September 15, 1995 in draft form and formally transmitted in an October 3, letter (See Attachment A and B).
 3. Since this process was intended to be iterative and because ADC intends to embark on a comprehensive strategic planning process, these comments will be considered as the existing programs and sub-programs are re-evaluated.
 4. Established standards will be developed after adequate historical data has been collected. Since it was impossible to capture data prior to the establishment of the sub-program, bench marking an appropriate standard will be impossible. Prior to that bench marking, target estimates will be utilized.

Program Description -

How does the mission fit within the agency's overall mission and the program's enabling authority?

This sub-program's resources and functions should be re-allocated among an administrative Program and a prison operations Program.

ADC Response: See ADC Response 1 in Overview section.

Do the historical performance measures and the future performance targets adequately measure goals?

It is not possible to measure the cost effectiveness of this sub-program because too many other factors such as prison overcrowding, impinge upon the utility of the available expenditure data. Consistency could be illustrated if the agency submits data that compares performance measures among the several complexes and clearly establishes acceptable ranges of variations for each measurement; future program progress could be measured by the reduction of variations.

ADC Response: ADC has submitted performance data on several measures at the complex level. After a few years of data collection, appropriate variation standards can be set. However, without longitudinal data, meaningful variation targets can not be developed.

Additionally, significant facility and operational differences among the various complexes may confound any meaningful comparisons even after longitudinal data has been collected.

Does the Program perform efficiently and effectively, including comparisons with other jurisdictions?

It is impossible to ascertain the effectiveness and efficiency of this sub-program. Insufficient evidence is presented to substantiate the agency claims that the sub-program is not funded adequately or that the sub-program is responsible for the low cost per inmate.

ADC Response: *Under funding* - While system-wide data to support under funding may not exist at this time, an anecdotal review of the effort to split the Florence prison into two reasonably sized complexes demonstrates the under funding of the two largest complexes in the prison system.

The Florence Complex prior to separation into two separate complexes housed nearly 5,000 inmates, employed 2,400 employees, and the warden had 21 direct reports. All other prison complexes were approximately 2,000 inmates, 800 employees, and wardens had reasonable spans of control among direct reports.

Since Florence was continuing to grow, ADC submitted budget issues to split Florence into two complexes of approximately 3,500 inmates. Funding was not recommended by JLBC two years in a row. Finally, ADC split the complex into two smaller complexes using existing resources.

The split, however, required a senior warden to control maintenance and support operations which due to resource limitations could not be adequately allocated to both complexes. The result is neither complex was appropriately funded in areas such as business, maintenance, and personnel.

Inmate Cost - This Department submitted an analysis of the additional costs that would be incurred if the complex structure did not exist. The analysis indicated costs would increase \$ 8.1 million (See Attached). That \$8.1 million increase would ultimately increase the cost per inmate eroding the low cost ADC currently experiences. This information was provided to GOSPB on August 10, 1995 (See Attachment C).

Are there other cost-effective alternative methods of accomplishing the program's mission?

Complex administration is the most applicable management model for the manner in which Arizona has chosen to build prisons. The alternative would be to shift the functions to the prison units, which would require duplicate staff and higher costs. (These administrative functions do not lend themselves to complete centralization in Phoenix).

ADC Response: ADC agrees.

DROPOUT PREVENTION
Arizona Department of Education
JLBC/OSPB Executive Summary

Overview - The mission of the Arizona Department of Education (ADE) Dropout Prevention program is to assist dropouts and potential dropouts in progressing toward and successfully completing their secondary education by developing, promoting and supporting comprehensive education programs. Conclusions that have been reached after reviewing this program are as follows:

- Legislative intent for the program needs to be clarified. The program began as a pilot and never received clear guidance as to what its mission and scope should be after the completion of the pilot phase in 1992. As a result of this uncertainty, ADE has funded the original pilot sites only, to the exclusion of other interested school districts.
- Funding for this program is incorporated into the State Block Grant starting in FY 1996. The State Block Grant allows the shifting of funding between the line items within the grant once funds reach school districts. This creates uncertainty in the year-to-year spending amounts for the program.
- Although the program has been in effect since 1989, its impact on dropout rates is unclear. Effective strategies for dropout prevention have not been clearly documented. There are no measures of costs and success ratios for the different dropout prevention strategies used in the program. Overall, the current performance measures do not adequately gauge the effectiveness of the program.

Overall, the agency's initial Self-Assessment did not meet the minimum requirements. The report did not provide adequate information on several key self-assessment questions as provided to the agency in the Self-Assessment Checklist. For example, the agency did not address the question "*How is the agency coordinating its program activities to avoid duplication or conflict with related programs*" or special questions identified by the Legislature/Governor such as "*How do 'success rates' compare for program participants versus non-participants?*" Recognizing that there was key information missing from their self-assessment, the agency chose to submit some additional information in the form of a "revised self-assessment."

Program Description - The Arizona Department of Education Dropout Prevention program seeks to keep at-risk 7th-12th grade students in school and encourage dropouts to return to school and earn a high school diploma. This is done by providing school districts with technical and funding assistance so they can implement dropout prevention and retrieval strategies. Such strategies include the use of "alternative schools," "school-within-a-school" programs, support groups, and computer-assisted instruction. At-risk students are defined by the State Board of Education as being "*Those students who have dropped out or who have identifiable characteristics, including academic and economic factors, which are recognized as increasing the likelihood of their dropping out of the educational system.*"

Laws 1988, Chapter 308 created the Dropout Prevention program as a four-year pilot program funded on a competitive grant basis. Thirteen sites with high proportions of at-risk students participated in the pilot program. Laws 1992, Chapter 305 extended the program indefinitely beyond the pilot phase "until such time that sufficient funding for statewide at-risk programs and services is provided by the Legislature through a weight in the funding formula." Such a weight, however, has not been

established, and the original sites have continued to receive program funding during the past three "post-pilot" years. State funding for these sites will be reduced in FY 1996, and discontinued thereafter, though, so that new sites will be eligible for program funding. With only about 4,000 of Arizona's approximately 320,000 7-12th grade students participating in the program each year, it probably is too small to have a measurable impact on statewide dropout rates.

How does the mission fit within the agency's overall mission and the program's enabling authority?

The overall intent of the program needs to be clarified regarding 1) its permanence, 2) district eligibility, and 3) the types of projects to be funded. The legislation that created the Dropout Prevention program (Laws 1988, Chapter 308) created it as a four-year pilot program for fiscal years 1989-92. The mission of this pilot program was to identify effective dropout prevention strategies which could be replicated around the state. Two pieces of session law (Laws 1991, Chapter 251; and Laws 1992, Chapter 305) extended the enabling authority for the program beyond the original four years. These laws, however, have not provided clear guidance regarding the mission of the program during its "post-pilot" phase.

Reference to a never-funded "at-risk weight" in enabling legislation creates confusion as to the nature of Dropout Prevention funding. Laws 1992, Chapter 305 extended the program "until such time that sufficient funding for statewide at-risk programs and services is provided by the Legislature through a weight in the funding formula." Although such a weight never was funded, a weight-based funding approach would have addressed the dropout prevention needs of *all* districts--not just those with the highest percentages of at-risk students (as in the pilot phase.) Likewise a weight would have provided funding "entitlement" (permanent) funding rather than "seed money" only (as in the pilot phase).

Do the historical performance measurements and the future performance targets adequately measure goals?

The program's performance measures do not adequately gauge its effectiveness in dropout prevention. The ideal measure of success for dropout prevention programs should be changes in dropout rates before and after such programs. Currently, there is not an effective system for tracking students as they move in and out of school districts. This results in the inclusion of "status unknown" students in the "dropout" data; therefore, making the dropout data unreliable.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

Although the program has been in effect since 1989, its impact on dropout rates is unclear. The original enabling legislation (Laws 1988, Chapter 308) created the Dropout Prevention Program as a four-year pilot program to specifically identify effective strategies that could be replicated statewide. However, effective strategies have not been clearly documented. There are no measures of costs and success ratios for each strategy to provide information for implementing future statewide dropout prevention programs. In addition, Laws 1992, Chapter 305, extended the program indefinitely beyond the pilot phase "until such time that sufficient funding for statewide at-risk programs and services is provided by the Legislature through a weight in the funding formula." Again, there is no cost information to provide a basis for the weight in the funding formula for potential future implementation of an at-risk weight.

As one of their performance measures for Dropout Prevention, ADE initially reported that 96% of all students in the program in FY 1994 either graduated at the end of the year or continued their education through the end of the year. Data for corroborating this measure were requested but not provided. In a later submission, ADE provided district-by-district data for FY 1994 and FY 1995 on dropout rates for all students in participating districts versus those students who participated in Dropout Prevention programs in the districts. Using these data for calculations, the percentage of students in the program that either continued their education or obtained a diploma is approximately 91% for FY 1994 and 90% for FY 1995. This means in FY 1994 the dropout rate for Dropout Prevention programs is 9% and 10% for FY 1995. However, this is a composite measure and program effectiveness varies substantially site-by-site. The data show that some districts have dropout rates of "zero" for program participants, while others have rates as high as 67%. Anecdotal evidence from program administrators and other sources indicates that this may largely be because program success is highly dependent upon the stability and support of a particular school's administration and faculty. Approximately 9% of *all* students in participating districts dropped out of school during FY 1994.

National census data from 1990 indicate a national dropout rate of approximately 11% and an Arizona rate of approximately 14%. This is based on the percentages of 16-19 year olds without a high school diploma who were not enrolled in school at the time of the census. Unfortunately, such census data on dropout rates are not useful as indicators of program success for the Arizona Dropout Prevention program because they are not available on a district-by-district level, and are collected only every 10 years.

Are there other cost-effective alternative methods of accomplishing the program's mission?

Because most inputs and outputs for these programs were not measured, and varied widely by location and program approach, it is difficult to discern whether cost effective alternatives exist for dropout prevention programs. Some dropout prevention programs, for example, rely on cost-intensive "alternative schools," while others are based on the provision of student "support groups" which are much less expensive on a per student basis. One alternative, however, would be systemic school reform aimed at improving education for *all* students rather than "enrichment" programs aimed only at "*at-risk*" students.



**DROP-OUT PREVENTION
STRATEGIC PLAN FY 1996 - FY 1998**

SUBPROGRAM SUMMARY

Drop-Out Prevention Laws 1987, Ch. 333, Laws 1988, Ch. 308, Laws 1992, Ch. 302, Sec. 32, Laws 1992, Ch. 305
 Contact: Trudy Rogers, Director 542-3729
 Voc. Tech. Educ., Comprehensive Training EDA0511.SUB

Subprogram Mission: *To assist dropouts and potential dropouts (grades 4-12) in progressing toward and successfully completing their secondary education by developing, promoting and supporting comprehensive education programs.*

Subprogram Description: There are two programs supporting dropout prevention and retrieval activities for middle and secondary school students. The first program was established by Laws 1987, Chapter 333 and focuses on grades four through twelve. All participating districts must indicate in their plan how they propose to reduce absenteeism, their dropout rate, their retention rate, and how they are going to improve academic performance.

The second program was established by Laws 1988, Chapter 308 and directed the state Board of Education to select school districts to receive grant monies to establish demonstration education and training programs to specifically address the needs of secondary (grades 7-12) level at-risk pupils through alternative programs and activities which provide academic and vocational training as well as support services for dropout and potential dropouts. The Comprehensive Training subprogram is responsible for reviewing the dropout prevention plans and demonstration site continuation grants for compliance and recommending approval to the State Board of Education; monitoring the progress of the programs; providing technical assistance; and developing customized in-service activities/workshops.

Subprogram Statutory Funding Formula: Laws 1992, Ch. 305 - Dropout Prevention Programs (Grades 7-12 receive discretionary funding.)

Laws 1992, Ch. 302 § 32 - Dropout Prevention Programs (Grades 4-12 allows twenty-one districts to generate local tax monies above their revenue control limit up to the level they budgeted under this program in FY 1991; it can *only* be spent on dropout prevention.)

Subprogram Goals and Performance Measures:

◆ Goal 1 - To decrease the absentee and retention rates of students participating in the Dropout Prevention Program.

→Objective #1a: By November 30, 1995, revise program reporting forms to collect data by grade level.

→Objective #1b: By September 30, 1996, collect baseline data from participating school(s) to compare with program statistics.

→Objective #1c: By July 1, 1997, incorporate Dropout Prevention Reporting into agency student tracking system.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|----------------|------------------|------------------|------------------|
| Outcome | Dropouts/potential dropouts who advance to junior high, high school, or graduate from high school | 3,666 | 3,587 | 7,000 | 3,600 |
| Quality | Percent of students enrolled in program who continue education or obtain diploma | 96 | 97 | 98 | 98 |

◆ Goal 2 - To decrease the dropout rate and increase the graduation rate for the participating school(s).

→Objective #1a: By November 30, 1995, revise program reporting forms to collect data by grade level.

→Objective #1b: By September 30, 1996, collect baseline data from participating school(s) to compare with program statistics.

→Objective #1c: By July 1, 1997, incorporate Dropout Prevention Reporting into agency student tracking system.

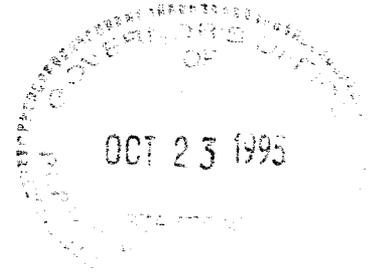
| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|----------------|------------------|------------------|------------------|
| Output | Technical assistance activities/workshops provided | 43 | 39 | 74 | 40 |
| Output | Districts funded and approved for dropout prevention/retrieval programs | 13 | 12 | 22-24 | 12 |
| Quality | Percent of technical assistance requests met | 98 | 100 | 100 | 100 |
| Outcome | Coordination and linkage partnerships developed | 75 | 83 | 120 | 85 |

Funding Source and FTE Amounts: (Thousands)

| Source | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
|---------------|-------------------|---------------------|--------------------|
| General Fund | 2,183.9 | 2,185.1 | |
| FTE Positions | | 1.5 | 1.5 |



Arizona
Department of Education



October 23, 1995

Mr. Ted Ferris, Director
Joint Legislative Budget Committee
1716 W. Adams
Phoenix, Arizona 85007

Mr. Peter Burns, Director
Governor's Office of Strategic Planning and Budgeting
1700 West Washington
Phoenix, Arizona 85007

Dear Mr. Ferris and Mr. Burns:

Enclosed are the Department of Education comments relative to the JLBC/OSPB assessment of our Dropout Prevention report. These are the comments requested for inclusion in the composite program authorization review (PAR) report.

Thank you for the opportunity to provide these comments.

Sincerely,

Lisa Graham by *Jean Barrett*
Lisa Graham
Superintendent of Public Instruction

DROPOUT PREVENTION
Arizona Department of Education
Comments on JLBC/OSPB PAR Analysis

Introduction: As one of the initial agencies to participate in the Program Authorization Review (PAR), we feel it has been a worthwhile exercise. The process itself could be an excellent management tool in getting a new program/activity off the ground. The PAR asks the hard questions any agency should ask itself. This process could also be used for program planning and implementation as well as an ongoing evaluation tool to monitor program/activity progress. This would give consistent organization and structure in order that progress and outcomes for all state programs could be measured effectively. Some suggestions for modification were given to OSPB staff at the roundtable discussion held with PAR agencies on August 10, 1995. Overall, however, the PAR process is comprehensive and covers the pertinent issues.

Page 1 of JLBC/OSPB Executive Summary

JLBC/OSPB PAR Analysis: Legislative intent needs to be clarified. The overall intent of the program needs to be clarified regarding 1) its permanence, 2) district eligibility, and 3) the types of projects to be funded (Page 7).

ADE Comments: We agree that legislative intent needs to be clarified. The original legislation which provided authorization for what is currently identified as the Dropout Prevention Program was directed to activities which integrated academics, vocational training and support services for at-risk students in grades 7-12. It was designed as a four-year demonstration project for districts to pilot strategies for effectively addressing the needs of at-risk students as they work toward high school graduation. Although this program was shown as the At-Risk (7-12) Program in the enabling legislation in July of 1988, it was labeled Dropout Prevention in the FY 1990 Appropriations Bill. Although the label changed, the legislative intent did not. Clarification in legislative intent would also aid the Department of Education in focusing on those components needing short-term and long-term measurement.

The Department of Education has received numerous requests to access the Dropout Prevention funds from additional districts who feel they have definite needs for resources to address their local Dropout Prevention issues. The original Comprehensive At-Risk Education (CARE) formula was not instituted. Legislation should be reviewed and modified to clarify the many issues that have cropped up during its eight-year life.

JLBC/OSPB PAR Analysis: Funding for the program is incorporated into the State Block Grant starting in FY 96 creating uncertainty in the year-to-year spending amounts for the program.

ADE Comments: We agree that this is an issue based on the belief that a State Block Grant should be a source of revenue that serves a similar population. An internal ADE committee has been responsible for overseeing and developing processes to administer the State Block Grant. One of the recommendations submitted in the FY97 budget is the realignment of the State Block Grant by removing the Dropout Prevention and Gifted Support programs. At-Risk Preschool, Full Day Kindergarten and K-3 Academic Assistance serve at-risk children who are in preschool through grade three, while the Gifted Support program serves students in grades kindergarten through twelve and the Dropout Prevention program serves students in grades seven through twelve. It was also recommended that Family Literacy, which is designed to promote the acquisition of learning and reading skills by parents and their preschool children in a shared instructional setting, be included in the Early Childhood Block Grant.

JLBC/OSPb PAR Analysis: Impact on dropout rates is unclear.

ADE Comments: The original intent of Laws 1988, Chapter 308 was not specifically to impact dropout rates as much as it was to identify strategies that worked in addressing issues facing at-risk students as they attempted to successfully complete their high school education. This was the first educational legislation which provided a commitment to four-year funding as well as a longitudinal study to determine what worked with at-risk students.

There was intent by the legislature that the results from this demonstration funding would be utilized in developing future legislation/funding to serve at-risk students. The initial funding of \$1.5 million did not provide support for enough districts to be involved that it could effectively impact the statewide dropout rate. Districts were encouraged to develop strategies, to eliminate what did not work, and to institutionalize what did.

At the time our agency self assessment was due, we were still missing a number of reports from school districts for both 1993-94 and 1994-95. The 96% reported figure, representing all students in the program in FY 1993-1994 who either graduated at the end of the year or continued their education through the end of the end of the year, was based on the district reports submitted to that date. We have received the last two district reports and the percentage has dropped slightly to 92.38%. This is itemized by district on pages 14E and 14F of our agency self-assessment.

The Morrison Institute for Public Policy at Arizona State University was commissioned to carry out the required longitudinal study. The following reports are available for review in the Department of Education. These reports incorporate extensive evaluation data from the funded at-risk sites.

February 1990 Formative Evaluation Reports
K-3 and 7-12 Phase 1 Programs

September 1990 FY 1989/90 Summative Evaluation Reports
7-12 Phase I and II Programs

| | |
|--------------|--|
| January 1991 | Formative Evaluation Reports K-3 and 7-12 Phase I Programs |
| June 1991 | FY 1990/91 Summative Evaluation Reports 7-12 Phase I and II Programs |
| June 1992 | FY 1991/92 Summative Self-Evaluation Reports 7-12 Phase I and II Programs |

JLBC/OSPB PAR Analysis: Agency coordination of dropout program activities to avoid duplication or conflict with related programs.

ADE Comments: We are in agreement that this type of coordination needs to take place at both the state and local levels. As part of the application for Dropout Prevention Continuation Grants, school districts are required to demonstrate how they coordinate with other complementary programs such as Title I, Vocational Education/School to Work, Safe and Drug Free Schools, etc. Within ADE, there are multiple efforts taking place for coordinated funding processes, technical assistance and professional development activities as well as review of local program progress. This includes State Block Grant activities, consolidation of specific federal programs under the Improving Americas Schools Act (IASA), plus a continued effort to review how programs can be integrated and support each other.

JLBC/OSPB PAR Analysis: How do "success rates" compare for program participants versus non-participants?

ADE Comments: There was no anticipation originally that the money would continue after the first four years. The legislative mandate included a longitudinal study of program impact at the site level. This study and the resulting report were also commissioned to Morrison Institute for Public Policy. The report was titled "Powerful Stories, Positive Results: Arizona At-Risk Report" (Appendix A to ADE Self Assessment). It was submitted to the State Legislature and accepted in November of 1991. This mandate did not include a comparison of "success rates" for program participants versus non-participants and processes were not developed to accomplish this.

Virtually no program has the student-level data necessary for evaluation of quantitative effectiveness. This is an issue with Special Education, School to Work and other specialized programs. The ADE's 1996-97 Budget Request includes \$7.9 million for a Student-Based Accountability Tracking System. This would allow us to track student information as they move from school to school not only for funding purposes but for determining program effectiveness.

Page 2 of JLBC/OSPB Executive Summary

JLBC/OSPB PAR Analysis: With only about 4,000 of Arizona's approximately 320,000 7-12th grade students participating in the program each year, it probably is too small to have measurable impact on statewide dropout rates.

ADE Comments: Districts are incorporating strategies that have proven effective. For example, a number of districts considering starting alternative schools have visited on-site successful programs such as Nogales and Marana Unified School Districts to glean strategies and ideas. As stated, we are also beginning to fund new Dropout Prevention sites in 1995-96 under the existing funding.

JLBC/OSPB PAR Analysis: The mission of this pilot program was to identify effective dropout prevention strategies which could be replicated around the state.

ADE Comments: It was a legislative intent for the program to identify those strategies that worked in addressing issues that face at-risk students. This was the genesis for "Promising Practices" for At-Risk Youth prepared by Morrison Institute for Public Policy at ASU. The document was designed to be a "user friendly" handbook for local district personnel in implementing programs. Although it was based on local and national research by Morrison Institute, it was not designed as a research document.

JLBC/OSPB PAR Analysis: Are there other cost-effective alternative methods of accomplishing the program's mission?

ADE Comments: As the report indicates, "One alternative (to the Dropout Prevention Program), however, would be systemic reform aimed at improving education for *all* students rather than 'enrichment' programs aimed only at '*at-risk*' students." The vision of the Department of Education is "to assure access of all students to an extraordinary education." Working toward this vision will result in reform to the education system as we currently know it. This reform must be well thought out and involve input from constituents.

It is important that we continue to provide support systems such as the Dropout Prevention Program for at-risk youth until such time that we have reformed the total education system to a level that these programs are no longer necessary. As we work toward consolidation of state and federal resources to meet the needs of students, we will also develop better mechanisms to help young people stay in school and retrieve those who have dropped out.

Additional ADE Comments: The PAR analysis does not address the success of the programs. ADE staff reviews progress a minimum of three times each program year. Their findings determine the technical assistance we provide the sites. Written monitoring reports are a part of each contract file. The files also include the actual contract, various reports, correspondence, etc. related to the project and are available for review.

Each year, the continuation sites are required to complete a Program Impact Summary. This report includes the site's accomplishments to date as evaluated against their individual project goals and objectives. An example is shown in the San Carlos Unified School District's report for 1994-95: "A total of 134 at-risk students (grades 7-8) enrolled in, and completed, the vocational career preparation/tech lab course. No students from this course dropped out of school. At the present time 100% have registered for high school courses compared with 89% of all 8th grade graduates."

Because schools design programs specific to local needs and available resources, our challenge is to identify those components which are comparable district to district and which document student success.

UNDERGROUND STORAGE TANK
Arizona Department of Environmental Quality
OSPB/JLBC Executive Summary

Overview—The focus of the Arizona Underground Storage Tank (UST) Program is to prevent, detect and clean up releases of hazardous substances and petroleum into ground waters, surface and subsurface soils. The program also provides financial coverage to UST owners and operators for upgrade, removal, and cleanup of site contamination. After examining the Department's self-assessment, the joint JLBC/OSPB review reached the following conclusions:

- The program performed poorly until late 1993. Since then, ADEQ has substantially improved program efficiency, particularly in the area of claims processing.
- The UST program is effective, especially in terms of initiating clean up and processing claims. However, remediation backlogs still exist.
- Diversions of monies from the Area A account may cause delays in remediation and reimbursement in Maricopa County beginning in FY 1996.

In general, the Arizona Department of Environmental Quality's (ADEQ) self-assessment of the UST program was timely and thorough. The Agency answered all the questions and worked diligently with OSPB and JLBC to help analysts better understand the issues related to this program.

Program Description—The Underground Storage Tank (UST) Program was established by the U.S. Congress in 1984 with the addition of Title I to the Resource Conservation and Recovery Act (RCRA). The State's program was created by the Legislature in Laws 1986, Chapter 33, to regulate the underground storage tank systems and implement the requirements of the provisions of RCRA. The main activities of this program include pollution prevention, leaking underground storage tank remediation, financial responsibility, and public outreach. The program regulates and serves a wide range of tank owners and operators and other private entities.

The UST program does not receive State General Fund appropriations. It is structured as a self-supporting program and funded through two Federal grants and the State UST Revolving Fund. The Revolving Fund revenue sources include an excise tax of one-cent-per-gallon of regulated substance, annual tank fees, cost recovery, and interest income. The Fund is divided into three accounts: the Regulatory Account, the Grant Account, and the State Assurance Fund (SAF) Account. The Assurance and Regulatory Accounts were divided into two subaccounts in the Sixth Special Session of 1993: Area A (Maricopa County) and all other areas (Non-Maricopa County). The Grant Account, the Assurance Account and the program's authority to provide financial coverage for corrective actions are respectively scheduled in statutes to terminate in 2002 and 2003. Current statutes also provide that after termination all revenues collected, that would have otherwise been deposited into the Assurance Account, be placed into the State General Fund.

How does the mission fit within the Agency's mission and the program's enabling authority?

The UST program's mission reflects the enabling authority and fits within the Agency's mission and goals. The program's focus is to prevent and minimize the release of regulated substances into the

environment which coincides with the Agency's mission to preserve, enhance and protect the environment and public health.

Do the historical performance measurements and the future performance targets adequately measure goals?

Although the Agency submitted suitable performance measures, some can be strengthened or added to better capture results of pollution prevention and financial assistance activities. The pollution prevention activities measures provide better information on the program's efficiency than on its effectiveness. It is difficult to assess how effective the program is in preventing/minimizing releases. Measuring annual confirmed releases per inspected facility may provide a better sense of release minimization and prevention. The performance measures for inspection and enforcement are suitable.

The leaking underground storage tank (LUST) performance measures are adequate in capturing effectiveness, but are weaker in measuring efficiency. This is because time and costs may not be meaningful measures for groundwater and soil contamination remediation. Time to complete remediation can range from less than one year to 30 years. Costs of remediation can vary widely, too. Therefore, it is difficult to measure time and costs to remediate in a meaningful way.

The measures for financial assistance could be enhanced to better appraise the efficiency of the program. For instance, it appears that pre-approval of remediation plans is an efficient procedure, but no performance measures were selected to gauge if it takes less time or is more cost-effective than post-remediation review.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

Pollution prevention activities appear to encourage compliance; however, long-term effectiveness has yet to be determined. The program is efficient and effective in terms of notifying violators and bringing those facilities into compliance within 120 days. Enforcement activities have also been effective in bringing more facilities into compliance within one year from the original year of inspection. However, it is not possible to measure how this relates to preventing/minimizing releases. What is lacking is a "bottom-line" measure of the number of releases relative to the total number of tanks. The Agency also needs to determine whether the facilities that remain in non-compliance are in fact the ones releasing substances into the environment.

The Leaking Underground Storage Tank (LUST) Program is effective in initiating cleanup. However, remediation backlogs still exist on sites that have yet to be fully evaluated. Based on FY 1994 data, cleanup has been initiated at over 85% of evaluated sites with a confirmed release. The Agency expects this percentage to increase annually. Many cleanups are not started until complex issues of responsible party identification are resolved, which can take up to a year. This is why cleanup has not been initiated at all sites with a confirmed release. Since remediation of groundwater contamination can take up to 30 years, the number of groundwater cases closed tends to be low. On the other hand, soil contamination requires less time to remediate and the number of closed soil cases tends to be higher.

The remediation program currently has a backlog of over 2,700 known sites with confirmed releases. This backlog is mainly composed of sites that have not been fully characterized (i.e., the extent of the contamination and cleanup costs have yet to be determined) and low-risk sites.

