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An Interview with Alison M. Hughes, MPA

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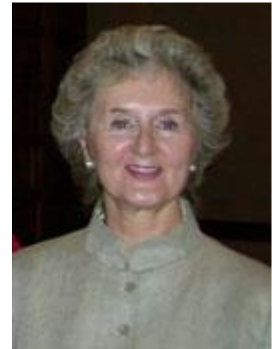

Alison Hughes has worked in the rural health field for over two decades. She currently serves as the Director of the Arizona Rural Hospital Flexibility program in the Arizona Rural Health Office and is a Director Emeritus of the Arizona Rural Health Office. For a decade Hughes has also been the Associate Director of Outreach at the Arizona Telemedicine Program, a position she currently retains. In addition, she is a faculty member in the Mel and Enid Zuckerman College of Public Health, and was the Faculty Chair of the Policy and Management Section from January 2007 to June 2008.

Throughout her career, Hughes has been involved with various rural and advocacy organizations including the National Organization of State Offices of Rural Health, where she served as president in 2007 and has been active since its inception in 1995. Hughes is currently a board member of the Arizona Rural Health Association, and has served on the board of the Southern Arizona Mental Health Corporation for over 15 years. She has been on the board of the Universal Services Administrative Company and on the Policy Board of the National Rural Health Association, and served as a member of the National Advisory Committee on Rural Health and Human Services from 1999-2002.

She holds a master's degree in public administration from Harvard University's Kennedy School of Government where she focused on leadership development and public policy interests.

Hughes was born in Glasgow, Scotland and moved to the United States when she was 19. She has lived in Tucson since 1970.

Hughes says she "is interested in absolutely everything and gets involved in absolutely too much." In addition to her other advocacy work, she is currently serving on the board of the Borderlands Theater in Tucson and has served on the board of her local neighborhood association for 20 years. She has been involved in local and state politics and has held a number of Arizona gubernatorial appointments, including currently serving as a Commissioner on the Arizona Arts Commission.

Photography is one of her major hobbies. Some of her pictures of Arizona scenery have appeared on the rural health office's website and one of her cacti photographs was published in the University of Arizona Alumni magazine.

Why did you emigrate from Scotland?

I moved to the states because my mother was here. She was born in Alabama of Scottish immigrant parents who eventually returned to Scotland. My grandfather was a union organizer and worked in the Alabama coal mines. Eugene Debs, an American union leader, introduced him to politics. When he returned to Scotland he was a member of the Fife Town Council, and later he ran for Parliament and lost. My mother found her way back to the states after WWII.

How did you get to Tucson?

The man I was married to at the time was accepted