The program performed poorly until late 1993. Since then, ADEQ has substantially improved program efficiency, particularly in the area of claims processing. Some of the most significant changes include expediting the State Assurance Fund (SAF) claim reimbursement process by contracting out technical review and application processing, shifting emphasis from post to pre-approval remediation plans, and providing more reliable technical assistance and assurance of financial coverage to the regulated community. Due to the recent streamlining of the process and contracting changes, the claims processing time has been reduced to less than 2.5 months, compared to the national average of 4.5 months. This is a significant improvement from FY 92 and FY 93 which averaged eight and ten months respectively. The changes in the service provider contract have also reduced the average processing cost per claim from approximately \$5,000 to \$2,000. By shifting from post to pre-approval of remediation plans, tank owners/operators reduce both claim turnaround time and unnecessary remediation procedures. The advantages of the pre-approval include the ability to control costs, manage cash flow, and prioritize site remediations based on the greatest risk to human health and the environment. This processing method also helps to ensure that work is appropriate, adequate and cost-effective.

Additionally, ADEQ has expanded its outreach effort to help and educate UST owners and operators. Examples of those efforts include application seminars, the UST/LUST ombudsman (hotline), and rural outreach workshops designed to provide assistance and guidance to the regulated community. The Public Outreach Team of ADEQ also produces and sends a quarterly newsletter to all UST owners and operators to notify them of upcoming events and any relevant changes to the program.

Diversion of monies for other programs may cause delays in Area A (Maricopa County) beginning in FY 1996. In 1992, the Legislature appropriated monies from the UST Revolving Fund to help the State General Fund overcome its shortfall. Also, during the Sixth Special Session of 1993, the UST Assurance Account was divided into Area A (Maricopa County) and all other counties (Non-Maricopa County). Monies were then diverted from the Area A Account for air quality programs, including the vehicle emissions program in Maricopa County. Beginning in FY 1996, the Area A Account may not have sufficient funds to pay all claims from Maricopa County applicants. This will lead to a queue for Maricopa County applicants and delays in clean-up. The Non-Maricopa County Account will continue to have sufficient monies for all applicants.

Moreover, the future financial liability associated with the backlog of potentially eligible LUST sites is not known at this time. Of those sites, approximately 1,521 are located in Maricopa County, and 1,213 in other areas of the State. On October 10, 1995, Peterson Consulting developed a framework for ADEQ to estimate future corrective costs of the known LUST sites eligible to request reimbursement from the State Assurance Fund. Peterson's findings were presented after JLBC/OSPB's commentary was completed, so the results have not been included in this document.

Are there other cost-effective alternative methods of accomplishing the program's mission?

Given the declining trend in the number of regulated facilities and tanks, one alternative to handle cleanup cost reimbursements would be to transfer the financial responsibility functions back to the

private insurance industry. This option may be more feasible when new tank standards and release detection methods become effective in 1998. As a result, the rate of occurrences and extent of contamination from new tank releases should be minimized, which should allow UST facilities to be privately insured at affordable rates. Other alternative methods, such as expanding competitive contracting and partnerships with private/public entities are being considered by the Agency.

**UNDERGROUND STORAGE TANK
STRATEGIC PLAN FY 1996 - 1998**

SUBPROGRAM SUMMARY

Underground Storage Tank A.R.S. §§ 49-1001 to 49-1071
Contact: Tara Roesler, Manager 207-4242
Waste Program Division EVA0304.SUB

Subprogram Mission: *To protect human health and the environment by assuring the proper installation, operation and closure of underground storage tanks (USTs), by ensuring the clean up of contamination emanating from leaking underground storage tanks (LUSTs) and by providing public education and financial assistance.*

Subprogram Description: The subprogram is responsible for identifying Underground Storage Tanks (USTs) and leaking underground storage tanks (LUSTs); preventing UST releases through compliance inspections and enforcement; cleaning up of LUST sites through site investigations, technical guidance, enforcement and State lead actions; and promoting the UST release prevention program and LUST cleanup actions through expeditious and efficient processing of applications for financial assistance.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ **Goal 1 - To prevent or minimize releases from USTs through inspections and enforcement.**

→ **Objective #1: To increase the percentage of active UST facilities which have been inspected to 90% of all facilities by the year FY 1998.**

| | | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|------------|-------------------------------|---------|----------|----------|----------|
| Type | Performance Measures | Actual | Expected | Expected | Expected |
| Output | Inspections/ | 1,922 | 2,500 | 3,500 | 4,500 |
| | total facilities | 3,777 | 3,700 | 3,650 | 3,600 |
| | ratio | 50.9 | 67.6 | 95.9 | 100+ |
| Efficiency | Inspections/ | 848 | 578 | 1,000 | 1,000 |
| | Inspectors | 4 | 4 | 5 | 5 |
| | ratio | 212 | 145 | 200 | 200 |
| Input | Facilities in compliance | | | | |
| | at inspection/ | 273 | 137 | 200 | 300 |
| | inspected facilities | 848 | 578 | 1,000 | 1,000 |
| | ratio | 32 | 24 | 20 | 30 |
| Outcome | Facilities brought into | | | | |
| | compliance within 120 days of | | | | |
| | notification of violation | 392 | 355 | 560 | 600 |
| | non-compliant facilities | 436 | 433 | 800 | 700 |
| | ratio | 90 | 80 | 70 | 85 |
| Outcome | Facilities in | | | | |
| | compliance/ | 1,948 | 2,400 | 2,700 | 3,000 |
| | inspected facilities | 1,992 | 2,500 | 3,500 | 3,600 |
| | ratio | 98 | 96 | 77 | 83 |
| Efficiency | Complaints investigated | | | | |
| | within 5 working days/ | N/A | 30 | 30 | 30 |
| | complaints received | N/A | 30 | 30 | 30 |

ratio 100 100 100

◆ **Goal 2 - To ensure timely remediation of LUST.**

→ **Objective #1: To increase the percentage of sites with cleanup initiated to at least 90% by FY 1998.**

| | | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|---------|----------------------|---------|----------|----------|----------|
| Type | Performance Measures | Actual | Expected | Expected | Expected |
| Outcome | LUST cases with | | | | |
| | cleanup initiated/ | 2,770 | 3,500 | 4,000 | 4,500 |
| | confirmed releases | 3,240 | 4,000 | 4,500 | 5,000 |
| | ratio | 85 | 87 | 89 | 90 |
| Outcome | LUST cases closed/ | 810 | 1,260 | 1,764 | 2,369 |
| | confirmed releases | 3,240 | 4,000 | 4,500 | 5,000 |
| | ratio | 25.9 | 31.5 | 39.2 | 47.4 |

◆ **Goal 3 - To meet our customers' needs for financial assistance.**

→ **Objective #1: To increase the percentage of claims paid to at least 95% by FY 1998.**

| | | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|------------|----------------------|---------|----------|----------|----------|
| Type | Performance Measures | Actual | Expected | Expected | Expected |
| Outcome | Claims paid/ | 498 | 1,095 | 1,700 | 2,520 |
| | eligible claims | | | | |
| | received | 777 | 1,368 | 2,000 | 2,800 |
| | ratio | 64 | 80 | 85 | 90 |
| Efficiency | Length of time to | | | | |
| | process claims | N/A | 49 | 36 | 31 |
| Input | Length of time to | | | | |
| | receive a complete | | | | |
| | claim package | N/A | 67 | 58 | 50 |
| Quality | Positive responses/ | | | | |
| | total responses from | | | | |
| | UST customers | N/A | N/A | N/A | N/A |

Funding Source and FTE Amounts: (Thousands)

| Source | FY 1995 | FY 1996 | FY 1997 |
|--------------------------------|-----------------|-----------------|-----------------|
| | \$ Actual | \$ Estimate | \$ Request |
| Other Non-appropriated Funds - | | | |
| Circle K Fund | 229.6 | 229.7 | 157.5 |
| UST Fund | 40,163.4 | 34,756.1 | 37,343.1 |
| Federal Funds | <u>1,567.1</u> | <u>851.1</u> | <u>1,784.5</u> |
| Subprogram Total | <u>41,960.1</u> | <u>35,836.9</u> | <u>39,285.1</u> |
| FTE Positions | <u>63.9</u> | <u>63.2</u> | <u>84.6</u> |

ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY

Fife Symington, Governor Edward Z. Fox, Director

October 2, 1995

Mr. Peter Burns, Director, OSPB
1700 West Washington
Phoenix, Arizona 85007

Mr. Ted Ferris, Director, JLBC
1716 W. Adams
Phoenix, Arizona 85007

Dear Mr. Burns and Mr. Ferris:

Thank you for the opportunity to review and comment on the Arizona Department of Environmental Quality (ADEQ) Underground Storage Tank/Leaking Underground Storage Tank (UST/LUST) Program Authorization Review (PAR) report. Overall, the ADEQ Management Team and I feel that the report: 1) acknowledges that the program's mission reflects the enabling authority and fits within the agency's mission and goals; 2) recognizes the substantial improvements that have been made in program efficiency since 1994; 3) correctly assesses current program effectiveness and efficiency; and, 4) identifies key areas which require additional Executive Office and Legislative Branch discussion and resolution. We offer the following comments in response to specific issues raised in the report. Issues from the report are in bold capital font; the ADEQ response follows.

ALTHOUGH THE AGENCY SUBMITTED SUITABLE PERFORMANCE MEASURES, SOME CAN BE STRENGTHENED OR ADDED TO BETTER CAPTURE RESULTS OF POLLUTION PREVENTION AND FINANCIAL ASSISTANCE ACTIVITIES.

ADEQ is continually assessing the appropriateness of its performance measures to provide management with the most effective means of monitoring program efficiency and effectiveness. We will explore the report's suggestion to develop a measure of program effectiveness in the area of release minimization and prevention.

ADEQ agrees that the LUST performance measures are weaker in measuring efficiency. However, efficiency of remediation is, for the most part, beyond ADEQ control as the LUST program is, by statute, primarily a post-remediation review. Selection of the remediation technology to be utilized at a given site is the responsibility of the owner/operator and their consultant. Efficiency is but one criteria. Cost and infringement on on-going business operations also affect the ultimate decision.

With respect to the suggestion that the measures for financial assistance could be enhanced to better appraise the efficiency of the program, ADEQ has initiated the necessary steps to begin gathering the necessary data, particularly as it relates to the voluntary pre-approval process. Since its inception in March 1995, ADEQ has received 75 pre-approval applications totalling \$6,553,473.69. Pre-approval authorizations relative to those applications were \$2,973,341.79 or a savings of approximately 55%. It is, however, too early to assess whether the pre-approval process lengthens or shortens the remediation time frame.

THE PROGRAM PERFORMED POORLY UNTIL LATE 1993. SINCE THEN ADEQ HAS SUBSTANTIALLY IMPROVED PROGRAM EFFICIENCY, PARTICULARLY IN THE ARE OF CLAIMS PROCESSING.

Mr. Peter Burns, Director, OSPB
Mr. Ted Ferris, Director, JLBC
October 2, 1995
Page 2

ADEQ acknowledges that the program performed poorly prior to Fiscal Year 1994. We appreciate your recognizing in the report the improvements initiated by management to deal with prior program deficiencies. Since submitting our program self-evaluation, additional documentation for Fiscal Year 1995 reveals further enhancements in program efficiency and effectiveness. Examples include:

- In FY 1995 the UST/LUST Financial Program Unit paid \$17,903,607 in State Assurance Fund Claims versus \$11,673,913 for FY 1994.
- In FY 1995 the Corrective Action Units closed 446 LUST cases compared to 341 cases for FY 1994, a 30.8% increase. This is particularly impressive when compared to the 840 sites that were closed from inception 1989 through 1994.
- In FY 1995, the Inspections and Compliance Unit completed 524 facility inspections and found 388 facilities to be out of compliance (84%). The Unit successfully returned 90% of those facilities to compliance within 120 days.

THE UST PROGRAM IS EFFECTIVE, ESPECIALLY IN TERMS OF INITIATING CLEAN-UP AND PROCESSING CLAIMS. HOWEVER, REMEDIATION BACKLOGS STILL EXIST.

ADEQ acknowledges a serious backlog of open LUST cases. A significant number of these cases have not completed the first step toward remedying their release, site characterization (determination of the vertical and horizontal extent of contamination). Delays in remediation can increase the risk to human health and the environment and increase the ultimate cost of clean-up. Additionally, lack of data on the extent of contamination inhibits the program's ability to precisely project total State Assurance Fund (SAF) liability and time lines for the 2,734 open LUST cases.

As a first step towards addressing the backlog, ADEQ expanded its outreach efforts, particularly in the rural areas of the State. Additionally, in FY 1995 the ADEQ established a "common sense" approach to enforcement to encourage owners and operators to comply with their responsibilities for: 1) preventing UST releases and 2) cleaning up releases from UST's.

DIVERSION OF MONIES FOR OTHER PROGRAMS MAY CAUSE DELAYS IN AREA A (MARICOPA COUNTY) BEGINNING IN FY 1996.

ADEQ is projecting that the SAF Area A fund obligations for FY 1996 will exceed available resources and further estimates that the shortfall will rise in FY 1997. ADEQ welcomes the opportunity to work with the Executive Office and the Legislature as they develop solutions to resolve the funding problems associated with both the Underground Storage Tank Area A account and the Vehicle Emissions Inspection Program fund.

ONE ALTERNATIVE TO HANDLE CLEANUP COST REIMBURSEMENTS WOULD BE TO TRANSFER THE FINANCIAL RESPONSIBILITY FUNCTIONS BACK TO THE PRIVATE INSURANCE INDUSTRY.

LUST financial assistance programs were formed in the late 1980's because releases from tanks had become so prevalent and costly that private insurance companies declined to continue writing policies. In order to return this function to private insurance, private companies will need to feel that: 1) the risk of releases to the environment have been reduced to a manageable level; 2) pre-existing LUSTs have been discovered and remediated; 3) a market exists for this coverage; and, 4) they can maintain an actuarially sound program while offering reasonable rates.

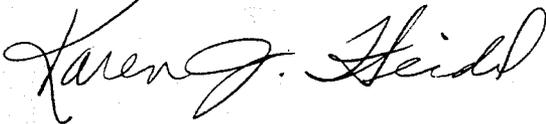
Mr. Peter Burns, Director, OSPB
Mr. Ted Ferris, Director, JLBC
October 2, 1995
Page 3

The UST/LUST program is addressing issues 1 and 2. Technical standards for release detection, corrosion protection and spill and overfill protection, along with methods for ensuring compliance with those standards, have been established with a deadline for implementation of December 22, 1998. Pre-existing releases are being identified and remediated through the State Assurance Fund.

ADEQ believes conditions 3 and 4 can be met after December 22, 1998 if the State aggressively enforces compliance with the aforementioned technical standards and ceases to provide SAF coverage for open facilities thus ensuring the insurance industry a market base of approximately 3,600 facilities.

In conclusion, I wish to compliment your staff members for their professionalism, thoroughness of review and diligence in working with our program staff to assure that this report correctly assessed the UST/LUST program effectiveness and efficiency and brought to our mutual attention issues which require our joint resolution. With this effort, we have created a new paradigm on how agencies and their evaluators can work together in order to benefit the citizens of Arizona.

Sincerely,



Karen J. Heidel, Ph.D.
Acting Director

cc: Ethel DeMarr
Director
Waste Programs Division

Tara Roesler
Manager
UST/LUST Section

**DIAGNOSTIC SERVICES / RECEPTION, ORIENTATION,
AND CLASSIFICATION PROGRAM
Department Of Juvenile Corrections
OSPB/JLBC Executive Summary**

Overview - The Diagnostic Services program has changed drastically since February of 1995. What started out as a redundant diagnostic program has been condensed into a Reception, Orientation, and Classification (ROC) program. The mission of the program is to provide accurate classification and placement of juveniles in the most appropriate, least restrictive environment within a functional work environment that promotes public safety. After reviewing the program's self-assessment, the following conclusions were reached:

- The ROC program should be more efficient than the Diagnostic Services program. The Cost per Juvenile Processed under the ROC program should be about one-fifth of the cost of the old Diagnostic Services program, because it requires fewer bed-days (5 to 10 days versus 30 days) and less staff time per juvenile.
- The Department cannot provide a reasonable estimate of the program costs. An overly-simplified method of allocating costs to the subprogram using percentages of beds was used to develop estimates of the cost of the subprogram.

The Department did not demonstrate significant cost savings because it used an overly simplified method for allocating cost which results in a "Annual Bed Cost" instead of a "Cost per Juvenile Processed." The OSPB/JLBC PAR team had to ask for supporting information, correct arithmetic errors, and develop additional calculations in order to establish reasonably useful funding information from which unit costs could be estimated.

Description of Program - The Department of Juvenile Corrections (DJC) (formerly the Department of Youth Treatment and Rehabilitation) has made a number of changes to the Diagnostic Services subprogram over the last three years. In the recent past, the program was designed to develop a comprehensive diagnostic package for each incoming youth, to develop an Individual Treatment Plan (ITP), and to make a determination on the youth's classification and placement. Now, DJC uses a streamlined process, called "Reception, Orientation, and Classification," which uses evaluations and materials already on file to classify each youth.

Under the old program, DJC would run a number of diagnostic examinations on every incoming youth, including but not limited to psychological evaluations, medical evaluations, social history, and educational assessments. That system ensured that all of youths in DJC custody had complete and fairly consistent evaluations. However, it was time consuming, resource intensive, and a redundant effort, since most of the youths the Department received had already gone through a diagnostic process at the county level. DJC receives approximately 85% of its youths from Maricopa and Pima counties. Those counties deliver youths to DJC with a complete or nearly complete diagnostic assessment. Thus, the majority of the functions the Diagnostic Services Program provided were duplicative.

In order to streamline the process and take advantage of the diagnostic work that the counties perform, DJC designed a new reception program called Reception, Orientation, and Classification (ROC). The

main functions of the new ROC program are to provide each youth with an orientation to DJC and a classification. The most important efficiency benefit of this change is that DJC has stopped conducting duplicative diagnostic tests, which greatly reduces the amount of time a youth needs to stay in the intake program.

How does the program mission fit within the Agency's overall mission and the program's enabling authority?

Accurately classifying and placing juveniles is the first step towards completion of the Agency's mission to "enhance public protection by reducing the risk level of juveniles committed to the Department." To measure such "risk level reduction," the Agency must know the initial risk level of a youth. The ROC program is the instrument that produces the initial risk level assessment.

By statute, the Department must complete a diagnostic evaluation if one is not received from the Courts.

Do historical performance measurements and the future performance targets adequately measure goals?

The historical performance measures were designed to provide feedback to the diagnostic process itself and do not adequately measure the program's contribution to the Agency wide mission of reducing juvenile risk level. Furthermore, because of the rapid changes in the diagnostic process (the redesign and pilot use of new instruments for risk assessment, needs assessment, and classification) culminating in the establishment of the new ROC program, past strategic planning goals and performance measures have become obsolete. The proposed performance measurements are a step in the right direction. However, some of the proposed performance measures do not relate to program goals, nor do they measure whether or not goals have been attained. The Agency will need to further develop the program's performance measures. Ideal performance measures would provide data on both program effectiveness and efficiency. Unit cost, accuracy of placement as measured by number of overrides, and percent of youth received with complete diagnostic evaluations would provide useful data that could be used in later program evaluations.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

Theoretically, the ROC program should be more efficient than the Diagnostic Services Program. The unit by which to measure ROC cost efficiency is the "Cost per Juvenile Processed" which can be calculated by dividing the Cost per Day by the Average Daily Population. Under ROC this should be about one-fifth of the cost of the old Diagnostic Services Program, because ROC is using one-fifth fewer bed-days and less staff time per juvenile. DJC did not provide the data necessary to calculate this unit cost, however, or to compare the unit cost change from FY 1994 to FY 1995. DJC did submit information about the annual program costs, from which resulted a daily Cost per Bed of \$114.79 in FY 1995. This figure can be used to calculate a baseline Cost per Juvenile Processed when cost data can be reconciled to the population data.

The Department cannot provide a reasonable estimate of the program costs. An overly- simplified method of allocating costs to the program using percentages of beds was used to develop estimates of the cost of the program. Such a method can provide an estimate of the cost but cannot provide an actual

cost. Therefore, measuring the true performance of the program will always be difficult if not impossible unless the Agency changes its tracking method.

Are there other cost-effective alternative methods of accomplishing the program's mission?

Sharing Juvenile Court information and developing a uniform standard for all county-level evaluations may be alternative actions to further reduce costs and increase the effectiveness of the existing ROC program. DJC is exploring two new levels of coordination with the courts to further streamline the diagnostic and classification process. One possible new level of coordination called the "Mobile Diagnostics Process" would place DJC staff at the juvenile detention center(s) who would help with the completion of a diagnostic evaluation and would apply a Classification, Risk, and Needs Assessment Tool. A second level of coordination DJC is currently developing with the courts is a uniform standard for all of the various evaluations administered which can be electronically transferred. The courts already collect the diagnostic evaluations and input them into their computer database. If DJC was able to electronically download all of the evaluations and each was of a standard content and format, DJC staff would be able to further reduce the length of stay of a youth in the ROC program. This appears to be the least resource intensive option.

Are there other special issues of interest?

The future of the ROC program could change dramatically depending on how the Juvenile Courts decide to implement certain provisions of Laws 1994, Chapter 201 (SB 1356), which are effective on October 1, 1995. After that day, Juvenile Court judges will be allowed to send youths to DJC with a mandatory length of stay in secure care.

Chapter 201 also requires the State Supreme Court, in cooperation with DJC, to develop a common risk and needs assessment instrument to be used for each youth referred to the Juvenile Courts. The Juvenile Courts must then use the risk and needs assessment to determine the appropriate disposition of the youth. Additionally, the Supreme Court and DJC must develop guidelines to be used by the Juvenile Court judges in determining which juveniles should be committed to DJC. What has come out of this is a new classification system that determines a security placement level by using a matrix that cross references the offense severity to a risk level. Use of this common instrument would mean that, in the future, no youth will be delivered to the Department who has not already been classified.

RECEPTION AND CLASSIFICATION
STRATEGIC PLAN FY 1996 - FY 1998

SUBPROGRAM SUMMARY

Reception and Classification A.R.S. § 41-2802
 Contact: Dave McCarroll, Asst. Dir., Institutions 542-5593
 Secure Care DJA0203.SUB

Subprogram Mission: *To promote public safety by providing accurate classification and placement of juveniles.*

Subprogram Description: The Reception and Classification subprogram completes all intake processing of new juveniles committed to the Department, provides juveniles with a basic orientation to institutional services, completes appropriate assessments, and completes the initial assessment.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ **Goal 1 - To ensure all committed juveniles and their families receive orientation services.**

- Objective #1a: To improve the distribution and retention of Youth Handbooks by juveniles to 90% by June 30, 1996.
- Objective #1b: To improve the distribution and retention of Youth Handbooks by juveniles to 100% by June 30, 1997.
- Objective #1c: To maintain the distribution and retention of Youth Handbooks by juveniles to 100% by June 30, 1998.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|--------|--|-------------------|---------------------|---------------------|---------------------|
| Output | Percent of juveniles receiving Youth Handbook | N/A | 80 | 90 | 100 |
| Effic | Percent of juveniles bringing Youth Handbooks to Superintendents' Review Board | N/A | 80 | 90 | 100 |

◆ **Goal 2 - To ensure all committed juveniles are classified and placed into appropriate programming.**

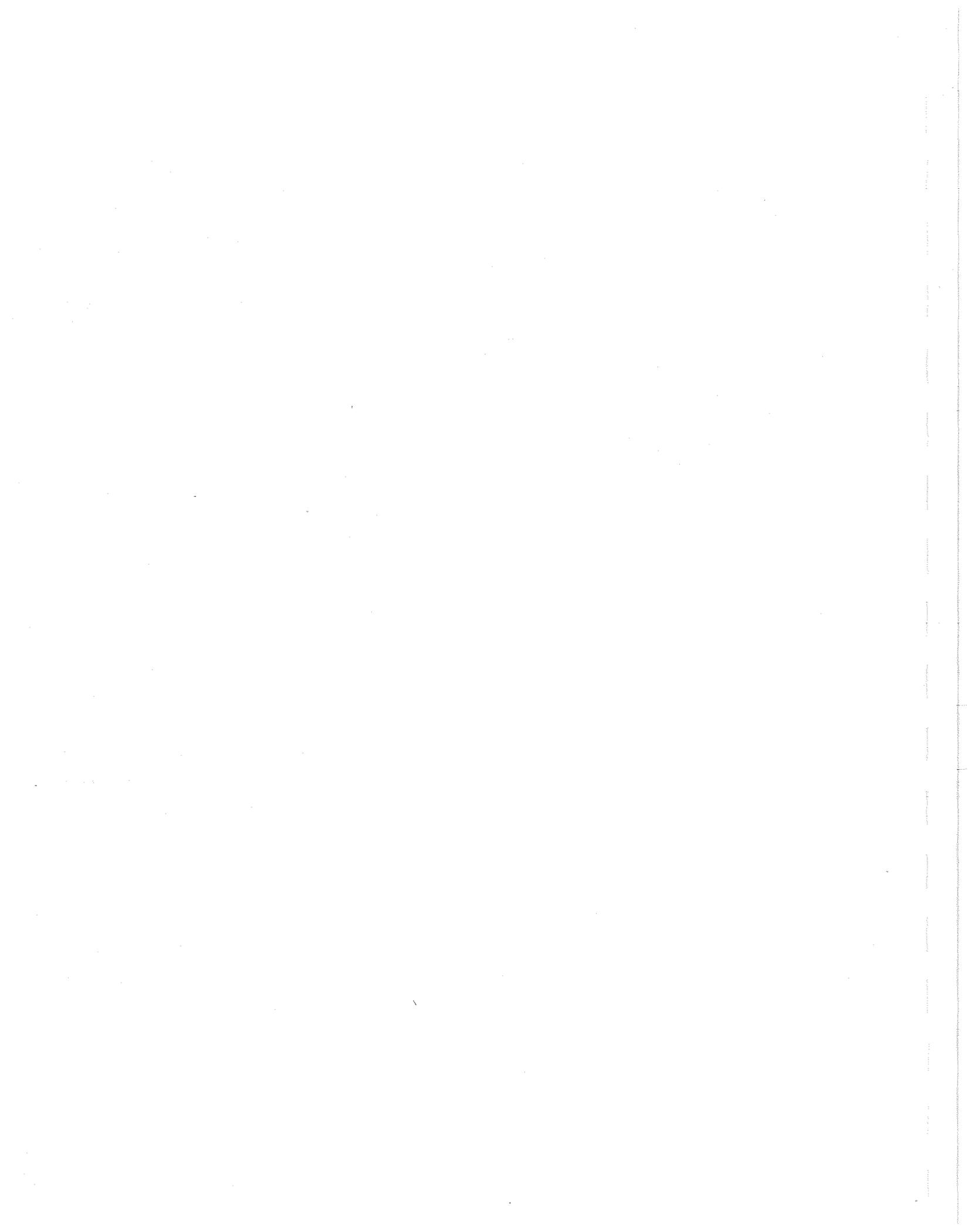
- Objective #1a: To place 70% of committed juveniles in accordance with their identified risk level and service needs by June 30, 1996.
- Objective #1b: To place 80% of committed juveniles in accordance with their identified risk level and service needs by June 30, 1997.
- Objective #1c: To place 90% of committed juveniles in accordance with their identified risk level and service needs by June 30, 1998.

- Objective #2a: To improve the accuracy of offense classification data in YOUTHbase to 85% by June 30, 1996.
- Objective #2b: To improve the accuracy of offense classification data in YOUTHbase to 90% by June 30, 1997.
- Objective #2c: To improve the accuracy of offense classification data in YOUTHbase to 95% by June 30, 1998.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|-------------------|---------------------|---------------------|---------------------|
| Effic | Percent of juveniles classified within agency timelines | N/A | 75 | 85 | 95 |
| Effic | Percent of juveniles placed in accordance with classification score | N/A | N/A | 70 | 80 |
| Quality | Percent of error-free offense classifications in YOUTHbase | N/A | 80 | 85 | 90 |
| Effic | Percent of re-assessments entered in YOUTHbase within established timelines | N/A | 80 | 85 | 90 |
| Output | Percent of juveniles requiring re-classification due to errors | N/A | N/A | 10 | 5 |
| Effic | Percent of juveniles in Reception Housing Units past established timelines | N/A | 20 | 15 | 10 |
| Output | Percent of Individual Treatment Plans completed within first 30 days | N/A | N/A | 80 | 90 |

Funding Source and FTE Amounts:

| Source | (Thousands) | | |
|---------------|----------------------|------------------------|-----------------------|
| | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
| General Fund | 569.7 | 569.7 | 569.7 |
| FTE Positions | 27.0 | 27.0 | 27.0 |





Agency Comments on JLBC/OSPB Analysis
Department of Juvenile Corrections
Diagnostic Services

The juvenile justice system in Arizona has gone through major changes since the mid 1980's. The Department of Juvenile Corrections has been a leader in managing these changes brought on by population, demographics, and public policy. In early 1994, the administration of the Department changed. One of the major elements within the agency that was reviewed in 1994 was the diagnostic process at intake. It was clear that this particular administrative process would have to change due to the redundancy of effort between the counties and the Department. In early 1995, the process was streamlined to allow for reception, orientation, and classification (ROC) of youth committed to the Department by the Juvenile Courts.

It is unfortunate that the Diagnostic Services program was selected as a PAR program during this time in the formation and fine-tuning of the agency. We believe that the changes as noted in the PAR review were warranted to bring about the following:

- The ROC process will allow for uniform intake of youth from all 15 counties.
- The agency would commit to utilizing county generated data on youth.
- The youth committed to the Department will be able to enter into their individual treatment programs sooner, thus allowing for more treatment time in secure care until their eventual transition to our community continuum.

“The question then is: Is the ROC program necessary?”

We believe that consistent with our mission statement - *“To enhance public protection by reducing the risk level of juvenile offenders committed to the Department”* we must maintain an assessment process that objectively considers both seriousness of the offense and the risk to re-offend while developing realistic treatment service options for each youth.

JUDICIAL COLLECTION ENHANCEMENT FUND
Administrative Office of the Courts
JLBC/OSPB Executive Summary

Created in FY 1989, the Judicial Collection Enhancement Fund (JCEF) has two distinctive statutory purposes: to increase collections of court-imposed fines and fees, and to improve case processing through automation projects. After having reviewed these two components, the following conclusions have been reached:

- Since its inception, the JCEF program has implemented a number of strategic initiatives to improve the collection practices of the courts. During this period, total revenues collected and revenues collected per filing have significantly increased. Additional and standardized data on court accounts receivable is needed in order to quantify the extent to which JCEF program activities have contributed to increased collections.
- Additional data is also needed to quantify the success of JCEF-funded automation projects. JCEF represents only one of multiple funding sources for the Administrative Office of the Court's (AOC) 10-year plan to automate courts statewide. JCEF projects seem generally consistent with this overall plan. A large-scale automation project largely funded with JCEF monies will be fully operational within the fiscal year and is expected to provide AOC with data needed to measure both collections and case processing performance.

In general, AOC's self-assessment of the JCEF program was timely and thorough.

Program Description - In FY 1988, the Supreme Court Chief Justice created the Commission on the Courts to develop the Judiciary's long-range plan into the year 2000. Among other recommendations, the Commission concluded that court revenues should be enhanced, and that a long-term funding proposal for court technology be developed. AOC completed a follow-up study in February, 1989, which concluded that by FY 1995, statewide court revenues could increase by as much as \$30 million with improvements in collection and cash management procedures, the automation of business functions, and fee increases. In response to these conclusions, JCEF was created in June 1989 as a method of funding revenue enhancement programs and automation projects which improve case processing.

The fund receives revenue from three sources: \$7 from a \$12 fee imposed on those paying court fines on a time-payment basis, a \$5 per person surcharge from each person attending traffic school, and 15% of all filing, appearance, and clerk fees. In FY 1994, approximately \$4.1 million was deposited into the fund and \$3.8 million was expended (\$3.5 million for project money and \$300,000 for administration). The remaining balance was carried forward. Monies are distributed to all courts through grants and strategic initiatives. JCEF staff and other AOC employees may serve the courts in a variety of capacities during the implementation of these projects, including technical consulting, system design, and program instruction.

The early years of JCEF were devoted to three primary activities. The first was changing the culture of the courts to emphasize the enforcement and collection of court-imposed monetary assessments through numerous strategic initiatives, such as the Debt Setoff Program, the Traffic Ticket Enforcement

Assistance Program, and court education. The second was restructuring the court fee structure to simplify the assessment and collection of fees. The third was planning for automation projects. In 1993, AOC's Commission on Technology was established and developed Vision 2004, a year-by-year plan describing the projects that would achieve a largely automated state court system by the year 2004. The vast majority of automation projects funded with JCEF monies since 1993 have centered around high-technology computer networks and communication systems consistent with Vision 2004. However, JCEF funds have also been used for comparatively low-technology projects in the rural courts.

How does the mission fit within the Agency's overall mission and the program's enabling authority?

By improving case processing through automation projects, the JCEF mission fits within the AOC mission and vision by producing a more efficient and expedient judicial system. Enhancing the collection ability of the courts also preserves the integrity of the court system. The JCEF mission is copied directly from its enabling statute.

Do the historical performance measurements and the future performance targets adequately measure goals?

Performance measurements for collection enhancement programs and automation projects are currently inadequate. In its self-assessment, AOC has provided the performance measurement "average increase in collection rates for all courts with JCEF grants" to gauge the statewide success of collection enhancement programs. Measuring collection rates based on total annual court revenues provides too broad a measure of strategic initiative performance because it does not, perhaps cannot, isolate extraneous influences on revenue. In measuring the performance of individual collection projects, a measurement such as "change in annual accounts receivable" would be very useful. Furthermore, although AOC is able to identify JCEF-funded automation projects and the dollars spent on them, it also lacks adequate measurements and quantifiable supporting data to gauge case processing performance.

Historically, AOC has had difficulty obtaining useful measures and statistics from the courts, due to their inability to track and standardize certain kinds of data. However, a portion of a new statewide computer system, the Arizona Court Automation Project (ACAP), will be fully on-line in FY 1996 and will provide AOC with needed statistics to measure both collections and case processing performance in county Superior Courts. AOC is planning to expand ACAP for municipal and justice courts as well. In addition, the Agency is working with local courts to adopt standardized statewide accounting procedures and definitions, which will provide uniform, consistent data with which to measure project performance.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

Total revenues collected and revenues collected per filing have significantly increased since the JCEF program was created. However, standardized data on court collections is needed to quantify the extent of the program's effectiveness. AOC had set a number of early goals for JCEF. One was to increase statewide court revenue from \$70 million in FY 1989 to \$100 million by FY 1995. This goal was achieved four years early in FY 1991, when revenues reached \$109 million. Another goal, to provide greater public access to courts through improved technology, was achieved via installation of 150 QuickCourt touchscreen kiosks in a number of county and city courts. Other goals,

such as improving efficiency of court operations through automation systems, are being pursued. In addition, the Debt Setoff Program has intercepted and collected \$607,700 since its creation in FY 1994. Also, of 26 collection pilot programs seeded with JCEF money, all 26 were assumed and retained by the local courts within one year or less. Finally, the initiative to standardize accounting procedures and definitions is still on-going, but making slow progress given that there are over 100 court accounting systems to coordinate.

While these initiatives and projects should be acknowledged, JLBC and OSPB seek additional direct measurement of JCEF's exact contribution to statewide court revenue. While the dollar impacts of certain strategic initiatives such as the Debt Setoff Program are quantifiable, it is difficult to directly measure the effectiveness of broader initiatives such as "changing court culture through education" or "restructuring court fees," but initiatives such as these have represented some of JCEF's primary activities. AOC suggests that statewide court revenue reflects the performance of various strategic initiatives not captured by individual JCEF pilot projects; however, itemizing those revenue increases into components such as "the collections education effect," "the automation effect," and "other effects" is probably not possible. Nevertheless, JLBC and OSPB agree that changing court culture to emphasize collection activities and improving case processing are goals worthy of pursuit, and look forward to receiving data in the future that will more *directly* reflect program success.

Likewise, without knowing the exact contribution of either collection enhancement programs or automation projects, JLBC and OSPB are unable to assess efficiency in light of program expenditures (\$3.8 million in FY 1994 for project monies and administrative costs).

Are there other cost-effective alternative methods of accomplishing the program's mission?

One alternative would be to shift all automation expenses and planning to local governments. This was the status quo prior to the formation of JCEF and to some extent remains so. Local courts are still free to use their own local general funds to finance whatever projects they wish, but AOC has final authority on the expenditure of JCEF monies. However, for the state to achieve an integrated, standardized network through the implementation of automation initiatives, some centralized planning authority must remain with the Supreme Court Chief Justice, who has recently charged the Commission on Technology with this responsibility. Another alternative would be to develop and utilize a more comprehensive vision and set of goals in the grant award process. Since the adoption of Vision 2004, AOC has a guide by which criterion for evaluating the merits of court automation projects are established. However, it appears that the process of awarding collection project monies is based on an older vision that needs reassessment. In the first two years of the program's existence, AOC had a definite objective in awarding collection monies: lower courts with the greatest potential for improving collections were given the highest priority. Currently, AOC is in the process of developing a new strategic collection plan using focus groups of judges and staff from across the State.

**JUDICIAL COLLECTION ENHANCEMENT
STRATEGIC PLAN FY 1996 - FY 1998**

→Objective #4: To have 100% customer satisfaction surveys with a rating of at least meet expectations in all grant applications/budget modifications, by 6/30/96.

→Objective #5: To maintain the percent of administrative budget spent on grant activities at 30% or less.

→Objective #6: To maintain administrative costs at less than 10% of revenue.

| <u>Type</u> | <u>Performance Measures</u> | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|-------------|--|---------------|-----------------|-----------------|-----------------|
| | | <u>Actual</u> | <u>Expected</u> | <u>Expected</u> | <u>Expected</u> |
| | Percent of non-CAF grant applications processed from receipt to notification within 15 working days | N/A | 17 | 15 | 15 |
| | Percent of non-CAF grant applications processed from receipt to notification within 30 working days | N/A | 33 | 30 | 30 |
| | Percent of customer satisfaction surveys with a rating of meet expectations or better in all grant applications/budget modification requests | N/A | N/A | 90 | 92 |
| | Percent customer satisfaction surveys with a rating of at least meet expectations in all grant applications/budget modification requests | N/A | N/A | N/A | N/A |
| | Percent of administrative budget spent on grants | N/A | 30 | 30 | 30 |
| | Percent administrative costs compared to JCEF revenue | N/a | 7 | >10 | >10 |

Funding Source and FTE Amounts: (Thousands)

| <u>Source</u> | FY 1995 | FY 1996 | FY 1997 |
|--|------------------|--------------------|-------------------|
| | <u>\$ Actual</u> | <u>\$ Estimate</u> | <u>\$ Request</u> |
| Other Non-appropriated Funds - Judicial Collection Enhancement Fund | <u>3,534.0</u> | <u>3,681.1</u> | <u>3,681.1</u> |
| FTE Positions | <u>4.0</u> | <u>4.0</u> | <u>4.0</u> |



Supreme Court

Stanley G. Feldman
Chief Justice

STATE OF ARIZONA
ADMINISTRATIVE OFFICE OF THE COURTS

David K. Byers
Administrative Director
of the Courts

October 25, 1995

Mr. Ted A. Ferris, Director
Joint Legislative Budget Committee
1716 West Adams
Phoenix, Arizona 85007

Mr. Peter Burns, Director
Office of Strategic Planning and Budgeting
1700 West Washington, Suite 500
Phoenix, Arizona 85007

Dear Mr. Ferris and Mr. Burns:

I appreciate the generally favorable review of the Judicial Collection Enhancement Fund (JCEF) program. This program has been highly successful in improving the collection and management of monies owed the courts, as evidenced by the approximately \$200,000,000 increase (a 118% increase) in revenue and trust monies collected (includes child support) since FY1989, despite a 2% decrease in case filings. Additionally, all of the 29 tactical collection programs funded initially with state JCEF were reviewed and are now locally funded due to their value. In these tight budget times, this is a phenomenal indicator of success. It is difficult to measure the success with the exact science you are looking for, but that is the nature of this kind of program. Trying to break down the revenue increase into components attributable to things such as changing the court culture, or education and training activities, is like trying to determine what portion of sales of Microsoft's Windows '95 is attributable to paid advertisements versus all the hype that preceded the release. You know you have a successful product, or in this case program, but you can't be that specific. However, it's hard to argue with the results!

As recognized in the report, when JCEF was created, the courts embarked on a number of strategic initiatives to increase collections, improve management of monies in the courts, and improve case processing through automation. If you look at improving collections in the same way you look at a company going through a restructuring, the strategic efforts to improve collections have been highly successful. "Sales" (in this case total case filings) decreased by 31,348, from 1,921,092 to 1,889,744 or 2% from the base year of FY 1988. Revenue and trust monies (including child support) collected by the courts increased approximately \$200,000,000, or 118%. That was a result of numerous strategic initiatives undertaken.

The key to many of the strategic and tactical initiatives of JCEF was changing the culture of the court regarding the importance of collections and educating judges and court staff on methods to improve collections. These additional strategic activities were initiated:

- restructuring the complex filing fee structure to make it simpler to assess and collect fees, while at the same time making it easier for those who cannot pay to get fee waivers or deferrals;
- consolidate surcharges to make them simpler to assess and collect;

- changes to A.R.S §13-808 to move time payment planning from judges to professional collections managers and probation officers;
- changes to other statutes to encourage payment of monies owed, such as allowing a 5% reduction on certain fines if paid in full the first day, and authorizing amnesty programs;
- a series of statewide and regional training and education programs, which continues today;
- creation of the Commission on Technology to coordinate statewide automation planning;
- implementation of court operational reviews;
- establishment of minimum accounting standards for courts;
- implementation of statewide collection programs for courts such as Debt Setoff to intercept tax refunds and lottery winnings, and Traffic Ticket Enforcement Assistance Program to put a hold on vehicle registration renewals if fines are unpaid.

The success of the projects above that do not have specific dollar results is measured by the overall steady progress the courts have made in collections measured by total revenues received by the courts. Some of the results of the strategic efforts are:

- JCEF has changed the culture in the courts in regard to the enforcement of court orders and collections of monies owed. Prior to the creation of JCEF and staff's training and education efforts, judges and court staff did not see the courts as responsible for ensuring the collection of fines and other monetary assessments. Those who were interested in improving collections did not have the tools and methods available. A program of education on the importance of enforcing court orders, and the methods to do so, changed the attitude of the court staff and judges around the state. A story will illustrate how this affected collections. A month after the JCEF director was hired, she did a training session at a judicial staff conference. During the presentation about how to improve collections right away, without additional funding, she presented the "Just Say No!" method, which involved saying no when people asked for time to pay a fine and directing them to pay the clerk. A few months later at another conference, a court clerk came up and told the JCEF director that she had gone back to her court and told the judge to "Just say no!", and it worked! People were paying instead of asking for time. This is just one way that training and education had an effect on collections without using JCEF grants.
- The enabling legislation for JCEF directed the Supreme Court to review filing fees at all court levels, and recommend appropriate fees for each type of action, based on the costs incurred in processing each type of action. JCEF funded, and JCEF staff coordinated, a study to do that. The study led to the passage of legislation to restructure fees at all court levels and increase them to approach 100% of cost recovery over four years. (Cost recovery means the amount of revenue from fees compared to costs of the clerk's office incurred in processing civil cases.) Almost 30 fees for 90 different activities located in more than 50 different statutes were simplified into a classification system with 7 categories. Fees for common activities were standardized across court levels. Subsequently, the fee waiver

statute was revised to simplify the process for indigent litigants to get fees waived. The simpler fee schedules made it easier for court staff, attorneys and litigants to identify, assess and collect the appropriate fees. From FY 1989, before the fee restructuring, through FY 1994, the year after the last increase in fees, fee revenues in the courts increased by over \$20 million, from \$13.7 million to \$34.6, a 151% increase. (That represents 10% of the total increase in monies collected by the courts.) During the same period noncriminal case filings decreased by .25%. The increased revenue was a result of the strategic efforts to simplify fees and raise them to a cost closer to 100% of cost recovery as defined above.

In addition a number of tactical collections projects were undertaken in individual courts or groups of courts to pilot and demonstrate the success of various kinds of collections activities. The chart attached shows measurable results for each project. The first year of the projects' operations total revenues for all the courts with projects increased an average of 11.25%. The second year revenues increased an average of 8%. As previously mentioned, each of the projects was reviewed and continued by the local funding authority when JCEF grant funding ran out due to the local funding authority's decision the program was a success. Specific data on each of the projects has been made available to your staff.

As noted on page JUD-2, it has been difficult to craft adequate performance measures for the overall improvement in collections and case processing. Accounts Receivable information is one good measurement, and will be available as courts come on-line with more sophisticated automation systems in the next few years. This is a measure planned for use when the data is available. However, using Accounts Receivable as an indicator of success also has its problems due to mandatory sentencing and restitution laws. Frequently judges must order high amounts of fine and restitution with no hope of receiving it. This distorts the Accounts Receivable balance significantly. For instance, someone ordered to pay millions in restitution may now be imprisoned. This individual's earnings in a lifetime wouldn't be enough to pay the debt, even if s/he wasn't imprisoned. Situations like this one in which collection is a fantasy significantly inflates Accounts Receivable. True, the measurement of total annual court revenues does not isolate extraneous influences on revenue, but it is a valid measure of the results of all the efforts to improve court collections. Additionally, many of the extraneous influences on revenue would normally result in a decrease, not an increase in revenues: filings have decreased; historically defendants have claimed an inability to pay, often resulting in nonpayment; fine amounts have increased and decreased over the years, but they certainly haven't increased by the same percentage (118%) revenues have. JCEF staff have already revised performance measures to use data currently available from the courts. As better information flows from the courts, we will continue to refine the measurements. In an attempt to find models for our revised measures, we spoke with other states, and with national organizations, and we even looked through the Master List of Programs at Executive and Legislative branch measurements. We were unable to identify automation or collection measurements that we could use to help develop ours. We welcome any suggestions.

The report notes on page 11a the definite objective in awarding collections monies in the first two years of JCEF operation. After the first two years, and continuing until today, there are revised priorities for awarding funds that looked at the type of project, rather than the type of court. These priorities were established by the JCEF Advisory Committee in existence at that time and are:

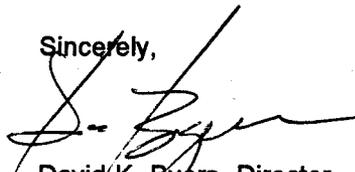
- Establishment or enhancement of court procedures and programs to: reduce the number of cases where deferred payments are unnecessarily granted, reduce the number of cases where payments are delinquent, and to monitor and collect payments both deferred and delinquent;

- Establishment of court procedures and programs to improve the management of monies assessed and received by the court;
- Automation of court procedures and programs above;
- Automation of court procedures and programs to improve case processing or the administration of justice. (JCEF Annual Report, page 2)

Those priorities have guided JCEF awards to this date. As the Commission on Technology has taken a more active role in planning court automation, awards for automation projects have been increasingly guided by their activities and priorities. A report is being finalized to set the strategic plan and funding priorities for JCEF activities in the future.

Finally, let me comment on the PAR process. It has the potential of producing great results. However, I find that we are not currently staffed with sufficient resources to put into effect the sophisticated strategic planning and measurements required nor do we have sufficient staff to adequately respond to many aspects of the review. Staff spent more than 168 hours solely on the self evaluation and an equal amount of time providing data and responses. Local courts, for the most part, do not have staff nor systems in place to handle these requests. Staffing cost for these courts comes from local jurisdictions. Trying to move forward with this process without adequate staffing invites frustration. If the process is to be successful, serious consideration must be given to providing adequate resources. We do appreciate the professional assistance from your staff throughout the project.

Sincerely,



David K. Byers, Director
Administrative Office of the Courts

c: Brad Beranek
Mark DeNunzio
Peggy O'Sullivan-Kachel
Marge Cawley

**Court Fines and Surcharges Collected in Years Before, During and After
Implementation of 29 State JCEF-funded Collection Programs in 25 locations**

| Program Location | Note | Prior Year (Base Year) | Implementation Year | Difference | % Chg | Succeeding Year | Difference from Base Year | % Chg |
|------------------|-------|------------------------|---------------------|------------------------|---------------|---------------------|---------------------------|--------------|
| 1 | (1) | \$890,795 | \$1,057,571 | \$166,776 | 18.72% | \$1,135,986 | \$245,191 | 27.52% |
| 2 | (2) | 1,155,094 | 1,486,325 | 331,231 | 28.68% | 1,519,418 | 364,324 | 31.54% |
| 3 | | 18,979,147 | 21,613,475 | 2,634,328 | 13.88% | 20,672,651 | 1,693,504 | 8.92% |
| 4 | | 1,846,450 | 1,988,007 | 141,557 | 7.67% | 2,297,045 | 450,595 | 24.40% |
| 5 | | 979,966 | 895,879 | (84,087) | -8.58% | 1,002,539 | 22,573 | 2.30% |
| 6 | (2,3) | 675,350 | 726,099 | 50,749 | 7.51% | 565,845 | (109,505) | -16.21% |
| 7 | | 800,671 | 880,889 | 80,218 | 10.02% | 847,982 | 47,311 | 5.91% |
| 8 | | 646,350 | 939,377 | 293,027 | 45.34% | 779,355 | 133,005 | 20.58% |
| 9 | | 310,323 | 276,991 | (33,332) | -10.74% | 242,417 | (67,906) | -21.88% |
| 10 | | 500,384 | 486,691 | (13,693) | -2.74% | 502,174 | 1,790 | 0.36% |
| 11 | (2,3) | 7,998,116 | 8,120,847 | 122,731 | 1.53% | 7,176,801 | (821,315) | -10.27% |
| 12 | | 103,086 | 137,150 | 34,064 | 33.04% | 169,767 | 66,681 | 64.68% |
| 13 | (1,3) | 707,550 | 658,767 | (48,783) | -6.89% | 842,827 | 135,277 | 19.12% |
| 14 | | 618,096 | 616,625 | (1,471) | -0.24% | 574,309 | (43,787) | -7.08% |
| 15 | (3) | 1,092,339 | 1,080,985 | (11,354) | -1.04% | 1,126,662 | 34,323 | 3.14% |
| 16 | | 235,383 | 239,663 | 4,280 | 1.82% | 258,718 | 23,335 | 9.91% |
| 17 | (2) | 2,282,373 | 3,043,925 | 761,552 | 33.37% | 2,632,262 | 349,889 | 15.33% |
| 18 | | 36,293 | 45,795 | 9,502 | 26.18% | 39,060 | 2,767 | 7.62% |
| 19 | (1) | 2,295,878 | 2,442,835 | 146,957 | 6.40% | 2,554,553 | 258,675 | 11.27% |
| 20 | | 25,716 | 36,942 | 11,226 | 43.65% | 29,233 | 3,517 | 13.68% |
| 21 | (4) | 33,855 | 39,965 | 6,110 | 18.05% | 41,853 | 7,998 | 23.62% |
| 22 | (3,4) | 2,040,129 | 2,349,150 | 309,021 | 15.15% | 2,409,420 | 369,291 | 18.10% |
| 23 | (4) | 272,589 | 304,178 | 31,589 | 11.59% | 375,123 | 102,534 | 37.61% |
| 24 | (4) | 22,452 | 32,581 | 10,129 | 45.11% | 34,627 | 12,175 | 54.23% |
| 25 | (4) | 385,641 | 490,550 | 104,909 | 27.20% | 702,928 | 317,287 | 82.28% |
| TOTAL | | \$44,934,026 | \$49,991,262 | \$5,057,236 (5) | 11.25% | \$48,533,555 | \$3,599,529 (6) | 8.01% |

- (1) Collections began in last 1-2 mos. of FY. Implementation year corresponds with full FY program was collecting.
- (2) Location had two state JCEF-funded collection programs. Only listed once because data is same for both programs.
- (3) Program involved multiple courts
- (4) Annualized 3 quarters of FY 95 revenue. Actual FY 95 data not available yet.
- (5) Compared to base year, collection of fines and surcharges increased a total of \$5,057,236 across courts with collection programs.
- (6) Compared to base year, collection of fines and surcharges increased a total of \$3,599,529 across courts with collection programs.

RURAL HEALTH PROGRAM AUTHORIZATION REVIEW JLBC\OSPB JOINT EXECUTIVE SUMMARY

Overview - The Program Authorization Review (PAR) legislation, (Laws 1995, Chapter 283), states that, **“The programs specified in sections (h), (I), and (j) shall be considered together in the state’s role in rural health.”** The programs specified are the Medical Student Loan Program, Arizona Health Education Centers (AHEC), and the DHS programs - Medical Malpractice, Primary Care, and the Loan Repayment Program. This presents a unique situation compared to the other PAR’s completed this year in that these programs are examined first individually in separate reports, and then together in relationship to rural health. In addition, these programs cross several agency lines, the Medical Student Loan Board, the University of Arizona, the Arizona Board of Regents, and the latter three programs operated by the Department of Health Services (DHS). It is important to note that there are a number of other programs in Arizona which impact rural health which are touched upon in this Executive Summary in order to present a more comprehensive view of issues.

The JLBC Staff and OSPB agreed to the following approach. Each program has an individual report addressing it specifically, while this overall report seeks to not duplicate that information but to look exclusively at the State’s role in rural health and how these programs impact that role. The first section of this report includes overall findings and answers to standard PAR questions. This section is then followed by a number of appendices that are included to provide information useful in making policy decisions. They include: a) current methods used to determine rural or underserved status; b) county health programs and expenditures; c) Indian tribal health expenditures; and d) a bibliography of sources to allow more in-depth review.

There were several findings made while looking at the five PAR programs in the overall scope of rural health. Each of the following findings is discussed in more depth in the body of this report:

- **Some programs perceived to be “rural health” programs do in fact serve underserved regions in urban communities.**
- **There is no common measure of adequate health care. Several different standards, some of which are mandated by State and Federal rules and regulations, are in use which cause complexity and may inadvertently make those targeted for assistance ineligible for programs.**
- **Rural health programs are fragmented and no single agency holds the responsibility for overall rural health policy.**
- **There are many areas of need for improved rural health in Arizona, yet these needs vary greatly by individual area.**
- **There are numerous complexities in finding solutions to rural health care problems. These complex factors should be understood in order to target programs effectively.**

During the PAR process, vast amounts of data were gathered on rural health care in Arizona. Unfortunately, it was beyond time and personnel resources to adequately summarize this information

and catalog all health care needs in each area of the State for the purpose of this report. However, some data are included on the health expenditures of both the counties and the Indian reservations in two of the appendices. This information is intended to assist state policy makers gain a better idea of the level of funding and the types of services provided by these other levels of government. Although there are no direct conclusions drawn from that information, it should be helpful in analyzing rural health needs in a more holistic manner.

How does the mission fit within the agency's overall mission and the program's enabling authority?

Each of the five programs studied fit within their agency's overall mission and authority and were carrying out their individual mandates. However, there is an apparent perception on the part of some policy makers that all five of these programs are directed towards improving rural health as their primary goals. Our study indicated that this perception of their goals was not shared by all of the individual programs. The program staff believe that the goal of the programs was to improve health in both urban and rural areas based on the criteria upon which the programs were established, as discussed in the finding below.

Some programs perceived to be "rural health" programs do in fact serve underserved regions in urban communities. When people discuss "rural health" they do not necessarily think of the same definition. Among the common uses are: 1) all counties except for Maricopa and Pima; 2) medically underserved areas (MUA) (which include both urban and rural); 3) Federally designated underserved areas (Federally designated MUA) (which include both urban and rural); 4) Health Professional Shortage Areas (HPSA) (which include both rural and urban); 5) medically underserved populations (MUP) (which include both urban and rural); and 6) areas outside of Metro Phoenix, Metro Tucson, and sometimes outside of Flagstaff. The problem that this creates is that some of the programs which were chosen to review as "rural health" programs are serving both urban and rural populations. For instance, the Arizona Loan Repayment Program in its first year awarded three of the first seven loan repayment slots to urban underserved programs. In addition, of those that were placed in rural areas only one was placed in one of the highest need areas as identified by the Department of Health Services Office of Health Systems Development. Of those who have participated in the Medical Student Loan Program, only 18 of 38 have served in rural areas. This use of program funding for non-rural areas of the State is due in part to the confusing number of definitions people use for "rural health," and partially due to differing opinions on the purpose of these programs. It should also be noted that when Federal funds are involved, Federal guidelines, and requirements may restrict which definitions may be used.

In any case, if the Legislature wants to focus a program exclusively on rural areas, additional requirements must be placed other than designation as a MUA, MUP or HPSA. The restrictions could include population density or specific counties. Without these additional requirements, most health programs designed for "rural health" needs will also focus resources on medical needs in urban areas. A full discussion of the various classifications of medically underserved areas is included in Appendix A.

Do the historical performance measurements and the future performance targets adequately measure goals?

Generally speaking, the performance measurements of the programs studied did not adequately measure performance. The goals used were very narrowly defined within the parameters of each program. These measurements could be improved by determining what factors of rural health need to be improved

in a specific region, finding a measurable performance statistic, and tracking whether the statistic improves. This is difficult to accomplish due to the several different standards in use, the imperfect nature of any static measure of health care, and the fact that many programs and factors affect these same measures in addition to a specific rural health program. The problem of multiple standards is discussed in the following finding.

There is no common measure of adequate health care. Several different standards, some of which are mandated by State and Federal rules and regulations, are in use which cause complexity and may inadvertently make those targeted for assistance ineligible for programs. There are many different standards for adequate health care currently used by programs in Arizona. In researching these programs it became increasingly difficult to distinguish between the various standards and which applied to each program. For the policy maker, the choice of a standard may actually make the target of the program ineligible. For instance, some health providers are in areas that have Medically Underserved Populations (MUP), or populations which have limited access to health services in an area where there may be an adequate number of physicians. However, a portion of the Tobacco Tax Revenues, which was apportioned for efforts similar to those performed by these health providers, was earmarked for Medically Underserved Areas (MUA) and for Health Provider Shortage Areas (HPSA). Since they do not technically qualify as a MUA or a HPSA, the MUP areas cannot apply for this grant funding. The MUP areas assert that at the time of the legislation, they were supposed to be included. Whether or not that is the case, the terminology and differing standards create unnecessary confusion. A single standard, or an improved explanation to policy makers of the various standards, would significantly improve understanding of precisely where health dollars are targeted. To the extent that Federal dollars are involved, either the Federal standard would have to be solely adopted or used in conjunction with the agreed upon state standard.

Beyond the confusing nature of using multiple standards, it is impossible for the various rural health programs to fix problems together if their different standards cause disagreement on where health care shortages exist. Use of more uniform standards would allow the entire State to be measured against these standards and geographical areas identified that are lacking in one or more health areas. Programs could then be directed to those specific areas and problems, and success measured by how many areas were brought up to the standard.

These standards would need to include at a minimum measures such as providers per capita, distance to nearest health providers, percentage of elderly population, and availability of obstetricians and other health care specialists. Many of these factors are already used in the various standards utilized by each program. However, one program may use a physician per capita standard of 1:1500 where another may use 1:2500, with each identifying different areas for services. Some health agency staff have been told that the Federal government is currently attempting to agree on a single standard to replace the HPSA, MUA and MUP definitions.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

The programs that were studied varied in their efficiency and effectiveness. Due to changes in Federal malpractice laws and the limited impact of relatively low financial incentives, the Medical Malpractice Program has not been effective at recruiting and retaining rural health providers. The Area Health Education Centers (AHEC's) have not effectively demonstrated their impact on rural health. While this does not mean they were ineffective, it does mean that no convincing evidence was provided to show

positive outcomes were achieved. Each of the other programs has had some measurable impact, but the size of the programs limits the ability to properly distinguish the impact of these programs from other factors that influence the same measures. Two issues arose in our overall study, the fragmentation of rural health efforts and the variety and complexity of rural health needs.

Rural health programs are fragmented and no single agency holds the responsibility for overall rural health policy. Many programs exist which in whole or in part address rural health concerns; however, each was created independently and there is no overall goal setting and little coordination between these programs. Fragmentation of efforts between agencies and between levels of government exists as well. All of the five programs reviewed have difficulty answering the question, "What is the State's role in rural health, and what should our goals be for improvement?" The difficulty in responding arises from the current program structure, which encourages program staff to limit their vision to their own piece of the overall efforts. This is not to malign the programs because they are not currently designed to interact, nor was any agency given sole authority or responsibility for rural health issues. Individual coordination efforts have been made by the program staff. Where this has occurred, the participants talked to were very pleased with the results. The five programs reviewed did communicate with each other, while this was not always the case with other rural health programs. An example of where existing coordination fails would be the following hypothetical situation. If Area A of the State had a very high infant mortality rate, it would be desirable to have a program responsible for identifying the problem and then contacting all the programs which could help improve conditions in that area so that all efforts could be brought to bear on the problem. This is often handled through the informal organization due to the fragmentation of programs.

Within State government there are a number of agencies and programs that impact rural health. These include the five programs reviewed by the PAR process, emergency medical services (EMS) programs of the Department of Health Services (DHS), the Office of Health Systems Development at DHS, the Rural Health Office of the University of Arizona, the health science departments of the universities and the community colleges, the EMSCOM and helicopter services of DPS, and many others. The number of different programs is likely to increase dramatically as Tobacco Tax funds are expended. Currently, \$10 million of the over \$90 million in estimated annual Tobacco Tax revenues are earmarked for community health programs. This new funding is significantly increasing the number of separate programs.

Some of these current programs have very similar goals and some are duplicative. For example, the Medical Student Loan Program and the Arizona Loan Repayment Program both address the shortage of health care providers by providing incentives for medical professionals to locate in underserved areas. While they differ in strategy, one focusing on students, the other on graduates, they share a common goal. Similarly, the Medical Malpractice program provides incentives to attract or retain obstetric professionals. There are also many programs which have large indirect effects on rural health, such as AHCCCS-provided health services, some DES programs, and other DHS programs.

The fragmentation is more pronounced among the different levels of government and between government and the private sector. Each of the rural County Health Departments operates a wide array of health services. Appendix B details some of these expenditures and some health indicators by county. Counties favorably mentioned the DHS Office of Health Systems Development and the Rural Health Office at the University of Arizona for their efforts to coordinate some programs. The importance of coordination and collaborating on efforts was very important to the counties. There are

some innovative programs at each county, yet there did not appear to be a structure in place for sharing the results of these efforts with other counties.

Research attempts to determine services provided on reservations seemed to indicate a general lack of coordination among those providing services on reservations. Very little summary data or comparative data between tribal services on different reservations was readily available. The lack of apparent coordination of State, Federal and tribal health efforts is a serious problem because both our limited survey of rural health care and our visit of tribal health facilities tended to indicate that the reservations suffer from shortages of quality health care. These shortages were primarily characterized by few provider locations, long transportation distances and some substantial waiting times at some locations for primary care treatment. Information on reservation health care expenditures can be found in Appendix C.

The Federal government also has a number of programs impacting rural health. The National Health Service Corps (NHSC) places health professionals in rural underserved areas in Arizona. A behavioral health provider in Prescott credited the NHSC for the placement of three psychiatrists in that area alone, all of which have remained. The Federal government also funds many county health efforts through Title V Maternal and Child Health Grants; the Women, Infants and Children (WIC) Program; at-risk grants; and other funding which is primarily passed through the state DHS. Most of the coordination of these programs is performed by DHS, while actual program services are provided primarily through county health departments.

In the private sector, non-profit hospitals and other health providers in rural areas often provide outreach and create their own special needs program. Two examples are the Yavapai Regional Hospital in Prescott, which is currently developing a Community Health Partnership to promote wellness in the community, and the Marcus J. Lawrence Hospital in Cottonwood, which is working on efforts to bring more affordable primary care to the Verde Valley and Sedona areas. Hospitals are important to rural health in that their location makes them a magnet for the health needs of the entire area. Some rural hospital staff that were interviewed indicated that 40% of the care they provide is uncompensated. In retirement areas where a larger number of clients are qualified for Medicare, some rural hospitals estimate that 70% or so of their compensation comes from Medicare reimbursement, and another 15%-20% from Medicaid. Since these are often fixed reimbursements, it is even more difficult for local hospitals to develop community programs or to increase their level of uncompensated care. The lack of alternative primary care can also clog local hospital emergency rooms with ailments that could have been treated more cheaply if other providers were available. Other non-profit health providers interviewed seemed to be doing what they can to provide comprehensive services while operating on very tight budgets.

When looked at in total, there are many agencies and resources attempting to improve health care for rural Arizonans. While the programs in question appear to be coordinating their efforts and collaborating at least to some degree, the very complexity of the problem and the number of efforts to address it makes it difficult to determine the relative effectiveness of each program, but also dilutes the overall impact that could have otherwise been obtained.

There are many areas of need for improved rural health in Arizona, yet these needs vary greatly by individual area. Many of the State programs which impact rural health are built upon a "one size fits all" philosophy. In a hypothetical case for instance, if there is a shortage of "Service A" in rural

areas, funding provided for this purpose will usually be divided between counties based upon population. While "Service A" may be a very serious problem in five counties, it may not be a problem in the others. The methodology then dilutes the funding going to the highest need counties by sending some to low-need counties. The counties that do not need more of "Service A" may, in fact, need funding for "Service B" for which they would like to use the "Service A" dollars. However, these funds are typically earmarked, which may force these counties to use funds for less-than-optimal purposes.

An excellent source of data on health care service levels and needs in each section of the State is found in the "Primary Care Area Profile," published cooperatively by the University of Arizona Rural Health Office and the Office of Health Systems Development of the Department of Health Services and updated on June 15, 1995. This report provides detailed information which allows various health shortage areas to be identified. Using this data, there are many rural areas of the State that suffer from a lack of adequate medical transportation, health care professionals, medical technology and emergency services. However, these problems vary widely and not all areas have all of these problems. One area may need an ambulance, another an obstetrician, another a general practitioner, and still another an emergency medical facility. Since each area has unique needs, rural health programs which are flexible and can be tailored to individual area needs would be more effective than inflexible "one size fits all" approaches.

Are there other cost-effective alternative methods of accomplishing the program's mission?

There are several alternative methods of impacting the quality of rural health care in Arizona. Some of these are mentioned in the five individual PAR reports, including Telemedicine, rural rotation, other existing State and Federal programs, and so forth. The complexity and diversity of health care needs in rural areas prevent any single program from solving all rural health problems. Therefore, a mix of alternatives and current programs specifically targeted at different areas would be more cost-effective than statewide "one-size-fits-all" types of programs..

Are there other special areas of interest?

There are numerous complexities in finding solutions to rural health care problems. These complex factors should be understood in order to target programs effectively. There are many different kinds of problems faced by rural Arizona in delivering quality health care. The varieties of problems require a variety of solutions and eliminate the possibility of any single overall programmatic solution. The JLBC and OSPB Staff could not reasonably expect through the PAR process to develop these myriad solutions. However, the following paragraphs are included for the purpose of clarifying some issues in order to further the debate toward improved rural health care in Arizona.

Access vs. Availability - A shortage of health care can have one of two causes. Either there are not enough health care providers and facilities (Availability), or there are patients which cannot receive services from existing providers due to financial, transportation, or other reasons (Access). The reason that this is important in reviewing the State's role in rural health is that both types of shortages currently exist in Arizona, and they each require different solutions.

The Medical Student Loan Program, the Medical Malpractice Program, and the Loan Repayment Program all directly address availability of health care. These programs may impact the number of health care professionals in a region, but do not directly increase access to care unless they are placed at

free or reduced price clinics. If an area already has a number of health care providers but has a large population that is unable to access these providers, it may be eligible for designation as a Medically Underserved Population (MUP). An example of this may be found in the Flagstaff area where a fledgling community health center is attempting to grow. It does not qualify as a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) because there are a number of health care providers in the area. However, the staff of the clinic claims that the clients they are serving in many cases have chronic diseases such as diabetes which have gone untreated due to financial inability to access the available health care providers. This community health center is not helped by programs that exclusively address availability issues.

On the other hand, staff at the Northern Arizona Regional Behavioral Authority explained that the area of Mohave County has been experiencing shortages of psychiatrists providing behavioral health. This area would benefit greatly from a program that addresses availability of these health professionals. A program directed toward access would not help with this problem because even if clients have all the money they need, they cannot access treatment that is not available. Therefore, for each need, it is important to identify if it is an availability problem, an access problem, or both.

Primary Services vs. Emergency Services - Some areas of the State have adequate emergency services and inadequate primary care, some the opposite, some are deficient in both, and some are adequate in both areas. An example is the fledgling community health center mentioned earlier, which is in an area with primary care access issues, but does not have a deficiency in local emergency care. This causes additional problems in developing overall solutions to health needs. Programs for primary services may need to focus on attracting and retaining general practitioners, insuring adequate nursing, space and equipment, and using preventive treatment and care of on-going conditions. Emergency care programs must address trauma systems, helicopter evacuation, emergency communications, ambulance coverage, emergency room availability, and paramedics and other specialized trauma care personnel. Both Appendix B and Appendix C contain some additional information on primary and emergency care service levels in rural areas.

During the PAR process, the five programs reviewed were primarily concerned with primary care services. However, the State has a number of programs which address emergency services in rural areas. Examples are the Emergency Medical Services Communications Network (EMSCOM), the Ambulance Replacement Program, the Emergency Medical Services (EMS) Program, EMS Special Projects, EMS Special Grants, and the Helicopter Evacuation Program. Many of these programs may impact both primary and emergency services. For instance, an increase in obstetricians in an area may dramatically reduce the number of deliveries performed in local emergency rooms. Because of the inter-related nature of programs, the existence of one often impacts the effectiveness of the other. In the previous example, a program to reduce the over utilization of emergency rooms might benefit from an obstetrician placement program and the impact on utilization be attributed incorrectly to other efforts.

Technology - Another issue in rural health is the difficulty in acquiring and maintaining the latest medical technology. The programs reviewed primarily address the availability of health care professionals. However, even with an adequate number of providers, care will be of a lower quality if the proper equipment is not available or is out dated. Some states have attempted to address this issue by allowing capital start-up funding for health providers in lieu of or in addition to loan repayments, or by allowing rural providers an exemption to state anti-trust rules to allow for joint purchase and use of expensive medical hardware.

Transportation - In many rural areas the biggest barrier to quality health care is simply distance. Transportation affects not only emergency response and the need for adequate ambulance coverage, but also the ability to make prenatal visits, provide immunizations, access to primary care, elderly access to care, and many other issues. The geographical barriers must be factored into the needs of an area in addition to the number of medical providers. A low population density in a geographical region could make a physician-per-capita measure look adequate when in fact the physicians were unable to reach many of the prospective patients.

There have been some innovative approaches to dealing with the transportation issue. Yavapai County has received a three-year Federal grant to operate a Mobile Health Clinic to bring services to outlying areas. Coconino County has implemented satellite health care at schools. Telemedicine has also recently been discussed as a program to reduce the effects of geographical barriers. This emerging technology has shown increasing promise as a method to bring the benefit of specialists and expert consultation to remote areas and thereby avoid costly and risky patient transportation over large distances. One problem these approaches often must face are high start-up and maintenance costs which must be weighed against the benefits. These are all programs which impact transportation issues and bringing medical care to hard-to-access regions.

Specialists vs. General Practitioners - It is important to look at the number of specialists and general practitioners in an area in addition to the overall number of health care professionals. Some areas of the State appear to be in dire need of obstetrical services or general family practitioners, but have an over abundance of medical specialists. Some ways of calculating eligibility for programs can overlook these needs by focusing on the total number of professionals per capita. Some providers in rural areas have expressed some anecdotal evidence and concerns that specialists prefer rural areas with fewer Health Maintenance Organizations (HMO's) and are easier to attract away from the urban areas. On the opposite end of the spectrum, interviewees from other rural areas expressed having difficulty attracting any specialists.

To be effective, rural health programs designed to attract and retain health care professionals need to gather data on the specific type of professional needed and then target their efforts. Programs that have difficulty attracting applicants will most likely encounter even more difficulty in targeting recruitment of a specific type of provider.

APPENDIX A: CURRENT METHODOLOGIES OF DETERMINING RURAL OR MEDICALLY UNDERSERVED STATUS

There are several different methodologies for determining whether an area is medically underserved. The programs reviewed used one or more of these to determine where to focus their efforts. In addition, there are several lay definitions for "rural health" used by some policy makers. This appendix will discuss the four main underserved standards used in Arizona: 1) the Health Professional Shortage Area (HPSA); 2) the federally designated Medically Underserved Area (MUA); 3) the Medically Underserved Population (MUP); and 4) the Arizona Department of Health Services' Primary Care Index. Following the discussion of these criteria is a brief description of other non-technical definitions in use.

Health Professional Shortage Areas (HPSA)

A HPSA is determined by meeting all of the following 3 criteria:

1. The area is a rational area for the delivery of primary care services. (For example, not a strip of ocean or an uninhabited mountain range.)
2. One of the following 2 conditions prevails within the area:
 - a) the area has a primary care physician to population full-time-equivalent ratio of 1:3500 or worse.
 - b) the area has a ratio of not more than 1:3500 nor less than 1:3000 and has unusually high needs for primary care services or insufficient capacity of primary care providers.
3. Primary medical care providers in contiguous areas are over utilized, excessively distant or inaccessible to the population of the area under consideration.

There are several pages of federal methodology on how to determine the ratios and what constitutes meeting each of these conditions, but at this simplified level a HPSA status is primarily determined by primary care provider ratios.

Medically Underserved Area (MUA)

Determination of whether an area is an MUA is based on the score the area receives using criteria called the Index of Medical Underservice (IMU). The score ranges from 0 to 100, with 0 representing completely underserved and 100 being best served or least underserved. Under established criteria, a service area that scores 62.0 or less is considered to be a medically underserved area.

The IMU uses weighted scores based on 4 variables: 1) primary medical care physicians to population ratio; 2) infant mortality rates; 3) percentage of the population with incomes below the poverty level; and 4) the percentage of the population over age 65. Using these criteria, retirement communities, areas with a large migrant labor force and rural areas tend to qualify more easily for MUA status.

Medically Underserved Population (MUP)

MUP determination is made using the same IMU scale and score as the MUA, with one notable exception. Rather than calculating the IMU score based upon the population of the whole area, the MUP determination is made using only selected populations and health providers. These are population groups which request MUP determination based on economic, cultural and/or linguistic access barriers

to primary care services. The IMU factors are then only applied to providers that provide services to the smaller population group involved, infant mortality rates for the population subgroup only, and so on.

For MUP designation, a score of 62.0 or less is still the standard cutoff for designation. However, there are provisions for areas that score between 62.0 and 70.0 to apply for status as a MUP under "exceptional designation." The area must prove that there are unusual local conditions that are a barrier to access to or the availability of personal health services. This special request must be recommended by the chief executive officer and local officials of the state where the requested population resides.

Arizona Department of Health Services Primary Care Index

The Office of Health Planning, Evaluation and Statistics within the Arizona Department of Health Services (DHS) uses a weighted criteria scale similar to the IMU except that many more factors are considered when looking at the health care delivery in a particular area. The Primary Care Index (PCI), uses the following weighted criteria:

- 1) population to provider ratio with points beginning at over 1:2000 and supplemental points for none or only one provider;
- 2) geographic accessibility measured primarily in travel time to the nearest provider with points beginning at over 20 minutes;
- 3) income and ability to pay based on population below 200% of federal poverty level (FPL), population between 100% and 200% of FPL, and percent of deliveries that were "self-pay" or "unknown";
- 4) natality statistics such as percent of low-weight births and percentage of mothers reporting no prenatal care or late start of prenatal care;
- 5) and supplemental criteria such as infant mortality rates, elderly population, minority population, number of seasonal and migrant workers, and the unemployment rate.

Comments on the 4 Major Standards Used for Underserved Designation

While each methodology may include or exclude one area that another does not, for the most part the methods identify the same areas. However, there are enough exceptions that the exact method to be used should be determined based on the areas desired to be targeted for assistance. It is also important to note that all of the methods apply primarily to primary acute care services and do not contain measures of emergency services, capital needs, or quality of care issues such as technology and provider education.

Other Interpretations of Rural Health

As discussed in the body of the Rural Health Program Authorization Review Executive Summary there are many lay interpretations of rural health. These include: 1) every county except Maricopa and Pima; 2) everywhere except for Phoenix, Tucson and maybe Flagstaff; 3) areas under a certain population; and many others. The problem is that dividing resources to focus on rural health is not accomplished by using any of the 4 criteria discussed above because they all include both rural and urban areas. If the Legislature wants to focus resources in areas of low population, certain counties or regions, additional specifications will have to be made in nearly all of the programs now considered to be "rural health" programs. When federal funding is involved, it should also be recognized that dollars may be restricted when the federal designations are not precisely followed.

APPENDIX B: COUNTY HEALTH EXPENDITURES

Every county in the state maintains a Local Health Department (LHD) which is responsible for the administration of area health programs. The information shown on the tables in this Appendix was taken primarily from reports each county has submitted to the Rural Health Office at the State Department of Health Services. The numbers were not verified against other sources but are provided in order to compare the relative county expenditures for various health programs. The first table shows these programs, listed in descending order of total county expenditure for Fiscal Year 1994, including the provision of Personal Health, Health Resources, and Environmental Health programs, and General Administration and Services. The individual LHDs manage programs with federal requirements, such as Women Infants and Children (WIC); state requirements, such as the Newborn Intensive Care (NIC) program, locally operated programs such as restaurant health inspections; and are also able to create their own programs according to area needs.

The second and third tables provide some sample data on the number of ambulances and specialized emergency medical technicians. The fourth table shows the change in number of physicians per county between June of 1990 and June of 1995. The fifth table lists actively practicing licensed physicians in Arizona by location. These tables have been included for information purposes only.

TABLE 1. COUNTY HEALTH EXPENDITURES - FY 1994

| Source of Funds | Apache | Cochise | Coconino | Gila | Graham | Greenlee | La Paz | Maricopa |
|---|-------------------------|---------------------------|---------------------------|-------------------------|-------------------------|-------------------------|-------------------------|----------------------------|
| State Funds (Through ADHS) | \$51,974 | \$241,383 | \$364,419 | \$76,760 | \$78,161 | \$59,614 | \$100,273 | \$981,909 |
| State Funds (Non-ADHS Sources) | | | | | | 66,218 | | 181,554 |
| Federal Grants & Contracts (Through ADHS) | 55,764 | 806,090 | 1,189,861 | 92,700 | 137,164 | 49,489 | | 7,073,227 |
| Federal Grants & Contracts (Non-ADHS Sources) | 11,579 | | 85,846 | | | 134,008 | | 3,195,594 |
| Funds From Local Sources | | 1,031,344 | 819,389 | 435,926 | 107,418 | 206,734 | 187,655 | |
| Patient Fees & Third Party Reimbursements | | | 186,111 | | | | | 1,245,793 |
| Other Fees | 18,232 | | 335,444 | 120,000 | | | 131,295 | 4,230,402 |
| Other Sources | 264,860 ^{1/} | | 138,113 ^{2/} | | | 1,849 ^{3/} | | 6,524,052 ^{4/} |
| Total Funds | <u>\$402,409</u> | <u>\$2,078,817</u> | <u>\$3,119,183</u> | <u>\$725,386</u> | <u>\$322,743</u> | <u>\$517,912</u> | <u>\$419,223</u> | <u>\$23,432,531</u> |
| Expenditure of Funds by Program | | | | | | | | |
| Personal Health | \$77,525 | \$1,366,334 | \$2,414,399 | \$373,510 | \$223,505 | \$311,178 | \$126,327 | \$2,999,681 |
| Environmental Health | 40,373 | 232,829 | 352,008 | 301,876 | 30,513 | 29,956 | 72,001 | 5,430,402 |
| Health Resources | | | | | | | | 11,286,673 |
| Local Health Dept Operated Institutions | | | | | | | | 366,591 |
| Local Health Dept Operated Laboratory | | | | | | | | 3,349,184 |
| General Administration & Services | 284,511 | 479,654 | 352,776 | 50,000 | 68,725 | 176,778 | 220,895 | |
| Other | | | | | | | | |
| Total Expenditures | <u>\$402,409</u> | <u>\$2,078,817</u> | <u>\$3,119,183</u> | <u>\$725,386</u> | <u>\$322,743</u> | <u>\$517,912</u> | <u>\$419,223</u> | <u>\$23,432,531</u> |
| Prevention Versus Other Spending | | | | | | | | |
| Prevention Expenditures | \$321,927 | \$629,466 | \$2,121,044 | \$675,386 | \$235,863 | \$341,134 | \$134,151 | \$11,286,673 |
| Treatment Expenditures | 80,482 | 726,868 | 436,686 | 0 | 18,155 | 0 | 100,614 | 3,366,272 |
| All Other Expenditures | 0 | 722,483 | 561,453 | 50,000 | 68,725 | 176,778 | 184,458 | 8,779,586 |
| Total | <u>\$402,409</u> | <u>\$2,078,817</u> | <u>\$3,119,183</u> | <u>\$725,386</u> | <u>\$322,743</u> | <u>\$517,912</u> | <u>\$419,223</u> | <u>\$23,432,531</u> |

- 1/ County General Fund
- 2/ CAP (Dental)
- 3/ Project Income
- 4/ County General Fund

TABLE 1. COUNTY HEALTH EXPENDITURES - FY 1994 (CONT)

| Source of Funds | Mohave | Navajo | Pima | Pinal | Santa Cruz | Yavapai | Yuma | Total |
|---|-----------------------|---------------------|---------------------|---------------------|------------------|-----------------------|--------------------|---------------------|
| State Funds (Through ADHS) | \$99,210 | \$89,500 | \$347,295 | \$197,079 | \$121,482 | \$230,459 | \$233,639 | \$3,273,157 |
| State Funds (Non-ADHS Sources) | | 321,640 | | 188,217 | | | | 757,629 |
| Federal Grants & Contracts (Through ADHS) | 586,364 | 246,240 | 1,980,016 | 871,861 | 18,746 | 638,420 | 342,903 | 14,088,845 |
| Federal Grants & Contracts (Non-ADHS Sources) | | | 771,072 | 674,724 | | 11,387 | | 4,884,210 |
| Funds From Local Sources | 557,358 | | 5,441,043 | 1,498,046 | 191,228 | 511,269 | 1,374,311 | 12,361,721 |
| Patient Fees & Third Party Reimbursements | 15,902 | | 2,397,333 | 1,583,717 | | 671,465 | | 6,100,321 |
| Other Fees | 486,009 ^{5/} | | | 27,422 | | 227,334 | | 5,576,138 |
| Other Sources | | 6,000 ^{6/} | | 7,834 ^{7/} | | 109,352 ^{8/} | 13,198 | 7,065,258 |
| Total | \$1,744,843 | \$663,380 | \$10,936,759 | \$5,048,900 | \$331,456 | \$2,399,686 | \$1,964,051 | \$54,107,279 |
| Expenditure of Funds by Program | | | | | | | | |
| Personal Health | \$899,687 | \$500,000 | \$6,524,262 | \$4,647,813 | \$172,264 | \$1,833,455 | \$1,386,406 | \$23,856,346 |
| Environmental Health | 589,969 | 85,000 | 2,836,422 | 198,300 | 159,192 | 248,278 | 269,602 | 10,876,721 |
| Health Resources | | | 486,133 | | | | | 11,772,806 |
| Local Health Dept Operated Institutions | | | | | | | | 0 |
| Local Health Dept Operated Laboratory | | | | | | | | 366,591 |
| General Administration & Services | 255,187 | 78,380 | 1,089,942 | 202,787 | | 317,953 | 308,043 | 7,234,815 |
| Unallocable | | | | | | | | 0 |
| Total | \$1,744,843 | \$663,380 | \$10,936,759 | \$5,048,900 | \$331,456 | \$2,399,686 | \$1,964,051 | \$54,107,279 |
| Prevention Versus Other Spending | | | | | | | | |
| Prevention Expenditures | 1,136,474 | 450,000 | 8,696,653 | 4,846,113 | 315,450 | 1,687,469 | 1,393,145 | 34,270,948 |
| Treatment Expenditures | 9,019 | 100,000 | 887,964 | 0 | 16,006 | 649,367 | 262,863 | 6,654,296 |
| All Other Expenditures | 599,350 | 113,380 | 1,352,142 | 202,787 | 0 | 62,850 | 308,043 | 13,182,035 |
| Total | \$1,744,843 | \$663,380 | \$10,936,759 | \$5,048,900 | \$331,456 | \$2,399,686 | \$1,964,051 | \$54,107,279 |

^{5/} Environmental Health Fees
^{6/} NACOG
^{7/} Family Planning Donation and Nutrition Income
^{8/} Transfer from Special Revenue Accounts Interest Earned, March of Dimes

TABLE 2.
Ambulance Services by County in 1994

| County | Number of Ambulance Service Providers | | Number of Ground Ambulance Vehicles |
|---------------|--|------------|--|
| | Ground | Air | |
| Apache | 4 | 0 | 11 |
| Cochise | 10 | 0 | 28 |
| Coconino | 8 | 3 | 20 |
| Gila | 3 | 0 | 10 |
| Graham | 1 | 0 | 4 |
| Greenlee | 1 | 0 | 4 |
| La Paz | 0 | 0 | 8 |
| Maricopa | 13 | 4 | 165 |
| Mohave | 7 | 0 | 23 |
| Navajo | 7 | 2 | 21 |
| Pima | 12 | 2 | 79 |
| Pinal | 4 | 0 | 11 |
| Santa Cruz | 4 | 0 | 10 |
| Yavapai | 6 | 0 | 22 |
| Yuma | 3 | 2 | 15 |
| Totals | 83 | 13 | 431 |

TABLE 3.
Comparison of Emergency Medical Professionals by County

| County | Population 1/ | EMTs 2/ | Paramedics 3/ | EMTs Per 1,000 Persons | Paramedics Per 1,000 Persons |
|---------------|----------------------|----------------|----------------------|-----------------------------------|---|
| Apache | 63,275 | 113 | 6 | 1.79 | 0.09 |
| Cochise | 108,225 | 270 | 45 | 2.49 | 0.42 |
| Coconino | 107,500 | 503 | 68 | 4.68 | 0.63 |
| Gila | 43,350 | 237 | 47 | 5.47 | 1.08 |
| Graham | 30,625 | 100 | 5 | 3.27 | 0.16 |
| Greenlee | 8,425 | 18 | 3 | 2.14 | 0.36 |
| La Paz | 16,075 | 63 | 7 | 3.92 | 0.44 |
| Maricopa | 2,355,900 | 4,469 | 974 | 1.90 | 0.41 |
| Mohave | 120,325 | 400 | 119 | 3.32 | 0.99 |
| Navajo | 81,750 | 217 | 32 | 2.65 | 0.39 |
| Pima | 728,425 | 1,353 | 329 | 1.86 | 0.45 |
| Pinal | 132,225 | 309 | 38 | 2.34 | 0.29 |
| Santa Cruz | 32,400 | 101 | 11 | 3.12 | 0.34 |
| Yavapai | 123,500 | 428 | 93 | 3.47 | 0.75 |
| Yuma | 119,650 | 249 | 46 | 2.08 | 0.38 |
| Totals | 4,071,650 | 8,830 | 1,823 | | |

1/ Population statistics compiled and approved by the Arizona Department of Economic Security, December 14, 1994.

2/ Figures composed of both basic and intermediate Emergency Medical Technicians.

**TABLE 4. ARIZONA PHYSICIAN SUPPLY -- JUNE 1990 AND JUNE 1995
LISTED BY FIRST FIELD OF PRACTICE BY COUNTY 1/**

| County | Emergency Medicine | | Gen/Fam Practice | | Internal Medicine | | Obstetrics/Gyn | | Other Specialties | | Totals | |
|-----------------------|--------------------|------------|------------------|--------------|-------------------|------------|----------------|------------|-------------------|--------------|--------------|--------------|
| | 1990 | 1995 | 1990 | 1995 | 1990 | 1995 | 1990 | 1995 | 1990 | 1995 | 1990 | 1995 |
| Rural Counties | | | | | | | | | | | | |
| Apache | 1 | 1 | 11 | 15 | 7 | 4 | 1 | 1 | 8 | 8 | 28 | 29 |
| Cochise | 3 | 6 | 30 | 37 | 9 | 14 | 5 | 7 | 37 | 33 | 84 | 97 |
| Coconino | 8 | 10 | 44 | 60 | 13 | 16 | 12 | 15 | 81 | 93 | 158 | 194 |
| Gila | 2 | 7 | 20 | 21 | 4 | 4 | 2 | 1 | 10 | 13 | 38 | 46 |
| Graham | 0 | 0 | 8 | 10 | 2 | 0 | 0 | 0 | 2 | 3 | 12 | 13 |
| Greenlee | 0 | 0 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 4 | 3 |
| La Paz | 0 | 2 | 6 | 7 | 3 | 2 | 0 | 0 | 3 | 3 | 12 | 14 |
| Mohave | 6 | 6 | 26 | 36 | 8 | 12 | 5 | 10 | 48 | 64 | 93 | 128 |
| Navajo | 4 | 7 | 28 | 28 | 5 | 5 | 1 | 1 | 14 | 17 | 52 | 58 |
| Pinal | 4 | 3 | 30 | 35 | 8 | 11 | 3 | 5 | 24 | 26 | 69 | 80 |
| Santa Cruz | 4 | 2 | 9 | 14 | 4 | 4 | 3 | 4 | 9 | 4 | 29 | 28 |
| Yavapai | 4 | 8 | 39 | 46 | 19 | 19 | 7 | 9 | 72 | 87 | 141 | 169 |
| Yuma | <u>11</u> | <u>6</u> | <u>27</u> | <u>41</u> | <u>13</u> | <u>19</u> | <u>10</u> | <u>11</u> | <u>58</u> | <u>65</u> | <u>119</u> | <u>142</u> |
| Subtotal | 47 | 58 | 282 | 352 | 95 | 110 | 49 | 64 | 366 | 417 | 839 | 1,001 |
| Urban Counties | | | | | | | | | | | | |
| Maricopa | 203 | 261 | 814 | 884 | 487 | 595 | 294 | 351 | 2,808 | 3,253 | 4,606 | 5,344 |
| Pima | <u>88</u> | <u>106</u> | <u>241</u> | <u>274</u> | <u>253</u> | <u>270</u> | <u>115</u> | <u>119</u> | <u>1,156</u> | <u>1,279</u> | <u>1,853</u> | <u>2,048</u> |
| Subtotal | 291 | 367 | 1,055 | 1,158 | 740 | 865 | 409 | 470 | 3,964 | 4,532 | 6,459 | 7,392 |
| Unknown | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 1 | 4 | 4 | 4 |
| Total | <u>338</u> | <u>425</u> | <u>1,340</u> | <u>1,510</u> | <u>835</u> | <u>975</u> | <u>458</u> | <u>534</u> | <u>367</u> | <u>4,953</u> | <u>7,302</u> | <u>8,397</u> |

1/ Many physicians may have more than one field of practice. For Instance, general and family practitioners may also have obstetrical services privileges at hospitals. However, to avoid double-counting the number of physicians, this table lists the physicians by their first field of practice only as identified by data from the Board of Medical Examiners and the Board of Osteopathic Examiners.

2/ Source: Data compiled by the Governor's Office of Strategic Planning and Budgeting from the Arizona Council for Graduate Medical Education, Arizona's Physician Supply, May 1992 (1990 data) and from the 1995 Board of Medical Examiners Reports and the 1995 Board of Osteopathic Examiner's Directory.

TABLE 5. LICENSED PHYSICIANS -- ACTIVELY PRACTICING IN ARIZONA 1995 1/

| County/Town | Practicing MDs | Practicing DOs | Total Docs 1995 |
|-----------------|----------------|----------------|-----------------|
| APACHE | | | |
| Alpine | 1 | 0 | 1 |
| Chinle | 3 | 0 | 3 |
| Eagar | 2 | 0 | 2 |
| Fort Defiance | 2 | 0 | 2 |
| Ganado | 12 | 0 | 12 |
| Greer | 0 | 0 | 0 |
| Springerville | 4 | 2 | 6 |
| St. Johns | 1 | 0 | 1 |
| Tsaile | 1 | 0 | 1 |
| Window Rock | 1 | 0 | 1 |
| Total | 27 | 2 | 29 |
| COCHISE | | | |
| Benson | 6 | 1 | 7 |
| Bisbee | 4 | 1 | 5 |
| Cochise | 0 | 0 | 0 |
| Douglas | 12 | 0 | 12 |
| Fort Huachuca | 6 | 1 | 7 |
| Hereford | 0 | 0 | 0 |
| Sierra Vista | 44 | 16 | 60 |
| Willcox | 3 | 3 | 6 |
| Total | 75 | 22 | 97 |
| COCONINO | | | |
| Flagstaff | 134 | 8 | 142 |
| Fredonia | 1 | 0 | 1 |
| Grand Canyon | 3 | 0 | 3 |
| Munds Park | 1 | 0 | 1 |
| Oak Creek | 0 | 0 | 0 |
| Page | 12 | 1 | 13 |
| Sedona | 26 | 1 | 27 |
| Tuba City | 4 | 1 | 5 |
| West Sedona | 1 | 0 | 1 |
| Williams | 1 | 0 | 1 |
| Total | 183 | 11 | 194 |
| GILA | | | |
| Claypool | 5 | 0 | 5 |
| Globe | 12 | 1 | 13 |
| Hayden | 1 | 0 | 1 |
| Miami | 2 | 0 | 2 |
| Payson | 14 | 5 | 19 |
| Pine | 1 | 0 | 1 |
| San Carlos | 3 | 1 | 4 |
| Young | 1 | 0 | 1 |
| Total | 39 | 7 | 46 |

| County/Town | Practicing MDs | Practicing DOs | Total Docs 1995 |
|------------------|----------------|----------------|-----------------|
| GRAHAM | | | |
| Fort Grant | 0 | 0 | 0 |
| Duncan | 0 | 1 | 1 |
| Safford | 12 | 0 | 12 |
| Total | 12 | 1 | 13 |
| GREENLEE | | | |
| Morenci | 3 | 0 | 3 |
| LA PAZ | | | |
| Parker | 5 | 6 | 11 |
| Salome | 0 | 1 | 1 |
| Quartzsite | 2 | 0 | 2 |
| Total | 7 | 7 | 14 |
| MARICOPA | | | |
| Apache Junction | 9 | 3 | 12 |
| Avondale | 3 | 3 | 6 |
| Buckeye | 2 | 1 | 3 |
| Carefree | 4 | 3 | 7 |
| Cave Creek | 1 | 6 | 7 |
| Chandler | 101 | 15 | 116 |
| El Mirage | 2 | 0 | 2 |
| Fountain Hills | 7 | 1 | 8 |
| Gilbert | 66 | 12 | 78 |
| Glendale | 223 | 27 | 250 |
| Goodyear | 4 | 2 | 6 |
| Guadalupe | 2 | 0 | 2 |
| Litchfield Park | 8 | 3 | 11 |
| Luke AFB | 17 | 0 | 17 |
| Mesa | 436 | 101 | 537 |
| Paradise Valley | 45 | 8 | 53 |
| Peoria | 83 | 4 | 87 |
| Phoenix | 2,716 | 277 | 2,993 |
| Rio Verde | 0 | 0 | 0 |
| Scottsdale | 658 | 63 | 721 |
| Sun City | 115 | 0 | 115 |
| Sun City West | 36 | 6 | 42 |
| Sun Lakes | 7 | 1 | 8 |
| Surprise | 4 | 0 | 4 |
| Tempe | 218 | 28 | 246 |
| Tolleson | 1 | 1 | 2 |
| Waddell | 0 | 0 | 0 |
| Wickenburg | 9 | 1 | 10 |
| Youngtown | 1 | 0 | 1 |
| Location Unknown | 0 | 4 | 4 |
| Total | 4,778 | 570 | 5,348 |

| County/Town | Practicing MDs | Practicing DOs | Total Docs 1995 |
|------------------|----------------|----------------|-----------------|
| MOHAVE | | | |
| Bullhead City | 31 | 7 | 38 |
| Dolan Springs | 0 | 0 | 0 |
| Kingman | 30 | 10 | 40 |
| Lake Havasu City | 41 | 3 | 44 |
| Mohave Valley | 1 | 0 | 1 |
| Riviera | 5 | 0 | 5 |
| Total | 108 | 20 | 128 |
| NAVAJO | | | |
| Holbrook | 3 | 0 | 3 |
| Kayenta | 2 | 0 | 2 |
| Keams Canyon | 1 | 1 | 2 |
| Lakeside | 2 | 0 | 2 |
| Overgaard | 0 | 1 | 1 |
| Pinetop | 9 | 1 | 10 |
| Show Low | 22 | 0 | 22 |
| Snowflake | 2 | 0 | 2 |
| Taylor | 1 | 0 | 1 |
| Whiteriver | 3 | 1 | 4 |
| Winslow | 9 | 0 | 9 |
| Total | 54 | 4 | 58 |
| PIMA | | | |
| Ajo | 3 | 0 | 3 |
| Arivaca | 0 | 1 | 1 |
| Cortaro | 1 | 0 | 1 |
| Green Valley | 18 | 2 | 20 |
| Marana | 0 | 1 | 1 |
| Oro Valley | 0 | 3 | 3 |
| Sahuarita | 1 | 0 | 1 |
| Sells/Other | 6 | 0 | 6 |
| Tucson | 1,869 | 142 | 2,011 |
| Vail | 1 | 0 | 1 |
| Total | 1,899 | 149 | 2,048 |
| PINAL | | | |
| Arizona City | 1 | 0 | 1 |
| Casa Grande | 45 | 5 | 50 |
| Coolidge | 2 | 0 | 2 |
| Eloy | 2 | 0 | 2 |
| Florence | 11 | 0 | 11 |
| Kearny | 3 | 0 | 3 |
| Maricopa | 1 | 0 | 1 |
| Oracle | 0 | 1 | 1 |
| Sacaton | 4 | 1 | 5 |
| San Manuel | 3 | 1 | 4 |
| Total | 72 | 8 | 80 |

| County/Town | Practicing MDs | Practicing DOs | Total Docs 1995 |
|-------------------|----------------|----------------|-----------------|
| SANTA CRUZ | | | |
| Nogales | 25 | 0 | 25 |
| Patagonia | 2 | 0 | 2 |
| Sonoita | 1 | 0 | 1 |
| Tubac | 0 | 0 | 0 |
| Total | 28 | 0 | 28 |
| YAVAPAI | | | |
| Bagdad | 1 | 0 | 1 |
| Black Canyon City | 1 | 0 | 1 |
| Camp Verde | 4 | 1 | 5 |
| Chino Valley | 0 | 1 | 1 |
| Cornville | 1 | 0 | 1 |
| Cottonwood | 38 | 8 | 46 |
| Dewey | 0 | 1 | 1 |
| Lake Montezuma | 0 | 1 | 1 |
| Prescott | 100 | 6 | 106 |
| Prescott Valley | 6 | 0 | 6 |
| Total | 151 | 18 | 169 |
| YU MA | | | |
| Somerton | 6 | 0 | 6 |
| Wellton | 1 | 0 | 1 |
| Yuma | 127 | 8 | 135 |
| Total | 134 | 8 | 142 |
| TOTAL | | | |
| Rural Counties | 893 | 108 | 1,001 |
| Urban & Unknown | 6,677 | 719 | 7,396 |
| Total | 7,570 | 827 | 8,397 |

1/ Data compiled by the Governor's Office of Strategic Planning and Budgeting from records submitted by the Board of Medical Examiners and the Board of Osteopaths. Doctors may practice in more than one city. However, to avoid double counting physicians, the table lists physicians by only one practice location.

RH - 17

**APPENDIX D: SOURCES CONTACTED DURING THE RURAL HEALTH PROGRAM
AUTHORIZATION REVIEW**

Garcia, Jorge Luis, State Representative, Social Services Director for Pascua Yaqui Tribe
Hill, Vanessa N., Chief, Office of Local Health, Arizona Department of Health Services
Iverson, Karen, Arizona Association of Counties
Taska, John, Emergency Medical Services Manager, Arizona Department of Health Services
Vanderwagon, Dr. Craig, Director of Clinical Preventive Medicine, Indian Health Services,
United States Department of Health and Human Services
Jacobson, Marsha, Yavapai County Health Officer
Ostendorf, Don, Executive Director, Hillside Center
Barnett, Timothy J., CEO, Yavapai Regional Medical Center
Poindexter, Rita, President and CEO, Marcus Lawrence Hospital
Eyer, Elsie, Coconino County Health Officer
Dube, David, Assistant Director for Health Promotion and Disease Prevention, Coconino County
Department of Health
Patton, Ginny, Coconino County Department of Health
Garcia, Pam, Newborn Intensive Care Program
Payne, Beth, Teen Prenatal Express
Craig, Carol, Flagstaff Community Free Clinic
King, Mike, Director, Winslow Memorial Hospital
Wilderman, Dr. Bob, Director, Community Counseling Centers Inc.
Johnson, Daniel, Assistant Director, Fort Defiance Indian Hospital
Burke, Erlan, Administrator, White Mountain Communities Hospital
Hockman, Jean, CEO, The Guidance Center, Flagstaff
Bray, Earl, Assistant Director, Business and Finance, Arizona Health Care Cost Containment System
Pilcher, Dave, Comptroller, Department of Public Safety
Moore, Robert, Program Coordinator of Wellness on Wheels, Yavapai County Health
Department
Aumack, Lisa, Director of Programs, Northern Arizona Behavioral Health Authority
Latham, Elizabeth G., Program Coordinator, Childrens' Primary Care Services, Coconino County
Health Department
Dalder, Greg S., Youth Program Coordinator, Northern Arizona Behavioral Health Authority
Indian Health Services, Phoenix Area Office
Indian Health Services Advisory Council
United States Department of Health and Human Services
AZ Commission of Indian Affairs
University of Arizona, Rural Health Office
Lopes, Phil, Program Manager, Rural Health Office, Arizona State Department of Health Services
American Association of Retired Persons (AARP), Various Health Reports
"Telemedicine: Just what the Doctor Ordered," Government Technology, July 1995, volume 8,
number 7
Interim Rural Health Care Task Force of the Arizona House of Representatives, Representative
Lou Ann Preble, Chairman, Final Report
Arizona Board of Regents, Board Meeting Minutes, April 27 & 28, 1995, Agenda Item 25a,
Formation of an Advisory Group on Health Professions Education

University of Arizona, "Blue Book," Health Professions for the 21st Century
Pew Health Professions Commission of 1993
"Assessment of Market Demand for Mid-level Health Care Providers," by AHEC and the
University of Arizona Rural Health Office, November 1993
Vituro, Anthony University of Arizona College of Medicine
Mac Lean, Diane, State Supervisor for Health Occupations, Arizona Department of Education
Anderson, Shirley, Health Committee Research Analyst, State House of Representatives
"Primary Care Area Profile", published cooperatively by the University of Arizona Rural Health
Office and the State Department of Health Services Rural Health Office
Mansfield, Sue, Chair, Dental Hygiene, Northern Arizona University
Van Ort, Suzanne, Dean and Professor, College of Nursing, University of Arizona Health
Sciences Center
St. Germaine, Patricia, Associate Dean, Administration, University of Arizona Health Sciences Center



**RURAL HEALTH PROGRAM AUTHORIZATION REVIEW
COMMENTS ON THE JLBC/OSPB JOINT EXECUTIVE SUMMARY
SUBMITTED BY THE RURAL HEALTH OFFICE, UNIVERSITY OF ARIZONA**

Overall Perspective on the Report

The report does an excellent job of focusing on some of the rural health programs in Arizona which are responding to the primary care needs of rural residents. Given the immensity of the legislative directive, combined with lack of sufficient staff resources, the PAR reviewers did an excellent job of synthesizing some rural health issues which should be faced if the state is to meet its commitment to meeting the health care needs of the rural population.

Absent from the report, however, is recognition of the involvement in the field of primary care by a large network of rural-based clinics, many of which function with state and federal funding support. This absence may be, in part, because the Program Authorization Review in this cycle was limited to five specifically named programs. (One of those, named "Primary Care," does not exist as a program within ADHS.)

PAR reviewers have, however, included programs in this rural health review which were not included in this legislative PAR cycle (for example, the Rural Health Office at the University of Arizona). Furthermore, the report does make reference to the role of rural hospitals in providing care. Thus, the report's lack of acknowledgement of the role played by rural clinics in primary health care is a major omission.

To this end, because the Program Authorization Review staff chose to comment on some aspects of the Rural Health Office (RHO) in addition to the mandated rural-related programs coming under the PAR process, this report concentrates on those comments.

The Rural Health Office of the University of Arizona

The PAR Report is unclear with respect to the breadth of programs underway at the Rural Health Office. It cites the RHO's affiliation with the Area Health Education Centers program, and the ADHS Office of Health Systems Development. It does not address those programmatic elements of the RHO which deal with direct primary care, health care provider placement, health care policy research, and community development. The importance of fully understanding the extent of these activities cannot be underestimated, as this has implications for any policy recommendations ultimately made with respect to rural health in Arizona.

Primary Care

For over eight years the RHO has administered a mobile clinic which provides direct primary care services to three rural communities in Pima County.

Provider Placement

For over eight years the RHO has provided assistance to rural clinics and hospitals to help them find health care personnel. Titled, the "Arizona Health Provider Resources Program," this program recruits health care practitioners for rural areas and assists rural communities in expanding their own recruitment capacity.

Community Development

1. Workshops and seminars for rural communities are regularly provided by the RHO to help rural clinics, hospitals, social service agencies, and others learn how to write grants and how to reach out to federal, state and private funding resources. (Staff members are currently assisting rural agencies with their proposal applications for state Tobacco Tax Funding.) The RHO recently organized three town halls on the status of health care in Arizona's rural communities and presented the results to Legislators and committee staff members as a resource for utilization during the legislature's public hearings on rural health care.
2. The Rural Health Office staff members regularly provide support to rural communities in developing health care and economic development services. For example, staff assistance was provided to Ajo to help establish a Health Service District, which now funds the Ajo clinic. Another example is of staff assistance is currently being provided to Eloy to mobilize the community to make decisions regarding how to improve their health services within the context of the community's overall economic development plan.
3. To promote networking among rural health agencies, the RHO annually sponsors and organizes a state-wide rural health conference which generally draws 200 people from throughout the State.
4. The RHO also annually sponsors a legislative forum to educate rural health agency personnel on current legislative directions at the state level and to offer community feedback to legislators attending the forum.

Policy Research

Drawing on a large cadre of academic researchers within the RHO and the University of Arizona in general, the RHO has completed many policy-related research studies on rural health issues. Under the aegis of an RHO program called "The Southwest Border Rural Health Research Center," (SWBRHRC) reports have been published such as the "Border Health Services Utilization Study" which examined the cross-border utilization of health care services at the U.S.-Mexico border and its implications for health care in Arizona; the "OB/GYN Malpractice Study" which examined why Arizona physicians who provide OB/GYN services discontinued doing so and/or moved out of rural communities; The Primary Health Care Review/Maternal and Child Health Assessment in Nogales which studied maternal and child health, adolescent health, working women's health and environmental health issues in this geographic area.

Many other publications of the RHO are important source documents in Arizona, such as, "Directory of Clinical Sites for Medical Student and Resident Rotations;" "Arizona Rural Hospital Chartbook;" "Registered Nursing in Arizona;" "Special Tax-Supported Ambulatory Care Health Districts;" and "The Arizona Rural Health Provider Atlas."

Area Health Education Centers

Because this particular program which functions out of the RHO has been highlighted

in the PAR report, the following comment is offered.

The report states that, "The AHECs have not effectively demonstrated their impact on rural health. While this does not mean they were ineffective, it does mean that no convincing evidence was provided to show positive outcomes were achieved..."

A separate AHEC response to this PAR Report challenges this conclusion and argues that documentation has been provided which DOES provide that the AHEC's have effectively demonstrated their impact on rural health. The reader is referred to the AHEC response document for further information.

Statewide Policy Direction

Fragmentation of Rural Health Programs.

The PAR Report indicates that rural health programs are fragmented and no single agency holds the responsibility for overall rural health policy.

While some staff members in different rural health programs do coordinate activities creatively, it is true that fragmentation exists among others. A new level of cooperation is now occurring between the University of Arizona's Rural Health Office staff members and staff members in the University's Agricultural Extension Service (another important entity serving rural needs which is not mentioned in the report), as well as the Arizona Department of Commerce in order to capture the involvement of rural communities in new initiatives generated by NAFTA agreements (e.g., enterprise zone activities).

The physical and mental health, and total well-being of the residents in any community are interconnected with the economic realities of its infrastructure. Health policy, and rural health policy in particular should examine the total dynamic of a community prior to recommending policy. This should include such components as economic development activities, infrastructure capacity including roads, transportation, social services, health and mental health services, as they are all interrelated in some way.

The University of Arizona is in an excellent position to serve as a catalyst for policy recommendations in this regard. The Rural Health Office staff members have strong ties throughout the university environment and are in a good position to mobilize the expertise of faculty and staff members on economics, health care, public health, public policy, and public administration in order to serve the needs of rural Arizonans. RHO staff are also closely connected with representatives of the Arizona Department of Health Services, the Arizona Association of Community Health Centers, the Arizona Hospital Association, the Arizona Rural Health Association, the Arizona Medical Association, the Arizona Nurses Association, the Arizona Physical Therapists Association, AHCCCS, the Arizona Department of Commerce, and at the Federal Level representatives of the Federal Office of Rural Health Policy, the National Health Service Corps, the Bureau of Health Professions, and many more agencies.

Policy-makers should consider directing the University of Arizona's Rural Health Office to coordinate activities which will result in recommendations pertaining to rural health policy to state lawmakers.



Office of the Director

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FIFE SYMINGTON, GOVERNOR
JACK DILLENBERG, D.D.S., M.P.H., DIRECTOR

October 23, 1995

OCT 23 1995

Mr. Ted Ferris
Director, JLBC
1716 West Adams
Phoenix, Arizona 85007

Dear Mr. Ferris: *TBD*

As requested, JLBC/OSPB final comments on the Department of Health Services' executive summary and the three PAR'd reports, Medical Malpractice, Primary Care, and Arizona Loan Repayment, have been reviewed.

Thank you for allowing the agency to review and comment on these documents. We have attached our final comments for inclusion in the published report (on page DHS-13).

We appreciate the opportunity to work with the JLBC and OSPB staff on the rural health PARs.

If there are any questions, please contact Rebecka Derr, 542-1269.

Sincerely,

A handwritten signature in black ink, appearing to be "Jack Dillenberg".

Jack Dillenberg, D.D.S., M.P.H.
Director

Attachment

cc: Dr. Larry Platt, Associate Director, Public Health
Claudette Frederickson, Associate Director, Business & Financial Services
Michael Kearns, Assistant Director, Strategic Planning & Budget Office
Rebecka Derr, Manager, Strategic Planning
Jane Pearson, Assistant Director, Community & Family Health
Phil Lopes, Chief, Health Systems Development

The Department has the following comments regarding the:

Rural Health Program Authorization Review--JLBC/OSPB Joint Executive Summary:

- 1) "The program staff believe that the goal of the programs (is) to improve health in both urban and rural areas based on the criteria upon which the programs were established...." (page RH-2)

The agency would point out that the programs chosen for PAR were designated as "rural health" programs by the legislature. The agency would also like to point out that there is no "*program staff belie(f)*" regarding the mission of any of the three programs included in this year's PAR reports. Rather, state laws and federal regulations *require* that urban areas be included in the programs. This executive summary states in the *same paragraph* that all of the programs "fit within their agency's overall mission and authority and (are) carrying out their individual mandates." In fact, the ALRP's enabling legislation (see page 4 of the report) specifically requires that application and eligibility requirements are consistent with the NHSC Loan Repayment Program. The NHSC requires a portion of the funding to go to urban sites. The PCP is federally funded to designate the state MUAs and federal HPSAs. Definition of both of these types of designation include both rural and urban unserved and underserved populations. The MMP's subsidy award criteria are explicit in Arizona law (see page 3 of that report).

- 2) DHS disagrees with the statement that "All of the 5 programs reviewed have difficulty answering the question, 'What is the state's role in rural health and what should our goals be for improvement?'" (page RH-4)

DHS feels that the answer provided to the question reflected a clear vision for the role of the state in rural health. For clarity, the entire original response to this question is included below.

"The role of state government in both rural and urban areas is to assess the health status of residents, and develop policies for and collaborate with programs aimed at health status improvements. The assessment of health status can and should be the primary responsibility of the state. Similarly, population-based public health programs such as health education, surveillance, disease control, health planning, and federal assistance to local health departments should also be the responsibility of government in rural areas, as elsewhere.

"Programs to improve health status through the provision of personal health services are the primary responsibility of the private sector. Medicaid (AHCCCS), of course, funds personal health services for some of the indigent. State government should support and collaborate with the private sector in their efforts at improving personal health services. A good example of this is the payment with Tobacco Tax revenues for services

provided by the private sector to persons unable to pay or without insurance coverage and state efforts related to quality assurance. Finally, many rural areas have difficulty in recruitment of health professionals and the state is in a position to efficiently assist in meeting such needs on behalf of rural communities."

- 3) The Department would like to clarify a statement that "Research attempts to determine services provided on reservations seemed to indicate a general lack of coordination among those providing services on reservations." (page RH-5)

The lack of services on reservations has much to do with the Federal government determining funding for the services on the reservations through IHS and tribal sovereignty. AHCCCS and DHS do, in fact, coordinate care for Title XIX services to Native Americans. However, the tribes have the right to choose IHS or state entitlement.

- 4) The Department disagrees strongly with a statement regarding the "many *lay interpretations* of rural health." (page RH-10)

DHS specifically noted in all three reports where the definitions and "interpretations" of rural health were derived. In some cases, rural health definitions are from Federal guidance, in others from state law. As such, none of these definitions of rural health in any way constitute "lay interpretations."

A principal characteristic of the system is that it links students with universities, community colleges, and private schools and the clinics, hospitals, and other health care providers in Arizona's rural and underserved communities.

How does the program mission fit within the Agency's overall mission and the program's enabling authority?

The Agency mission does fit within the program's authority as established at both the Federal and State levels to develop needed health care services in rural and underserved portions of the State based on academic-community partnerships.

Do the historical performance measurements and the future performance targets adequately measure goals?

The performance measures relate to activities rather than to outcomes. State funding has been eliminated, and the estimated performance measures for future years are reduced accordingly.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

Although the AHEC program has been in existence since 1984, its long-term effect on improving rural health care is uncertain. For example, it is a long-term process to educate students in elementary and high school on the desirability of becoming health professionals and ultimately practicing in a rural area of Arizona. Only in the last two years have the first doctors (a total of six) who cited the AHEC program as being responsible for their decisions located their practices in rural Arizona. The effort to influence students' career decisions can span decades, particularly for those who become medical doctors.

Since the inception of AHEC in 1984, the health provider/population ratio has improved throughout Arizona. The greater increase in ratios has been in the rural areas compared to urban centers. For example, comparing the number of medical doctors in 1991 with the number in 1984, the per cent increase in rural areas was 21% compared to 6% in urban areas. Enrollment of underrepresented minority students at the University of Arizona College of Medicine has been increasing. For example, 23% of the incoming students in 1994 were from underrepresented minorities. This compares to 14% in 1992. However, establishing a direct correlation between the ratio improvements and AHEC programs is impossible. The choices made by those medical doctors and students may have been influenced by a number of factors including their contact with AHEC programs.

Some individual health practitioners credit their presence in rural and other medically underserved areas to AHEC. As a tangible indicator of the program's impact, a list is presented in the self-assessment of 112 individuals who were supported through coordination, training, and financial assistance in their education by the AHEC program and who are still working in a rural or medically underserved practice setting. Included in this list are students in medicine, nursing, pharmacy, and a variety of other health professions. It is impossible, of course, to determine whether any or all of these health professionals' decisions to locate in rural Arizona are directly tied to the AHEC effort.

Are there cost-effective alternative methods of accomplishing the program's mission?

There may be other cost-effective means of continuing AHEC's rural health support services. Key elements of the program's mission such as clinical rotations and continuing medical education for professionals practicing in rural Arizona can be organized by individual college and university personnel. (Clinical rotations are the period of time in college and university students' medical education when they "rotate" out of the classroom setting into a clinical site such as a hospital to begin the work-experience portion of their training. Faculty monitor students' progress to be certain the educational objectives are being achieved.)

With limited funding in universities or colleges in FY 1996 and a delay in expectations that rural clinical rotations relative to Chapter 207, Laws of 1995, are required, it is assumed that the costs of coordinating and providing rotations will not be absorbed in the base budgets of the affected university or college for at least two years.

One alternative for accomplishing a part of the program's mission of delivering continuing medical education to remote parts of the State is expansion of the existing information technology system for "telemedicine." College and university courses are presently being delivered through satellite, microwave, and other data communication lines. Interactive television hookups can be utilized to a much greater extent for medical consultation and diagnosis in addition to the delivery of coursework through lecture and classroom activities. The cost of expansion is unknown, but equipment, maintenance, and line costs would be required.

The limited scope of this review did not permit an analysis of the private sector's level of effort toward recruiting and retaining qualified health care professionals in rural Arizona. However, this option should be pursued with the assumption that a joint public/private effort provides opportunity not only to those living in the rural part of the State but also to the providers.

**ARIZONA HEALTH EDUCATION CENTERS
STRATEGIC PLAN FY 1996 - FY 1998**

PROGRAM SUMMARY

PASS-THROUGH PROGRAM - AHEC A.R.S. § 15-1643
 Contact: Mary McKeown, Asst. Exec. Dir. 229-2520
 Donald E. Proulx, Assoc. Director, AzaAHEC 626-7946
 AzaAHEC BRA03.PRO

Program Mission: *To improve the development, recruitment, minority representation, distribution, and retention of health professional personnel in Arizona's rural and medically underserved communities. Through community and academic partnerships, Arizona's System of five (5) regional AHECs deliver educational programs and services which support the provision of primary health care in rural, remote-site, resource-poor, and medically underserved neighborhoods.*

Program Description: The Arizona Health Education Centers (AHECs) are administered through the Rural Health Office at the University of Arizona and are partially supported by state funds appropriated to ABOR for pass-through to the Rural Health Office. The system consists of five centers, which provide health care education to underserved areas of the state. In addition, the AHECs provide subsistence support for health professions students doing remote-site rural and medically underserved clinical education rotations. The AHECs initially were federally funded, and as the federal funds expire, support is assumed by the state.

Program Statutory Funding Formula: Not applicable.

Program Goals and Performance Measures:

◆ **Goal 1 -** To provide health professions educational programs that recruit rural, minority, and socioeconomically disadvantaged students and that encourage graduates to serve in Arizona's rural and medically underserved communities.

→ **Objective #1:** Provide health career programs that nurture the interests of rural, minority, and socioeconomically disadvantaged youth.

→ **Objective #2:** Develop rural and medically underserved community-based clinical education sites and support clinical education rotations for students in multiple health professional disciplines.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|--|----------------|------------------|------------------|------------------|
| Input | Career Education programs provided | 89 | 72 | 0 | 59 |
| Output | Youth served/participating in these programs | 10,962 | 13,881 | 0 | 8,225 |
| Outcome | Participants tracked into health professions education programs* | 48.4 | 86.7 | N/A | N/A |
| Output | Clinical Education rotations | 559 | 488 | 25 | 300 |
| Outcome | Graduates tracked to rural/underserved employment* | 47 | 61 | N/A | N/A |

◆ **Goal 2 -** To provide health professions continuing education programs and practice site educational support services that enhance the retention of health professionals serving in Arizona's rural and medically underserved communities.

→ **Objective #1:** Provide regular, remote-site, community-based continuing (medical) education programs and offer mini-sabbaticals to keep providers current in their practices and to assist them in meeting continuing credentialing requirements.

→ **Objective #2:** Provide remote-site library/medical information and learning resource services to support providers serving as preceptors and to support clinical students completing rotations in Arizona's rural and medically underserved practice sites.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|--------|--|----------------|------------------|------------------|------------------|
| Output | CE/CME Programs | 550 | 467 | 2 | 300 |
| Output | CE/CME Participants | 13,981 | 13,703 | 250 | 7,500 |
| Output | Mini-sabbatical participants | 105 | 71 | 0 | 40 |
| Output | Computer-supported medical information training partic's | 179 | 90 | 20 | 100 |
| Output | Interlibrary loan: requests received | 131 | 423 | 300 | 400 |
| | requested by AHEC | 269 | 109 | 0 | 100 |
| Output | Literature searches | 132 | 147 | 120 | 150 |

◆ **Goal 3 -** To provide health promotion and disease prevention community health education programs for people who live and work in Arizona's rural and medically underserved communities.

→ **Objective #1:** Complete annual community-based health education needs assessments by AHEC service region to identify priority issues for programming.

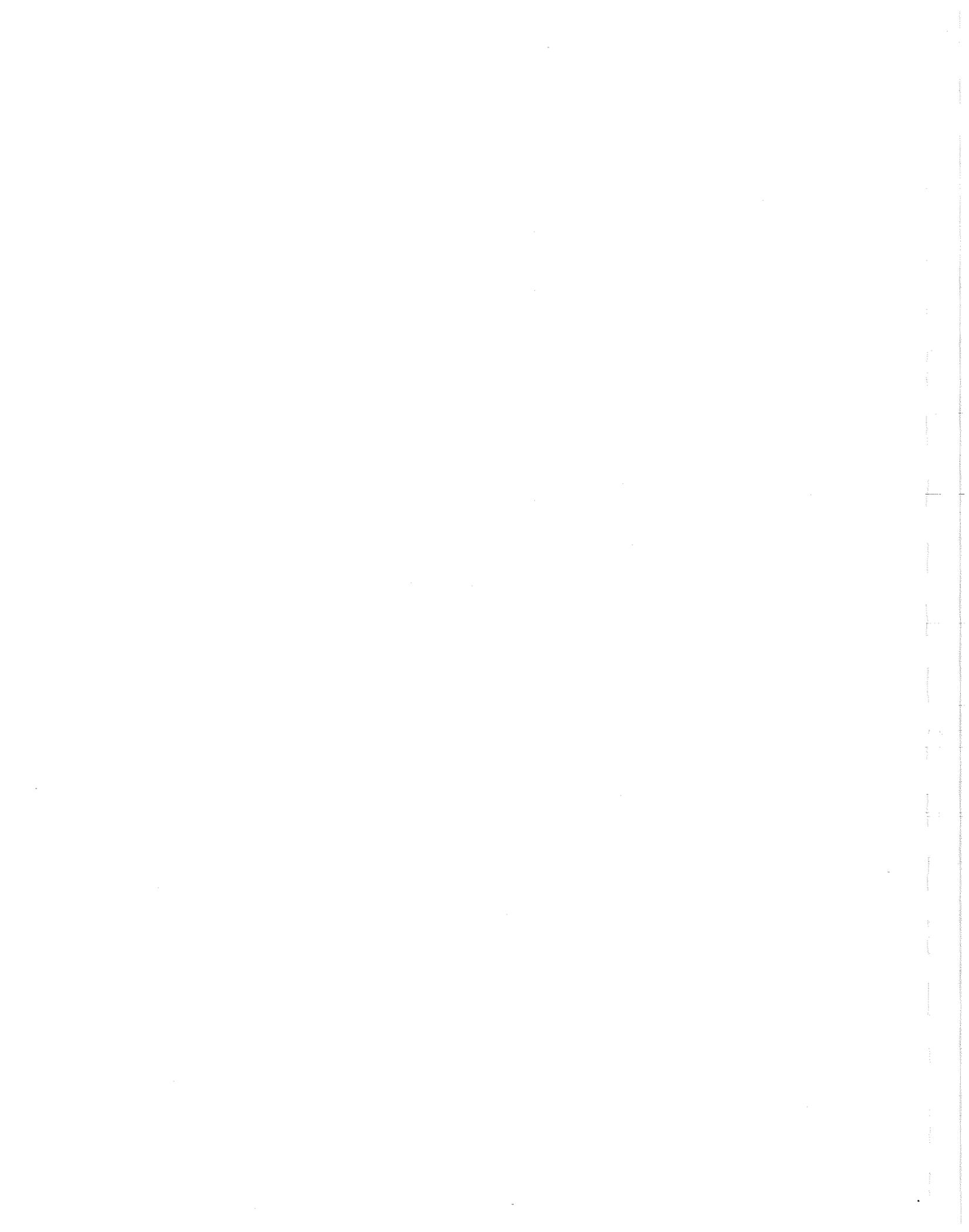
→ **Objective #2:** Design and provide community health education programs which are responsive and tailored to priority needs of communities.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|--------|-------------------------------------|----------------|------------------|------------------|------------------|
| Output | Community health education programs | 255 | 189 | 0 | 200 |
| Output | Community health education partic's | 14,262 | 21,670 | 0 | 12,000 |

Funding Source and FTE Amounts: (Thousands)

| Source | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
|----------------------|-------------------|---------------------|--------------------|
| General Fund | 1,150.2 | 0.0 | 1,900.0 |
| Federal Funds | 951.4 | 721.4 | 544.1 |
| Program Total | 2,101.6 | 721.4 | 2,444.1 |
| FTE Positions | 33.4 | 9.2 | 39.0 |

* Percent of return for those sample populations contacted through AzaAHEC follow-up tracking surveys.



AZAHEC PROGRAM COMMENTS ON THE JLBC/OSPB PAR ANALYSIS



Concerning the Overall Perspective:

AHEC is an education program. The AHEC Program provides support for and tracks youth (career education) into health professions programs and tracks health professions students (clinical education) into initial employment sites. These goals have clear program outcome measures, and the AzaAHEC System is currently engaged in a ten-year evaluation process, which includes a follow-up survey to all individuals who have been through an AHEC-supported experience. Specific outcome data referred to in the PAR Report are based on preliminary random sampling surveys. Results of those surveys indicate a trend which the program believes will be documented upon completion of the AzaAHEC Evaluation Report -- that the AHEC Program has influenced improvement in health care work force distribution in rural Arizona communities.

Much research would be needed to show that the AHEC educational experience is the dominant, or principal, factor over many other factors -- economic, social, cultural, political, familial, or spousal factors -- which influence the choices that students and graduates of health professions education programs make or to show how such choices impact health. The AHEC Program has never been funded to conduct this kind of sophisticated outcome research. Indeed, such findings may not be possible for any educational program, given the complex web of modern society.

Historically, public policy and social persuasion to fund education has been based upon the belief (philosophy) that education plays a significant role in contributing to the human experience, which expands options and influences choices. If the greater dissemination of health professions education into Arizona's rural and medically underserved communities through AHEC does not merit funding by the state, then funding of education itself is brought into question.

According to two National AHEC Program reviewers of the Arizona PAR Findings presented by the OSPB and JLBC, the Arizona AHEC is being held to a higher standard of outcome accountability, demanding direct and demonstrable correlations to the AHEC experience, than are other education programs and services funded in the health care field. This suggested to at least one of these reviewers that the findings and critiques in the Arizona PAR review may be related to funding decisions already made, as opposed to guiding funding decisions for the future. ¹

When one looks at the **exponential increase and presence of health professions education in Arizona's rural communities from 1985 through 1995, there is a singular new institutional resource which was sequentially developed and which matured in these communities over this same time period -- the Arizona AHECs.** It has been the AHEC which has linked urban-based resources to the needs of Arizona's rural and resource-poor neighborhoods. It has been AHEC which has expanded

¹ National AHEC Program reviews of Arizona's AHEC PAR Self-Assessment were provided by Virginia Fowkes of Stanford University and by Richard E. Schmidt of RSA, Ltd., both of whom have served as reviewers in the National AHEC Program's evaluation process. **The AzaAHEC Program requests that these be added to the list of appendices available to this PAR Report.**

opportunity, has strengthened communities through improved access to primary care services, and has stimulated the retention of remote-site practices and remote-site providers' options for continuing professional education to remain current in their practices. It has been AHEC which has provided the greater dissemination of higher education services in rural Arizona. AHEC has its identity apart from the urban higher education centers, yet serves as a bridge or pipeline between those centers and the communities it serves. It is truly a decentralized, community-based program in a very centralized and top-down world.

Concerning Universities Taking Up the Work of AHEC:

To believe that our urban-centered institutions of higher education (IHEs) can replace the role and function of AHECs, which live and work in the communities across Arizona, is to ignore the history and tradition of acadamia, the pedagogical behavior of our state-supported urban campuses, and the dynamics of higher education financing. If our state-supported IHEs are expected to carry out the outreach education that has been the hallmark of AHEC, one can be certain that they will require exceptional levels of support for staff, travel, capital investment, and other operating costs, many times over what it costs to continue an already well-established Arizona AHEC System. This system has served as the pivotal coordinator and conduit through which the IHEs have increasingly conducted their outreach education programs in the past decade, relying on the AHECs' assessment of local community needs and resources.

Representatives of these IHEs, as well as all other agencies in the state involved with health professions education and delivery of health care services, have served on the Boards of Directors of the individual AHECs and the statewide AzaAHEC Advisory Commission. It is unrealistic to expect that leaving individual schools to decide whether and what kind of outreach education programs to offer, without substantially more funding than the AHEC System requires, will result in anything other than a reversal of the results achieved in the past ten years of AHEC Program operation. Given the high degree of cooperation and coordination of IHEs with the AzaAHEC in the design and implementation of student training programs, Arizona had a well-coordinated and efficient system of outreach education programs for health professions students prior to July 1, 1995 -- when state funding for the AHEC was withdrawn. An objective observer might wonder why a state with a program as successful as Arizona's AHEC Program would choose to dismantle it and revert to a pre-AHEC condition in which the schools had individual responsibility for outreach education.

Concerning Telemedicine Overtures:

A belief that "telemedicine" and "distance learning telecommunications technologies" are the panacea for the greater dissemination of higher education into Arizona's rural communities overlooks the fact that not all learning/training can be addressed by "technology/distance learning delivery." Hands-on supervised skills training and practical evaluation are the imperatives of health professions education programs. Clinical supervision, precepting, and mentoring are now, and will continue to be, the necessary "warm body" instructional functions in health professions education. They will likely never fully be replaced by "telecommunications," or "telemedicine," at least not with the technology as we know it today. The question here is what can AHEC do in the foreseeable future to replace functions currently handled person-to-person, and what will

it cost? Regional coordinating centers for telecommunications are required to have on-site conveners, technical-support personnel, and program-specific instructional support personnel in order to function. Telecommunication is a proper role for AHEC and should be made part of the statewide AHEC Program, not separated and placed elsewhere.

Additional Findings Recommended:

Three initial primary PAR findings are suggested, based on the material presented --

"The Area Health Education Center program model is national in scope, currently found in nearly 40 states and representing some 25 years of experience. As such, the AHEC model has been subjected to multiple national evaluations, all of which have pointed to its success in addressing the AHEC mission. Similar success may be reasonably projected for Arizona, based on preliminary studies."

"AHEC is an educational response to a complex problem of health professional maldistribution, with inadequate representation in rural and other medically underserved areas. The key to AHEC success is a change in academic-community relationships, in which a partnership is established between the two for the purpose of altering the practice environment in such a way that students and practitioners will be more likely both to chose to go to and remain in medically underserved areas."

"The Arizona Area Health Education Center System (AzaAHEC) has, over the past ten years, successfully implemented multiple program interventions consistent with its purpose and has demonstrated these activities through detailed process evaluations. These activities have been extensive, both in number and in scope."

In addition, it is suggested that three final primary PAR conclusions be added --

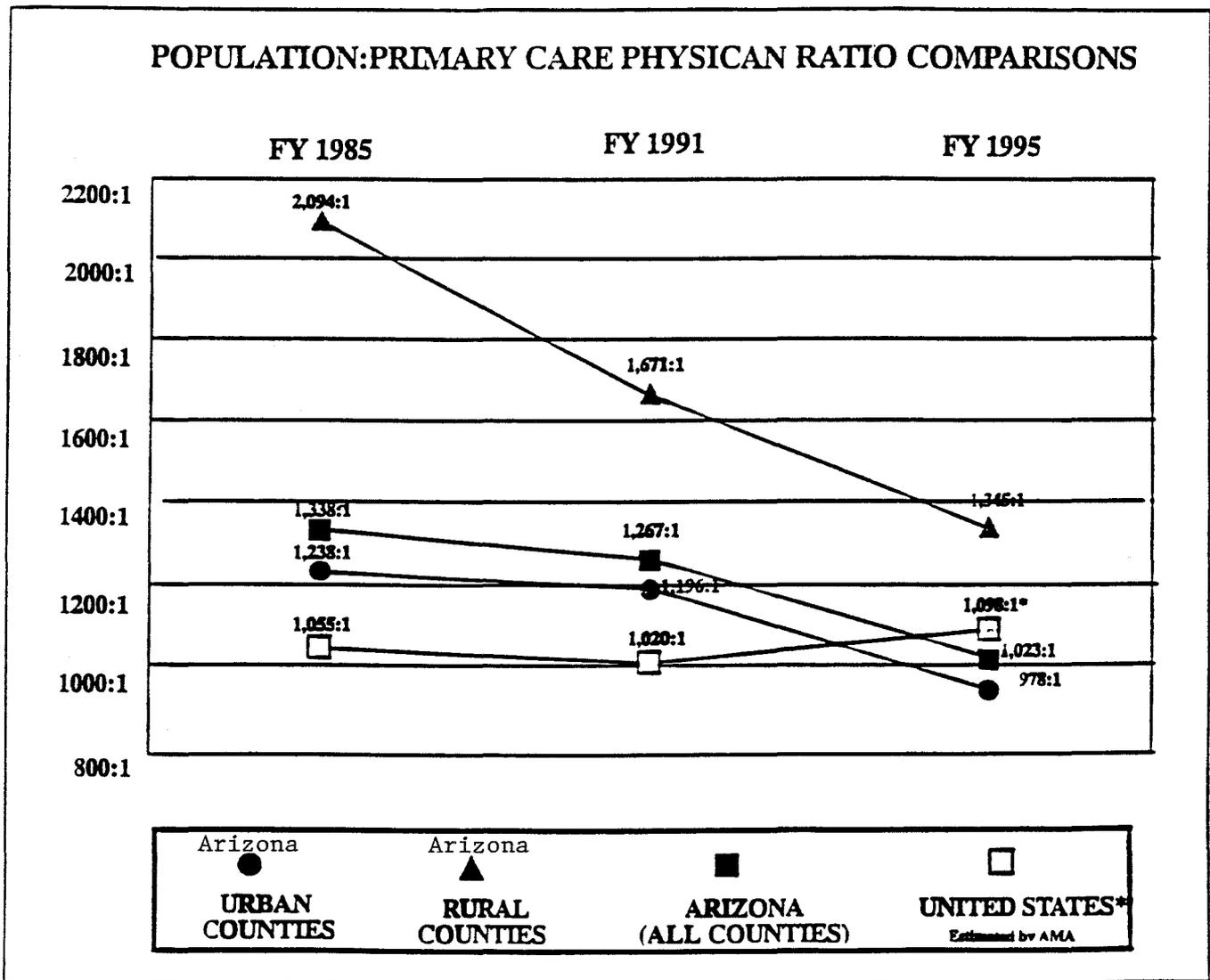
"While it would be ideal if the AHEC could conclusively prove its relative impact on health care professional distribution and on the improvement of health care outcomes, to expect it to do so would be to hold the AHEC to a higher standard of outcome evaluation than are other educational and service activities in the health care field. This would be both unreasonable and unrealistic."

"The AHEC is a relatively efficient program, employing a small staff to achieve substantial objectives and operates out of modest and inexpensive facilities. Administrative expenses are low compared to program expenses for other organizations of this type."

"AHEC is a locally based and directed program. AHEC Centers have their own board and staff structure and relate to the Program Office contractually. This often leads to variations in the program model, which can complicate evaluation, while reflecting responsiveness at the local level."

Concerning AzAHEC Program Impact:

The distribution of health care providers across the state is of primary concern to the AzAHEC System. The following table reflects, for the most part, a positive change in the population-to-primary care physician ratios (particularly in Arizona's rural counties), from FY 1985 to FY 1995. It should be noted that Arizona data compare favorably with U.S. data, as provided by the American Medical Association. As Arizona's ratio has been improving, figures for the nation have been worsening. While Arizona's improvements cannot solely be attributed to the efforts of the AzAHEC Program (which had its inception in late 1984, and focuses primarily on rural and other medically underserved areas), the AHECs believe they have played a significant role in supporting these outcomes over the past decade.



FY 1985
FY 1995

Arizona AHEC Program Begins
Arizona AHEC System Completes a Decade of Service

Findings of House Interim Rural Health Care Task Force:

We also wish to cite some of the findings related to AHEC contained in the Arizona House of Representatives Interim Rural Health Care Task Force Report, issued November 3, 1993, which strongly support a continuing state appropriation for Arizona's AHEC System:

"FINDING 2: The Arizona Area Health Education Center (AzaAHEC) has thus far pioneered the continuing education programs currently in existence in rural communities."

"The AzaAHEC Program serves as a bridge between Arizona's academic institutions and its health care communities. It creates, coordinates, and provides education in the health professions with an emphasis on primary care for rural, underserved, and culturally distinct populations of Arizona."

"In rural and medically underserved areas of Arizona, busy and isolated health providers have special needs for continuing education programs. The AzaAHECs meet these needs through a continuing education program for health professionals, as well as mini-sabbatical educational opportunities. In 1991-92, 658 programs, constituting over 2,600 hours of continuing education, were attended by 16,151 participating health professionals (this included many programs held in the urban areas)."

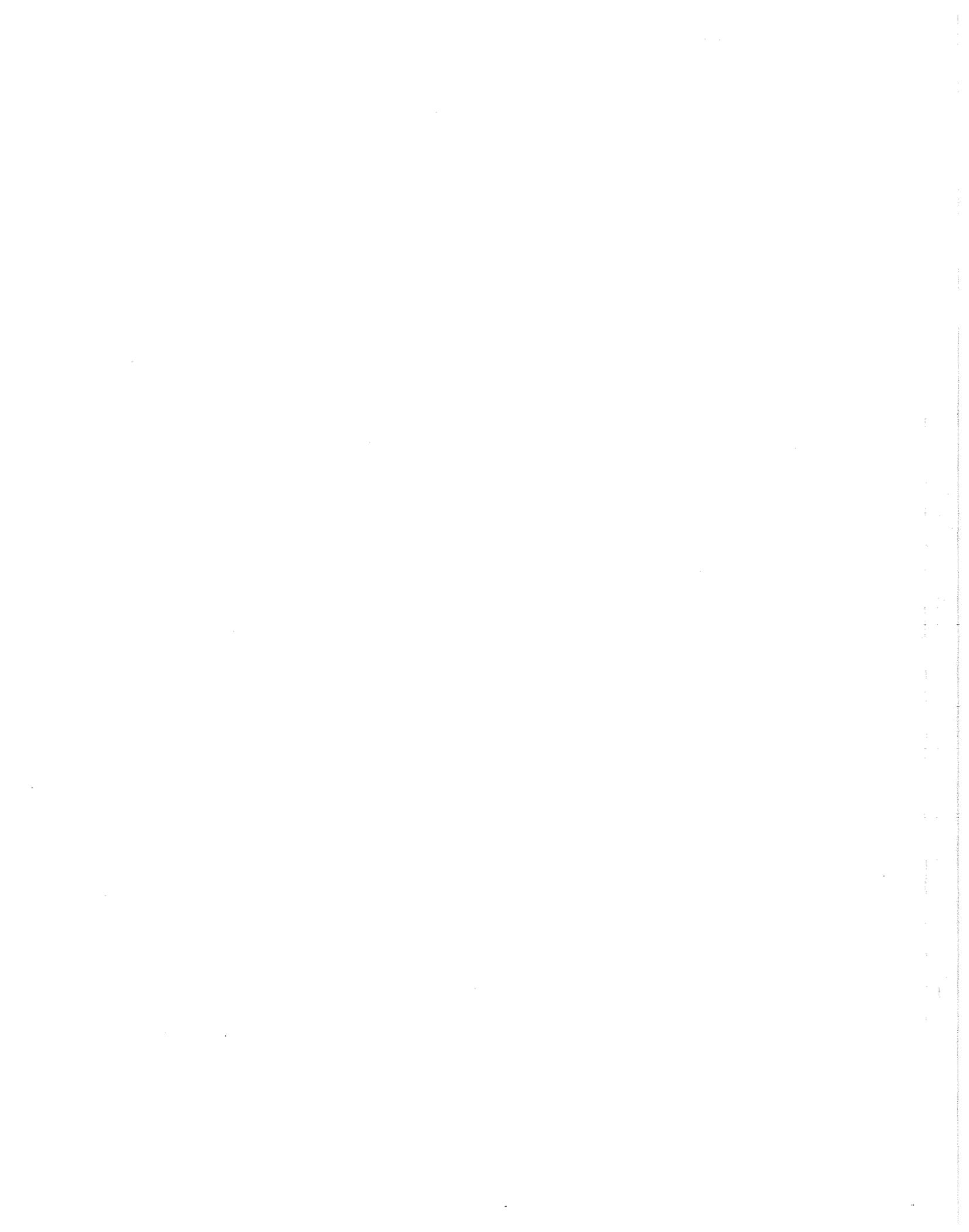
Recommendation: The Task Force acknowledges the need for not only continued financial support, but also the need for increased financial support as the federal funding elapses on each individual AHEC project in Arizona. The Task Force recommends that the AzaAHECs work closely with NAUnet in an effort to coordinate services in the rural communities."

"FINDING 7: The Arizona Area Health Education Centers (AzaAHEC) Program has been instrumental in health education and recruitment in all the rural communities visited by the Task Force."

"Rural communities utilize AzaAHEC's continuing education programs, recruitment programs, and education subsidy programs. The primary AzaAHEC programs being utilized by rural communities are: continuing education programs for health professionals; off-campus education for medical students, allied health students, pharmacy students, and nursing students; GRATEFUL MED (a system for computerized health information retrieval); health careers recruitment programs for youth from rural, minority, and socioeconomically disadvantaged communities."

"Since its federal designation in 1984, the AzaAHEC Program has received nearly \$20 million in federal support. Federal law stipulates that no individual center can be federally funded for more than six years."

Recommendation: The Task Force recommends that the Legislature continue to support the AzaAHEC programs which have provided a foundation for recruitment of young people into the health care fields for our rural and medically underserved communities."



MEDICAL MALPRACTICE PROGRAM
Arizona Department of Health Services
JLBC/OSPB -- Executive Summary

Overview - The Medical Malpractice Program (MMP) was established in 1989 in response to two problems: 1) rising medical malpractice insurance premiums made it difficult for obstetrical service providers to continue their practice and 2) many rural Arizona communities are within designated medically underserved or unserved areas. After reviewing the MMP's performance in addressing these problems, the following conclusion was reached:

- While the MMP has awarded malpractice insurance premium subsidies in accordance with State law, the MMP has had little, if any, impact on retaining or recruiting obstetrical service providers to rural communities. Furthermore, the need for subsidizing malpractice insurance premiums no longer exists.

In general, the MMP Program Authorization Review (PAR) Self-Assessment complied with the general guidelines concerning completeness, clarity, adequacy and accuracy.

Program Description -- The MMP provides medical malpractice subsidies to physicians, mid-level providers and medical clinics that offer obstetrical services in medically underserved communities. Per legislation, a community's eligibility and priority for the program is determined by 1) the availability of obstetrical services based on a population to provider ratio; 2) the area's geographic accessibility to obstetrical services; and 3) the percentage of the area's population that is at or below a designated Federal poverty level. Obstetrical service providers who receive the subsidy agree to practice in a qualifying underserved community for the period of the contract year.

Funding for the MMP is divided between two different subsidy grants: subsidy grants for individual providers (physicians and mid-wives) and subsidy grants for community health clinics. Since the program's inception, 60 different physicians have received subsidy contracts. Prior to FY 1996, the average number of contracts entered into each year was 25. However, because of recent funding cuts, the Department will contract with only 17 physicians in FY 1996.

In addition to the physician contracts, six different clinics have participated in the program. In FY 1996, the Department has contracted with five of these six clinics. The one clinic not receiving a contract in FY 1996 is receiving malpractice coverage through the Federally Supported Health Centers Assistance Act. The Department expects that in the future, the other clinics will be covered by this Federal program and will no longer need the State's assistance for malpractice insurance.

In the six years since the MMP began, there have been three major changes that affect the program's effectiveness in retaining and recruiting obstetrical service providers. First, medical malpractice insurance premiums have dropped substantially. Second, all of the health clinics receiving assistance from the MMP are eligible to apply for malpractice insurance coverage through the Federally Supported Health Centers Assistance Act. Third, the Legislature has passed other legislation associated with two related programs: the Medical Student Loan Program and the Medical Loan Repayment Program. These programs provide financial incentives to physicians willing to practice in underserved areas that are several times the amount available through the MMP.

How does the program mission fit within the Agency's overall mission and the program's enabling authority?

The MMP's mission, as currently defined, is consistent with the program's enabling legislation and the Department's overall mission to improve the delivery of health services. The Department has defined the MMP's mission as "to provide medical malpractice subsidies to enhance the ability of unserved and underserved communities to attract and/or retain needed obstetrical service providers." While the MMP's mission statement is narrowly written to stay within the enabling legislation's parameters, the Department has established goals and objectives to eliminate medical malpractice insurance premium subsidies within three years.

The Department has suggested that an alternative method to increase the number of obstetrical services providers in rural communities would be to redirect the MMP's current resources into a new program. The new program would provide communities with a two to three year grant to attract an obstetrical service provider to their community. The Department's proposal would require additional legislation and would change the MMP's current mission to focus more on the problem of addressing the needs of underserved, rural communities, rather than the current focus of providing medical malpractice insurance premium subsidies.

Do the historical performance measurements and the future performance targets adequately measure goals?

It is difficult to determine the program's success in increasing the availability of obstetrical services in underserved, rural communities because historical data has never been compiled. The MMP's enabling legislation set forth some of the measures for the program and required that the participating providers submit reports on these measures. These measures include the annual number of patients seen by each provider and the average annual number of prenatal visits per provider. While the Department has received these reports since the program's beginning, the Department has not compiled or analyzed the data. Therefore, past performance and future targets have not been supplied for these measures.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

There is no direct evidence that the MMP actually attracts or retains obstetrical service providers to underserved areas. The following items suggest that the program has had no discernible impact on recruiting and little impact on retaining obstetrical providers to rural areas.

- 1) A \$5,000 to \$10,000 medical malpractice insurance premium subsidy is an insufficient amount to recruit new physicians to a rural area. Information obtained from the Board of Medical Examiners and the Board of Osteopathic Examiners (for 56 of the 60 physicians participating in the program) found that none of the 56 physicians received a subsidy in the first year they were licensed to practice in Arizona. Furthermore, over 73% of the 56 physicians were licensed prior to 1989 (the year the legislation was passed). This data suggests that the program has not attracted new physicians to rural communities. Rather, it has focused on retaining already established physicians in the area.

- 2) Eliminating the subsidy would not affect most physicians' decisions to continue to offer obstetrical services. Ninety-four percent of the program's former participants, who no longer receive the subsidy and who currently practice in Arizona, continue to provide obstetrical services in rural communities.

There is no benchmarking data with which to compare the MMP's performance. The Department's review found only six other States that have a similar program to the MMP. Two of the six States recently eliminated funding for their program and none of the States have performed program evaluations. Additionally, there are no other State programs that provide the exact same service as the MMP. However, the Arizona Medical Student Loan Program (AMSLP) and the Medical Loan Repayment Program (MLRP) provide financial incentives to recruit physicians to medically underserved communities. The financial assistance available from these programs is several times that available from the MMP. (Note: The AMSLP and MLRP are also currently under PAR review.)

Are there other cost-effective alternative methods of accomplishing the program's mission?

There may be other more effective ways to retain or recruit obstetrical service providers to rural areas. Alternatives to the MMP include offering salary subsidies to physicians and other health professionals providing obstetrical services in medically underserved areas, and/or providing underserved communities with funding to recruit their own obstetrical service providers. In their PAR Self-Assessment, the Department proposed the latter. At this point, there is no evidence that these alternatives would be more effective than the MMP nor do these alternatives address the critical social issues that affect an underserved community's ability to attract medical professionals. These issues include fewer spousal employment opportunities, limited access to housing, smaller school systems, limited access to cultural and commercial facilities, difficulty in traveling and general isolations.

**MEDICAL MALPRACTICE/OBSTETRICAL SERVICES
STRATEGIC PLAN FY 1996 - FY 1998**

SUBPROGRAM SUMMARY

Medical Malpractice/Obstetrical Services (SLI)

A.R.S. § 36-132

Contact: Rick Weber, Manager 542-1870

Medical and Public Health Services, CFHS HSA0808.SUB

Subprogram Mission: *To provide medical malpractice insurance premium subsidy to enhance the abilities of unserved and underserved rural areas to attract and/or retain needed obstetric service providers.*

Subprogram Description: The subprogram provides medical malpractice subsidies to physicians and medical clinics that offer obstetric service in the rural areas of Arizona. Per legislation, priority is given to those areas where: a) 50 percent or more of resident live births occur outside the area of residence; b) obstetrical services are threatened with discontinuance; c) obstetrical backup services are unavailable; d) the number of prenatal visits are less than the state average and the population is less than 10,000 people.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ Goal 1 - To maintain the service delivery level of OB providers in rural areas, while reducing dependency on malpractice awards.

→Objective #1a: Solicit and award up to 25 contracts to physicians for medical malpractice insurance subsidy in FY 1996.

→Objective #1b: Solicit and award up to 15 contracts to physicians for medical malpractice insurance subsidy in FY 1997.

→Objective #1c: Solicit and award up to 5 contracts to physicians for medical malpractice insurance subsidy in FY 1998.

→Objective #2a: Maintain the number of OB providers in any rural community/catchment area. (In 1990 there were 94)

→Objective #2b: Maintain the number of OB providers in any rural community/catchment area. (Baseline 1996: n/a)

→Objective #2c: Maintain the number of OB providers in any rural community/catchment area.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|--|----------------|------------------|------------------|------------------|
| Output | Contracts awarded each year | 33 | 34 | 25 | 15 |
| Outcome | Percent of annual change in OB providers by community area | N/A | N/A | N/A | N/A |
| Outcome | Average prenatal visits per physician annually | N/A | N/A | N/A | N/A |
| Outcome | Patients seen by each physician annually | N/A | N/A | N/A | N/A |

◆ Goal 2 - To improve availability of OB services in unserved and underserved areas.

→Objective #1a: Reduce the number of community clinics applying for the program by two in FY 1996.

→Objective #1b: Reduce the number of community clinics applying for the program by two in FY 1997.

→Objective #1c: Reduce the number of community clinics applying for the program by one in FY 1998.

→Objective #2a: Decrease the number of unserved/underserved communities by one in FY 1997.

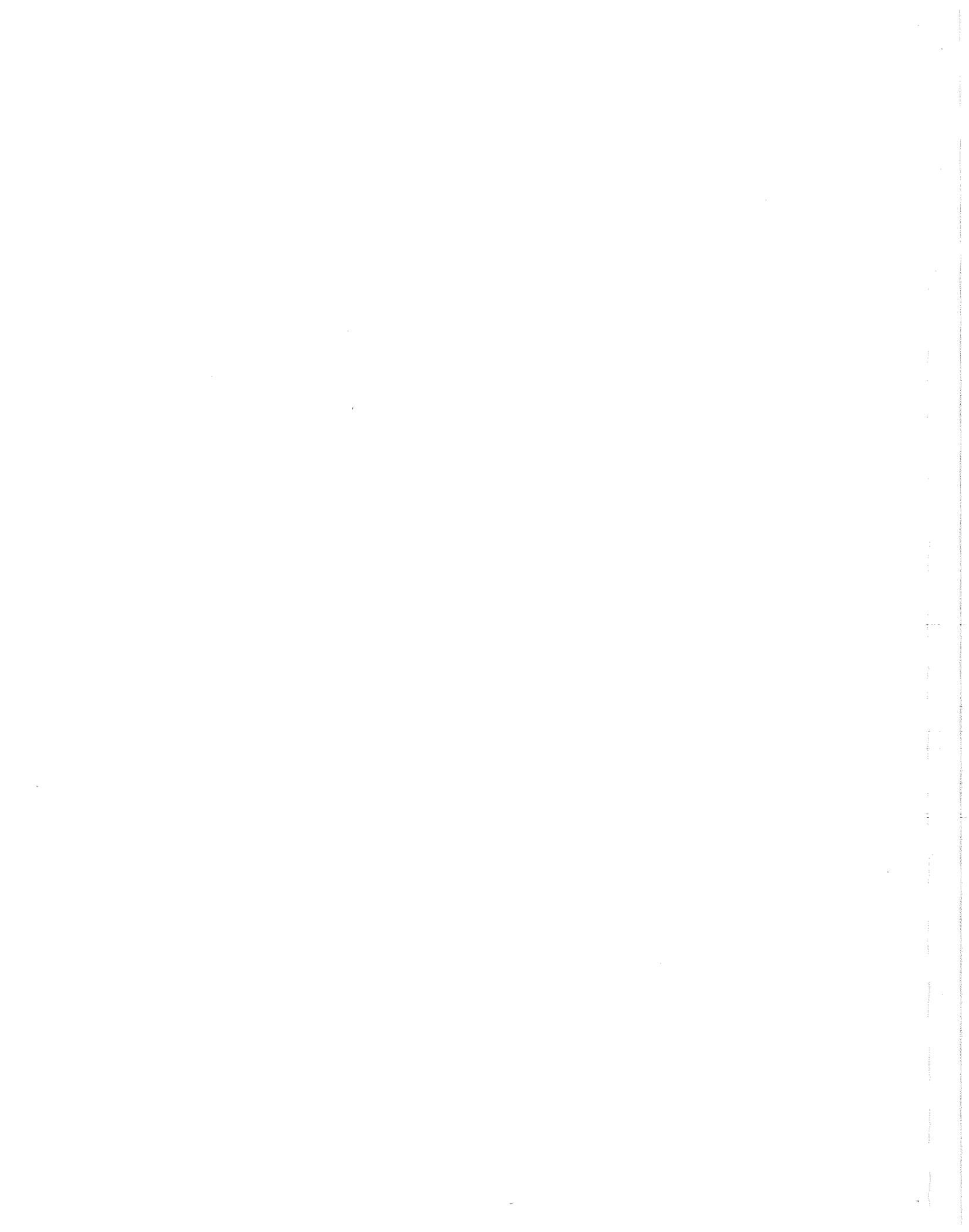
→Objective #2b: Decrease the number of unserved/underserved communities by an additional one in FY 1999.

→Objective #3a: Increase the ratio of provider/childbearing women (ages 15-44) in rural and unserved/underserved areas by at least 10% each year.

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|---|----------------|------------------|------------------|------------------|
| Outcome | Clinic contracts in place each year | 5 | 5 | 3 | 1 |
| Outcome | Average prenatal visits recorded by each clinic under contract annually | N/A | N/A | N/A | N/A |
| Outcome | Patients seen by each clinic annually | N/A | N/A | N/A | N/A |
| Outcome | Communities adding OB service | 4 | 0 | 0 | 1 |
| Outcome | Ratio increases in communities that receive subsidy contracts | N/A | N/A | +10% | +10% |

Funding Source and FTE Amounts: (Thousands)

| Source | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
|--|-------------------|---------------------|--------------------|
| General Fund | 395.0 | 395.0 | 395.0 |
| General Fund Non-reverting/ FY 1991 Medical Malpractice | 2.9 | 0.0 | 0.0 |
| Subprogram Total | 397.9 | 395.0 | 395.0 |
| FTE Positions | 0.0 | 0.0 | 0.0 |



PRIMARY CARE PROGRAM
Department of Health Services
JLBC/OSPB Executive Summary

Overview - The Primary Care Program (PCP) identifies underserved communities and is involved with plans to increase the number of services in those areas. Recently, the Department has restructured the program to encompass their new responsibilities under the Tobacco Tax legislation. However, for the purposes of the Program Authorization Review, the JLBC/OSPB team focused on the program as originally conceived. After reviewing the program, we have concluded the following:

- The program provides useful consulting services to underserved areas, services which are similar to those provided by the Rural Health Office at the University of Arizona.
- The program's mission and goals have changed dramatically as a result of receiving \$10 million in Tobacco Tax monies to distribute to underserved areas.

In general, the PCP's self-assessment was timely and thorough.

Program Description - The PCP was established in 1986 through a Federal grant from the Bureau of Primary Health Care. Initially, the Federal government placed the program at the Rural Health Office at the University of Arizona. Later, at the urging of the Federal government, the program was moved to the Department of Health Services. The PCP updates Federal Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) designations. (Please see the Rural Health Program Authorization Review Executive Summary for further discussion of these standards.) The PCP also updates reports on the health status of each of the 102 primary care areas in the State and ranks those areas according to their level of medical underservice. In addition, the PCP monitors the implementation of the State primary care plan, provides technical assistance to underserved communities, and administers the J-1 Visa Program, a program which places foreign physicians in underserved areas.

On November 8, 1994, voters approved Proposition 200, which increased the State tax on tobacco products. Revenue from the tax is to be distributed to fund services for the medically needy, to educate the public about the dangers of tobacco use, and to conduct research into the prevention and treatment of tobacco-related diseases. Of the estimated \$96 million in total FY 1996 Tobacco Tax revenues, the PCP will receive \$10 million to distribute to community health centers and to health care practitioners to fund medical services provided to those in underserved areas. In addition to the \$10 million in Tobacco Tax monies, the program will also receive an additional \$182,000 in Federal dollars and \$42,000 in grant dollars in FY 1996.

How does the mission fit within the Agency's overall mission and the program's enabling authority?

The program's mission and goals have changed dramatically as a result of receiving \$10 million in Tobacco Tax monies to distribute to underserved areas. In the 1995 Master List of State Government Programs, the PCP lists its mission to be identifying underserved communities and implementing plans to increase the amount of services provided in those areas. Since receiving the \$10 million in Tobacco Tax monies, the PCP's mission has become much broader. The PCP's new mission

is to increase the availability of and access to primary care services for Arizonans. This new mission appears to further the Department's mission, which includes both assessing the health status of Arizonans and improving that health status through the delivery of services. Since the PCP will continue to perform planning and assessment tasks, its strategic plan should continue to reference those activities as well.

Do the historical performance measurements and the future performance targets adequately measure goals?

Overall, the PCP has selected measures that effectively assess its progress in meeting its stated planning, assessment, and placement goals, though it should add a measure assessing the percentage of local communities satisfied with the program's planning activities. However, now that the PCP has \$10 million dollars in Tobacco Tax revenues to increase the amount of services provided to underserved communities, it should add some measures that assess the general availability of services in Arizona, such as the percentage of Arizonans with geographic access to health care (within a 30 minute drive of a practitioner), the percentage of rural primary care sustainable positions filled, and the number of primary care areas in the State moving below the cutoff score designating underserved areas.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

The program provides useful consulting services to underserved areas, services which are similar to those provided by the Rural Health Office at the University of Arizona. The PCP and the Rural Health Office both provide technical assistance to communities (i.e., draw up contracts with potential practitioners, determine whether the patient population can support a practitioner, etc.) to help them recruit practitioners and assist those communities in their efforts to retain existing practitioners.

The information contained in the primary care area reports is useful. The primary care area reports contain valuable information (# of beds per thousand residents, travel time to nearest practitioner, population to practitioner ratios, etc.) about each of the primary care areas in the State. The large number of data sets contained in these reports has allowed the State to develop an index of underservice that is much broader in scope than the Federal government's HPSA, MUA, or Medically Underserved Population indexes.

Measuring the efficiency or effectiveness of the other PCP activities such as developing linkages between organizations and monitoring the Primary Care Plan and the Primary Care Cooperative Agreement is difficult because the results of these activities are not easy to quantify.

Are there other cost-effective methods of accomplishing the program's mission?

Until the PCP decides which programs will receive Tobacco Tax dollars and reviews the results of those programs, it will not be possible to assess whether or not there are other cost-effective methods of accomplishing the program's mission to increase the accessibility and availability of services.

In terms of the PCP's other activities, the terms of its Federal grant require it to perform certain planning and assessment functions. (Those functions vary from state to state.) Not performing those functions or contracting all of those functions out would result in the loss of those Federal dollars.

PRIMARY HEALTH CARE
STRATEGIC PLAN FY 1996 - FY 1998

SUBPROGRAM SUMMARY

Primary Health Care A.R.S. §§ 6-2351, 15-1721
 Contact: Tracy Kirkman-Liff 542-1216
 Medical and Public Health Services, PHPES HSA2102.SUB

Subprogram Mission: *To improve the availability of and access to basic health care services for people in medically underserved areas of Arizona.*

Subprogram Description: The subprogram develops a statewide primary health care access plan; maintains an index which identifies state-designated medically underserved areas; submits documentation for federal designation of medically underserved and Health Professional Shortage Areas (HPSAs); develops community-based plans and strategies to address needs for primary health care providers and services; coordinates with state and federal agencies involved in improving primary health care delivery systems and access to services.

Subprogram Statutory Funding Formula: Not applicable.

Subprogram Goals and Performance Measures:

◆ **Goal 1 -** To ensure that communities can qualify for federal and state programs through designation as a federal Health Provider Shortage Area (HPSA) or a state medically underserved area (MUA).

→Objective 1: By January 31st of every year ensure that all HPSAs and MUAs are qualified for appropriate programs.

| Type | Performance Measures | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|---------|---|---------|----------|----------|----------|
| | | Actual | Expected | Expected | Expected |
| Outcome | State MUAs qualified for new designations | N/A | N/A | 28 | N/A |
| Outcome | State MUAs qualified as renewals | N/A | N/A | N/A | N/A |
| Outcome | HPSAs qualified for new designations | N/A | 44 | N/A | N/A |
| Outcome | HPSAs qualified as renewals | N/A | N/A | N/A | N/A |
| Outcome | Federally funded Community Health Centers established | N/A | N/A | N/A | N/A |

◆ **Goal 2 -** To develop the skills of community groups so they can maintain and improve the local availability of and access to basic health services.

→Objective #1a: By 3/31/96, establish a skills-based training program to present to community groups. (Skills could include group facilitation and consensus-building, community needs assessment, strategic planning, grant writing, developing a local recruitment/retention program, etc.)

→Objective #1b: By 3/31/97, conduct on-site training in two locations.

→Objective #1c: By 3/31/97, conduct on-site training in two new locations.

| Type | Performance Measures | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|---------|--|---------|----------|----------|----------|
| | | Actual | Expected | Expected | Expected |
| Outcome | Primary Care needs assessment | | | | |
| | groups formed | N/A | N/A | N/A | N/A |
| Outcome | Communities trained | N/A | N/A | N/A | 2 |
| Outcome | Physicians recruited as a result of training | N/A | N/A | N/A | N/A |

◆ **Goal 3 -** To maintain or increase the number of primary care providers placed through federal or state programs of underserved areas and or medically indigent people in the state.

→Objective #1a: By 3/31/96, sponsor at least 5 physicians requesting J1 Visa waivers from the United States Information Agency (USIA).

→Objective #1b: By 3/31/97, sponsor at least 8 physicians requesting J1 Visa waivers.

→Objective #1c: By 3/31/98, sponsor at least 10 physicians requesting J1 Visa waivers.

| Type | Performance Measures | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|---------|---|---------|----------|----------|----------|
| | | Actual | Expected | Expected | Expected |
| Outcome | Additional patients seen due to H1 physician placed | N/A | N/A | N/A | N/A |
| Outcome | Additional patients seen due to DHS recruitment program | N/A | N/A | N/A | N/A |
| Outcome | HPSA Primary Care physicians getting Medicare bonus | N/A | N/A | N/A | N/A |

◆ **Goal 4 -** To improve the retention of primary care providers in underserved areas of the state.

→Objective #1a: By 3/31/96, develop an ADHS provider retention plan that addresses the stated needs of service-obligated providers in underserved areas of the state.

→Objective #1b: By 3/31/97, retain 30 percent of the providers in underserved areas for at least one year past obligation.

→Objective #1c: By 3/31/97, retain 40 percent of the providers in underserved areas for at least one year past obligation.

**PRIMARY HEALTH CARE
STRATEGIC PLAN FY 1996 - FY 1998**

| <u>Type</u> | <u>Performance Measures</u> | <u>FY 1994 Actual</u> | <u>FY 1995 Expected</u> | <u>FY 1996 Expected</u> | <u>FY 1997 Expected</u> |
|-------------|--|---------------------------|-----------------------------|-----------------------------|-----------------------------|
| Outcome | Estimated savings from retention recruitment efforts | N/A | N/A | N/A | N/A |
| Outcome | Percent of providers retained | N/A | N/A | N/A | N/A |

◆ Goal 5 - To define, plan, and implement Tobacco Tax programs in accordance with the statutes.

→Objective #1: To increase the number of low income uninsured state residents who are served by comprehensive community-based primary care providers.

| <u>Type</u> | <u>Performance Measures</u> | <u>FY 1994 Actual</u> | <u>FY 1995 Expected</u> | <u>FY 1996 Expected</u> | <u>FY 1997 Expected</u> |
|-------------|---|---------------------------|-----------------------------|-----------------------------|-----------------------------|
| | To be established when programs are defined | | | | |

Funding Source and FTE Amounts: (Thousands)

| <u>Source</u> | <u>FY 1995 \$ Actual</u> | <u>FY 1996 \$ Estimate</u> | <u>FY 1997 \$ Request</u> |
|------------------------------|------------------------------|--------------------------------|-------------------------------|
| Other Non-appropriated Funds | 76.2 | 0.0 | 0.0 |
| Federal Funds | <u>155.4</u> | <u>20.0</u> | <u>20.0</u> |
| Subprogram Total | <u>231.6</u> | <u>20.0</u> | <u>20.0</u> |
| FTE Positions | <u>2.0</u> | <u>0.0</u> | <u>0.0</u> |

ARIZONA LOAN REPAYMENT PROGRAM
Department of Health Services
JLBC/OSPB Executive Summary

Overview - The mission of the Arizona Loan Repayment Program (ALRP) is to increase the availability of primary care services by providing incentives for primary care health professionals to locate and serve in communities with a critical shortage of health professionals. After reviewing the program, we have concluded the following:

- It is too early to determine whether the program is effective in placing practitioners in rural as opposed to urban areas.
- The program could be more efficiently operated—17% of its overall funding and 24% of its State funding cover personnel and administration costs.

In general, the ALRP's self-assessment was timely and thorough.

Program Description - The House Interim Rural Health Task Force released a report in November 1993 containing recommendations to improve the availability of health care services in rural areas in the State. One of the Task Force's recommendations was to establish a loan repayment program to attract health care practitioners to rural areas. The lack of practitioners in these rural areas can be attributed to several factors: professional isolation, the lack of cultural activities, the lack of employment opportunities for spouses of practitioners, and the lower salaries offered by clinics. In direct response to the Task Force's recommendation, in 1994 the Legislature appropriated \$132,000 (\$100,000 for loan repayment; \$32,000 for administration costs) to create the ALRP to recruit and retain practitioners in underserved (both rural and urban) areas in the State. The program also receives \$100,000 in Federal matching funds. The program is directed by statute to prioritize rural areas over urban areas when placing practitioners.

Practitioners who receive awards must commit to serve a minimum of two years in underserved areas. Physicians can receive a maximum of \$20,000 in loan repayment monies during their first and second year of the program; a maximum of \$22,500 in their third year; and a maximum of \$25,000 in their fourth year. Physician assistants and nurse practitioners can receive a maximum of \$7,500 in loan repayment dollars each year. Eligible service sites include public or private non-profit clinics providing primary care services in Health Professional Shortage Areas (HPSAs). These entities must accept Medicare and AHCCCS beneficiaries and offer a sliding-fee scale based on a patient's ability to pay.

How does the mission fit within the Agency's overall mission and the program's enabling authority?

The program aims to increase the availability of primary care services by providing incentives for health care practitioners to serve in communities that lack practitioners. This program appears to further the Department's mission, which includes assuring the physical health of all Arizonans through the delivery of services. The enabling authority of the program and its mission essentially correspond.

Do the historical performance measurements and the future performance targets adequately measure goals?

Overall, the Department has selected relevant measurements such as the number of practitioners placed and relevant targets such as increasing the percentage of practitioners placed in rural areas. The Department could streamline its existing measures and add others (i.e., the percentage of practitioners that stay in underserved areas after their commitment has ended) that provide useful information regarding the value of the program.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

The program could be more efficiently operated—17% of its overall funding and 24% of its State funding cover personnel and administration costs. It is unclear that the program needs the approximate \$40,800 currently associated with placing 9 practitioners annually in underserved areas.

It is too early to determine whether the program is effective in placing practitioners in rural as opposed to urban areas. The statutes state that the Department should give priority to applicants who intend to practice in rural areas. The Department did set aside 84% of the ALRP's funding for awards in rural areas in the first two award cycles; however, in the program's first year (FY 1995), it was forced to award three of the first seven loan repayment slots to urban areas because it did not receive enough applications during the first two award cycles from practitioners willing to practice in rural areas. Two slots remain unfilled at this time.

Are there other cost-effective methods of accomplishing the program's mission?

The Arizona Medical Student Loans Program also offers to defray the cost of a medical school education for a student in exchange for a commitment to serve in an underserved area. This program currently does not require separate administrative dollars to administer, and the scholarships are not subject to taxation. However, practitioners must wait four to seven years before they begin service, during which time their interest in practicing medicine in an underserved area may waiver.

Since the ALRP functions as an income subsidy for practitioners, another service delivery option would be to provide direct income subsidies to all practitioners (not just those with loans) willing to practice in underserved areas. Alternatively, the dollars could be used to fund loan repayment awards for practitioners working in a private for-profit practice setting, since many HPSAs do not have non-profit clinics located in their communities. (The statutes require that providers be placed in non-profit settings.) Other options include guaranteeing reimbursement to individuals who practice a day or two a week in underserved areas or creating a low-interest loan pool that communities could apply for and use to purchase capital items that would attract practitioners.

None of these programs, however, would be eligible for the one to one Federal matching dollars that the ALRP receives.

**LOAN REPAYMENT PROGRAM
STRATEGIC PLAN FY 1996 - FY 1998**

| Type | Performance Measures | FY 1994 Actual | FY 1995 Expected | FY 1996 Expected | FY 1997 Expected |
|---------|--|-------------------|---------------------|---------------------|---------------------|
| Input | Percent of contracts in remote and rural HPSAs | N/A | 77 | 77 | 77 |
| Output | Percent of rural applicants that receive contracts | N/A | 100 | 100 | 100 |
| Output | Funds encumbered for rural contracts | N/A | 64,696 | 160,000 | 422,560 |
| Outcome | Patient encounters by rural physicians | N/A | 10,000 | 26,500 | 42,400 |
| Outcome | Patient encounters by rural mid-level providers | N/A | 4,240 | 8,480 | 8,480 |

Funding Source and FTE Amounts: (Thousands)

| Source | FY 1995 \$ Actual | FY 1996 \$ Estimate | FY 1997 \$ Request |
|---------------|----------------------|------------------------|-----------------------|
| General Fund | <u>132.0</u> | <u>132.0</u> | <u>132.0</u> |
| FTE Positions | <u>0.0</u> | <u>0.0</u> | <u>0.0</u> |



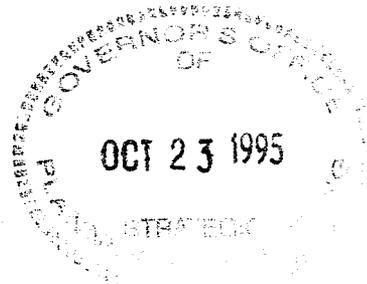
Office of the Director

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Phoenix, Arizona 85007-2670
(602)542-1025
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FIFE SYMINGTON, GOVERNOR
JACK DILLENBERG, D.D.S., M.P.H., DIRECTOR

October 23, 1995

Mr. Ted Ferris
Director, JLBC
1716 West Adams
Phoenix, Arizona 85007



Dear Mr. Ferris: *TBD*

As requested, JLBC/OSPB final comments on the Department of Health Services' executive summary and the three PAR'd reports, Medical Malpractice, Primary Care, and Arizona Loan Repayment, have been reviewed.

Thank you for allowing the agency to review and comment on these documents. We have attached our final comments for inclusion in the published report (on page DHS-13).

We appreciate the opportunity to work with the JLBC and OSPB staff on the rural health PARs.

If there are any questions, please contact Rebecka Derr, 542-1269.

Sincerely,

A handwritten signature in black ink, appearing to read "Jack Dillenberg".

Jack Dillenberg, D.D.S., M.P.H.
Director

Attachment

cc: Dr. Larry Platt, Associate Director, Public Health
Claudette Frederickson, Associate Director, Business & Financial Services
Michael Kearns, Assistant Director, Strategic Planning & Budget Office
Rebecka Derr, Manager, Strategic Planning
Jane Pearson, Assistant Director, Community & Family Health
Phil Lopes, Chief, Health Systems Development

Medical Malpractice Program--Executive Summary:

- 1) "In their PAR Self-Assessment, the Department proposed (providing underserved communities with funding to recruit their own obstetrical service providers). At this point, there is no evidence that (this alternative) would be more effective than the MMP nor (does this address) the critical social issues that affect an underserved community's ability to attract medical professionals. These issues include fewer spousal employment opportunities, limited access to housing, smaller school systems, limited access to cultural and commercial facilities, difficulty in traveling and general isolations (sic)."
(page DHS-3)
 - a) It is true that there is no evidence that the agency's suggested change in the implementation of the program will be more effective than the current method of distributing funding. However, without trying this alternative approach, no concrete evidence will ever be obtained.
 - b) The scope and authority of the program *does not* include addressing any critical social issues.

Medical Malpractice Program--Funding Commentary:

- 2) "In both the FY 1992 and FY 1993 General Appropriation Acts, the Legislature appropriated \$195,000 for Rural Obstetrical Services and \$205,000 for Medical Malpractice/Obstetrical Medical Services. In their PAR Self-Assessment, the Department states that the funding was divided equally, with \$200,000 for each program. However, Table 1 shows the appropriations as reported by GAO and JLBC." (page 7b)

The Agency would like to point out that despite the JLBC appropriations reports for FY 1992 and FY 1993, DHS was *following the original intent of the 1990 law*.

Medical Malpractice Program--Performance Measure Commentary:

- 3) "The Department stated that the ratio of providers for women of childbearing age should improve in the communities that receive the grant awards. However, the Department did not provide any information about what is an adequate ratio of providers to women."
(page 11b)

Although DHS agrees that the requested ratio and other performance measures would more accurately show the results of the program, it cannot be emphasized enough that *no* administrative dollars have been allocated to this program. Although the report acknowledges the lack of administrative staff, a recommendation is still made to collect additional data. However, the problems with collection of data in the past due to lack of staff will only increase if there are additional requirements placed on the program,

particularly if the program is not changed. The report concurs with the DHS staff that the program is not effective. It is unreasonable, therefore, to collect more data on a program that all agree does not work. DHS will, however, determine if an alternative source of the data can be found.

Loan Repayment Program--Executive Summary:

- 1) DHS strongly disagrees with the statement that "The (Loan Repayment) program could be more efficiently operated--17% of its overall funding and 24% of its state funding cover personnel and administration costs." (page DHS-9 and again DHS-10)

The administrative costs for the program are not too high. It has been noted in the original PAR that private firms would cost significantly higher than what DHS incurs in administrative expenditures. Also, when dealing with small programs, the administrative expenses, due to simple economies of scale, will be proportionately higher. In other words, if the program award dollars were increased, the administrative dollars would not go up.

Loan Repayment Program--Background Commentary:

- 2) "Both offices would also point out that the taxpayers do not realize any marginal benefit from services generated by loan repayment practitioners that are paid for with state dollars if in fact these services would have been provided elsewhere anyway." (page 8a)

DHS strongly disagrees with this statement. Taxpayers *do* derive a benefit from the services provided by this and other programs that place physicians in areas of need. One major benefit, pointed out a number of times in the report, is that of the role these services have in helping to contain health care costs, particularly through preventive primary health care. Additionally, absent these services, there is an increased use of costly emergency services. Both of these factors can increase overall health costs which are then passed on to all consumers through increased health insurance premiums and also public costs such as state employees and AHCCCS. (See Appendix J for more.)

Loan Repayment Program--Performance Results Commentary:

- 3) "...in the program's first year (FY 1995), it was forced to award 3 of the first 7 loan repayment slots to urban areas because it did not receive enough applications during the first two award cycles from practitioners willing to practice in rural areas." (page 20a)

The program used administrative dollars to solicit as much response as possible from the remote rural and rural areas. While it is true that not all applications were from practitioners willing to work in the rural areas, it should be pointed out that, as a result of this program, the critical need for practitioners in urban unserved and underserved areas was addressed. Finally, as the program pointed out on page 22 of the PAR report, state legislation authorizing the ALRP requires that application and eligibility requirements be

consistent with those of the National Health Service Corps (NHSC) Loan Repayment Program. While highest priority is given to rural placements (84%), NHSC guidance specifies that placements must be in both urban and rural HPSAs.

Loan Repayment Program--Performance Results Commentary:

- 4) "Perhaps the payment schedule needs to be changed in order to encourage more practitioners to serve in rural and remote rural HPSAs." (page 20a)

The suggestion of JLBC/OSPB to increase the rural portion, and lower either the urban portion or the total number of awards could be contemplated. However, there is no proof that a higher award would marginally increase the number of applicants in rural areas; and if higher awards are given with no corresponding decrease in the Urban amounts, this would lower the total number of awards. If a lower number of awards are given, then the issue of administrative dollars per recipient worsens and the program reaches fewer people.

Primary Care Program--Executive Summary:

- 1) "Now that the PCP has \$10 million dollars in Tobacco Tax revenues to increase the amount of services provided to underserved communities, it should add some measures that assess the general availability of services in Arizona..." (page DHS-6)

DHS concurs, all of the measures mentioned are available and will be added to the strategic plan and program list. However, the agency is in the process of planning the implementation of the Tobacco Tax programs pending legislative guidance.

Primary Care Program--Other Issues Commentary:

- 2) "Perhaps the PCP should...determine an appropriate cutoff score for underserved area status designation and then monitor how many areas fall below that cutoff score each year." (Rather than use the current cutoff of the top 25%.) (page 19a)

The underserved designation process is only a year in use. We will continue to monitor it, look for improvements and research other ways of designating the status.

ARIZONA MEDICAL STUDENT LOAN PROGRAM
Arizona Board of Medical Student Loans
JLBC/OSPB Executive Summary

Overview - The mission of the Arizona Medical Student Loan Program (AMSLP) is to recruit physicians to serve in medically underserved areas in Arizona by providing substantial funding in educational loans to medical students at the University of Arizona College of Medicine. After reviewing the AMSLP's self-assessment, the following conclusions were reached.

- Recent legislative changes should increase the percentage of medical students fulfilling their service requirement. As a result, revenues from medical student loan repayments *may* decline and additional state funds *may* be required to maintain the AMSLP's current service levels.
- The AMSLP is one of a number of programs that seeks to attract providers to underserved areas. Each program attempts to address this problem from a different perspective. This program's niche and mission are to subsidize Arizona students at the medical school level who are willing to commit to service in medically underserved areas designated by the Arizona Department of Health Services (DHS).

Overall, the AMSLP Program Authorization Review (PAR) Self-Assessment complied with the general guidelines concerning completeness, clarity, adequacy and accuracy.

Program Description - The AMSLP was established in 1978 to recruit physicians to serve full-time in medically underserved areas in Arizona by providing educational loans to medical students at the University of Arizona. To participate in the program, the medical students must agree to serve in a medically underserved area for at least two years, or one year of service for each year of loan support, whichever is longer, upon completion of medical residency training. After the student fulfills the service requirement, the amount of the loan is forgiven. Primary care service has been a requirement in contracts signed since October 1992, requiring service in Family Practice, Internal Medicine, Pediatrics or Obstetrics. If the student does not fulfill the service requirement, the Board of Medical Student Loans is mandated to collect liquidated damages equal to the full amount of the loan, in addition to the repayment of the loan at a 7% interest rate. The definition of liquidated damages in contracts signed since October 1992 is equal to the full amount of the loan; contracts signed prior to that time specified a \$5,000 liquidated damages penalty.

The AMSLP receives loan funds from two sources: General Fund appropriations and loan repayments to the Medical Student Loan Fund. For FY 1996 and FY 1997, the Legislature approved \$113,900 and \$236,600 General Fund appropriations, respectively, to fund 16 medical students at the maximum loan amount. Loan repayment funds available are estimated at \$167,100 for FY 1996 and \$49,800 for FY 1997. All of the AMSLP's funding is used for the medical student loans. Administration for the program is provided gratuitously by the Medical School Financial Aid Office at the University of Arizona.

How does the mission fit within the Board's overall mission and the program's enabling authority?

The AMSLP mission is consistent with the program's statutory authority. The program has successfully recruited and provided educational loans to medical students who, upon graduation, practice full-time in medically underserved areas in Arizona as determined by the DHS. Underserved population is evaluated and defined by several criteria relating to the accessibility of medical care, including primary care physicians per 1,000 residents, travel distances and times, income and insurance. Of the 38 physicians who are currently practicing or have practiced in medically underserved areas, 18 chose practices in rural areas and 20 chose practices in urban areas.

Do the historical performance measurements and the future performance targets adequately measure goals?

Generally, performance measurements for AMSLP effectively measure achievement within a narrow quantitative context. However, to better reflect the AMSLP's success, performance measures should focus on students placed and students fulfilling their service requirements. Ultimately, the Board's success in achieving its mission to recruit physicians to medically underserved areas is determined by 1) the number of loan recipients serving in medically underserved areas and 2) the percentage of loan recipients that fulfill their service requirement rather than repay the loan. The first measure indicates the program's ability to recruit physicians and the second measure indicates the program's effectiveness in providing loans to recipients who fulfill their service requirement.

Currently, the Board is reporting the number of loan recipients serving in medically underserved areas but is not reporting the percentage of recipients that fulfill their service requirements. While the Board's self-assessment provided information on this percentage, this measure is not listed as a performance measure that the Board will regularly collect and report on in the future. The Board's performance measures would be improved by adding this measure. Furthermore, to enhance the balance, additional qualitative measures could be added to assess customer and stakeholder perceptions about quality, efficiency, effectiveness and the success of the AMSLP in meeting their goals and objectives.

Does the program perform efficiently and effectively, including comparisons with other jurisdictions?

The efficiency and effectiveness of Arizona's medical student loan program are difficult to determine from the data available. However, to the extent efficiency and effectiveness are demonstrated by the percentage of students who have served or are serving in medically underserved areas of Arizona versus those in repayment, the AMSLP performed favorably when compared with other states' programs. Approximately 53% of the AMSLP participants fulfilled their service commitment to medically underserved areas; whereas, in four of six other states with comparable programs, less than 50% of the physicians fulfilled their service commitment to medically underserved areas. Illinois and Oklahoma have service participation rates of 84% and 71%, respectively, due to strict repayment penalties. In 1992, similar penalties were passed in Laws 1992, Chapter 338. These stiffer penalties are expected to substantially increase the AMSLP's service participation rates and will be reflected starting in 1999 (the first year students under the new

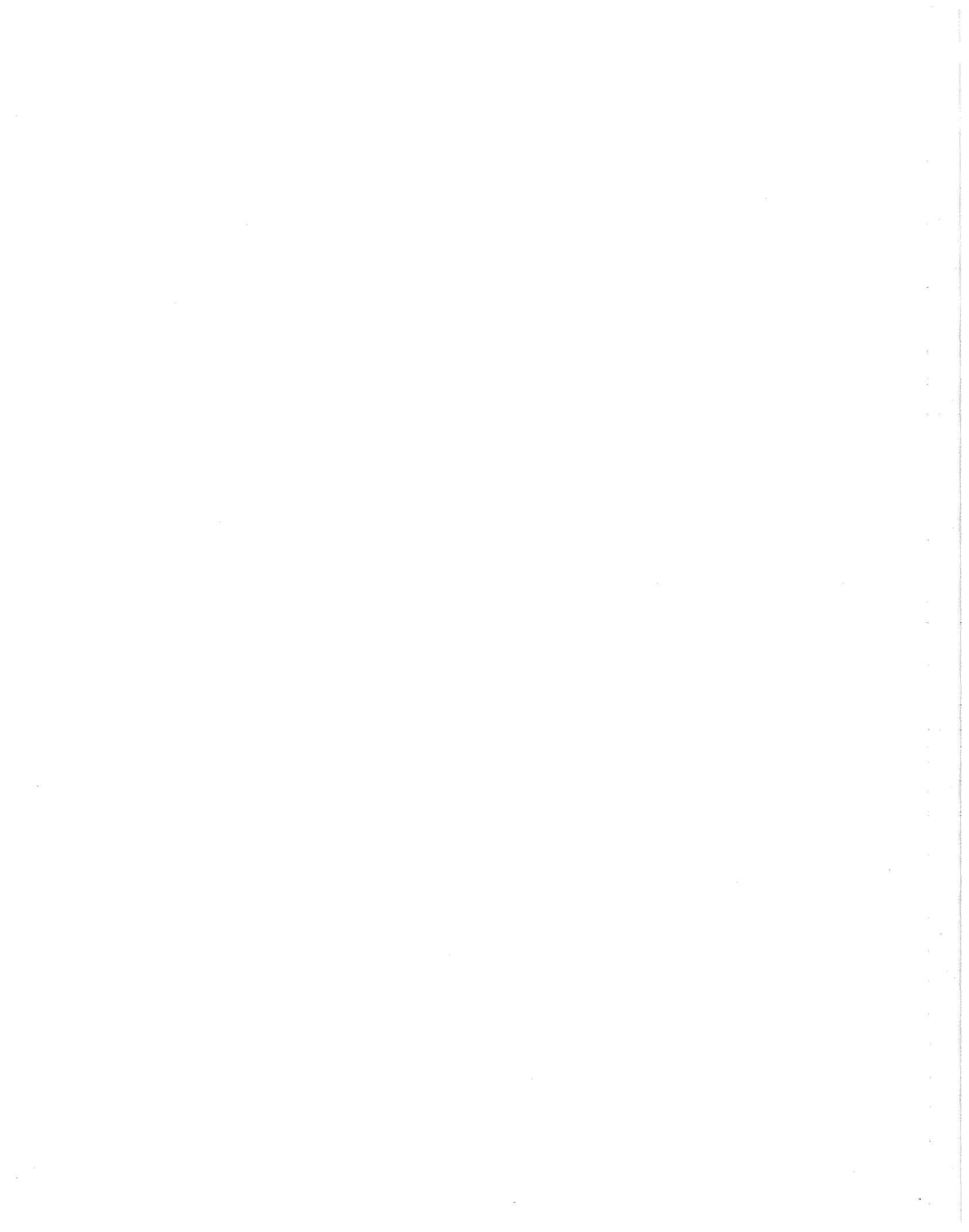
program are expected to begin their practices). As the service participation rates increase, there may be a decline in the revenues from medical student loan repayments and increased state aid may be required to sustain the viability of the AMSLP.

On a dollar amount per student basis, Arizona's program was in the median when compared with the other six states and the National Health Service Corps Program. For FY 1995, the AMSLP provided participating students with a \$17,320 loan, comprising of tuition plus a \$10,560 stipend. Both Illinois and Kansas provided funding on a similar basis of tuition plus stipends of \$8,400 and \$18,000, respectively. The other four states provided a fixed dollar amount per student ranging from \$7,500 to \$12,000 per year. The National Health Service Corps Scholarship Program provides funding for tuition and fees plus a stipend of \$9,600 for a total scholarship award of \$18,212.

Are there other cost-effective alternative methods of accomplishing the program's mission?

The AMSLP is the only state program that recruits potential physician providers while they are medical students to serve the medically underserved. Financial aid is granted in return for the student's commitment to practice in a medically underserved area in Arizona. While no other state program duplicates this exact service, there are other state programs providing financial incentives in order to recruit or retain medical providers to medically underserved areas. The Medical Loan Repayment Program provides already trained medical providers with financial assistance to repay medical student loans, in return for a minimum service commitment of two years in a medically underserved area. Another program administered by DHS, the Medical Malpractice Program, provides malpractice insurance premium subsidies to obstetrical providers who agree to start or continue obstetrical practices in a medically underserved area for one contract year.

Alternatives to the AMSLP include providing salary subsidies to physicians and other health professionals practicing in medically underserved areas and/or providing underserved communities with funding to recruit their own medical professionals according to their needs. At this point, there is no evidence that these alternatives would be more effective than the AMSLP, nor do these alternatives address the critical social issues that affect an underserved community's ability to attract medical professionals. Based upon discussions and interviews with physicians and students currently serving or considering service in rural medically underserved areas, these issues include fewer spousal employment opportunities, limited access to housing, smaller school systems, reduced access to cultural and commercial facilities, difficulty in traveling, and general isolation.



**MEDICAL STUDENT LOAN PROGRAM
STRATEGIC PLAN FY 1996 - FY 1998**

AGENCY SUMMARY

BOARD OF MEDICAL STUDENT LOANS

Christopher A. Leadem, Ph.D., Chairperson MSA.AGN
Contact: Christopher A. Leadem, Ph.D., Chairperson 626-6216

Agency Mission: *To provide substantial educational funding to qualified University of Arizona students in return for a service commitment.*

Agency Description: The Board of Medical Student Loans consists of seven members who make decisions necessary for the operation of the program. Eligible applicants must be Arizona residents willing to commit themselves when they become licensed physicians to providing full-time primary care to medically-underserved people in Arizona. There is a minimum two years of service or one year for each academic year of loan funding, whichever is longer. The University of Arizona College of Medicine provides staff at no charge to arrange Board meetings, prepare reports to the Board, publicize and coordinate the student application and interview process, track participants, collect repayments, coordinate service placement with the Arizona Department of Health Services and the Board, and prepare the annual report and state budget requests.

| Program Summary: | (Thousands) | | |
|---|--------------|--------------|--------------|
| | FY 1995 | FY 1996 | FY 1997 |
| | \$ Actual | \$ Estimate | \$ Request |
| ► Medical Student Loan Program | <u>277.1</u> | <u>355.9</u> | <u>365.6</u> |
| Fund Summary: | | | |
| General Fund | 114.6 | 188.8 | 315.8 |
| Other Non-appropriated Funds - Loan Repayments | <u>162.5</u> | <u>167.1</u> | <u>49.8</u> |
| Agency Total | <u>277.1</u> | <u>355.9</u> | <u>365.6</u> |
| FTE Positions | <u>0.0</u> | <u>0.0</u> | <u>0.0</u> |

PROGRAM SUMMARY

MEDICAL STUDENT LOAN PROGRAM A.R.S. § 15-1723
Contact: Christopher A. Leadem, Ph.D., Chairperson 626-6216
Board of Medical Student Loans MSA01.PRO

Program Mission, Description, Funding and FTE Amounts:

This agency contains only a single program. The Program Mission, Description, Funding Sources and FTE Amounts are identical to those presented above for the agency.

Program Statutory Funding Formula: Each loan shall provide for tuition plus no more than ten thousand dollars per year adjusted by the percentage change in the GDP price deflator from the second preceding calendar year to the calendar year

immediately preceding the current year. "GDP price deflator" means the average of the four implicit price deflators for the gross domestic product reported by the U.S.C. for the four quarters of the calendar year.

Program Goals and Performance Measures:

◆ Goal 1 - To successfully recruit and retain students to participate in the Arizona Medical Student Loan Program (AMSLP) by providing substantial funding of educational costs to students in the College of Medicine.

- Objective #1: To provide for tuition and maximum stipend to each student participant each year as achieved in FY 1995.
- Objective #2: To recruit a minimum of 5 students per year to participate in the AMSLP by FY 1997.
- Objective #3: To fund a minimum of 20 students per year by FY 1997.
- Objective #4: To maintain a minimum of 80% funding of the average annual cost of medical education.

| Type | Performance Measures | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|--------|---|---------|----------|----------|----------|
| | | Actual | Expected | Expected | Expected |
| Output | Amount of loan provided to each student | 16,580 | 17,320 | 17,763 | 18,298 |
| Output | Percent of maximum loan amount allowed by law provided to each student as achieved in FY 1995 | 98 | 100 | 100 | 100 |
| Output | Students recruited | 4 | 10 | 2 | 5 |
| Output | Students funded | 8 | 14 | 18 | 20 |
| Output | Percent of maximum loan amount allowed by law provided to each student | 80 | 83 | 81 | 80 |

◆ Goal 2 - To provide physicians to medically-underserved areas in Arizona.

→Objective #1: To provide medically-underserved areas in Arizona yearly with service by physicians funded by the AMSLP.

| Type | Performance Measures | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|--------|-----------------------|---------|----------|----------|----------|
| | | Actual | Expected | Expected | Expected |
| Output | Physicians in service | 9 | 10 | 6 | 7 |

◆ Goal 3 - To increase the number of physicians providing service to medically-underserved areas in Arizona.

→Objective #1: To graduate 5 student participants per year beginning in FY 2000 from students recruited beginning FY 1997.

| Type | Performance Measures | FY 1994 | FY 1995 | FY 1996 | FY 1997 |
|---------|----------------------|---------|----------|----------|----------|
| | | Actual | Expected | Expected | Expected |
| Outcome | Students graduating | 2 | 1 | 2 | 5 |

College of Medicine
Financial Aid Office



AHSC Room 2112A
Tucson, Arizona 85724
(602) 626-7145
FAX (602) 626-4884

October 23, 1995

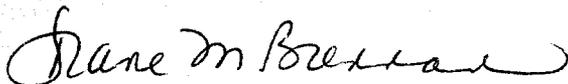
Peter Burns, Director, OSPB
Ted Ferris, Director, JLBC
Governor's Office of
Strategic Planning and Budgeting
1700 W. Washington, Suite 500
Phoenix, AZ 85007

Dear Mr. Burns and Mr. Ferris:

Attached are the comments from the Arizona Medical Student Loan Program for our agency Program Authorization Review (PAR) and for the Overall Rural Health PAR. We appreciate the opportunity to participate in this process.

Please contact me or Maggie Gumble, Financial Aid Counselor for the College of Medicine, if you have any additional questions. Ms. Gumble's telephone number is (520) 626-7145 and her fax number is (520) 626-4884. I can be reached at (520) 544-7641. My fax number is (520) 544-7621. The new mailing address is College of Medicine Financial Aid, AHSC/UMC, P.O. Box 245026, Tucson, AZ 85724-5026.

Sincerely,



Diane M. Brennan, Vice Chairperson
Board of Medical Student Loans

cc: Members of the Board
Maggie Gumble

**ARIZONA MEDICAL STUDENT LOAN PROGRAM
PAR AGENCY COMMENTS**

The Arizona Medical Student Loan Program's "niche and mission" is an important one in recruiting future physicians who will focus on the needs of underserved areas in Arizona. It is a complementary program to the Arizona Loan Repayment Program which focusses on recruiting physicians who have completed medical training, and both are different from the Medical Malpractice Program which addresses the high malpractice insurance premiums faced by obstetrical providers.

Members of the Board of Medical Student Loans recently met with students on the Arizona Medical Student Loan Program. In our discussion, students indicated that the program has an impact on the decisions that they make as they go through medical school. It has increased their sensitivity to the needs and issues related to the medically-underserved population, has influenced their choices in clinical rotations, and has helped them withstand the pressures medical students often feel to specialize rather than go into primary care. One of the students who has five children commented that it has eased his financial concerns; he and another student from rural Arizona agreed that even though they planned to practice in rural locations, they have to wonder if the reality of their debt level would have caused them to change their mind without the support of the Arizona Medical Student Loan Program. Another single student has observed physicians in the area he comes from struggling with paying their student loan debts, and he is grateful he won't be in that situation. A fourth observed, during a recent clinical rotation in a medically underserved area, that only 1 out of 4 doctors there would take AHCCCS patients due to the physicians' educational loan debts and she doesn't want to be in that position. She will have a manageable level of indebtedness due to her participation for three years in the Arizona Medical Student Loan Program; importantly, those have been years in which the updated program has provided her with substantial educational funding toward her total cost of education.

We believe that the Arizona Medical Student Loan Program is financially assisting needy medical students who have the interest and concern for the people in Arizona who most need their assistance. Recruiting students under the terms and conditions of the revised program has resulted in attracting future physicians who are serious about service and who will provide respectful, caring, treatment to those in need.

Our Strategic Plan has focussed upon the key factors in recruitment of students and upon the bottom line, that is, the number of physicians provided. Since the Program has been recently revitalized, the percentage of physicians serving under the new conditions has not yet become meaningful since those students will begin service in FY 1999 and beyond. We expect that our 53% service rate will increase dramatically and be competitive with states such as Illinois and Oklahoma which have service participation rates of 84% and 71% respectively. Those states have strict repayment penalties which was one of the key changes in Arizona in 1992.

The Arizona Medical Student Loan Program could be strengthened by adding multi-year contracts as proposed in the JLBC/OSPB Strategic Planning Commentary.

U of A College of Medicine students who are willing to commit themselves are doing so when they still have seven or eight years of medical training prior to going into practice. We believe it is crucial that the program remain flexible for students to serve in areas of need, whether those areas are rural or urban. It is reassuring for these students that the program allows them the flexibility to choose a site which will match their needs to consider spouse employment, schooling for the children, and other personal factors which are unknown many years in advance.

We believe there is an advantage in retaining the Arizona Medical Student Loan Program's administration at the College of Medicine, since the College of Medicine Financial Aid Counselor then has full knowledge of all aspects of the program and frequent contact with participating students. At present, the College provides gratuitous administrative support for this loan program which financially assists U of A College of Medicine students.

Through this program, Arizona is providing its own students with financial support in return for their giving something back to the community.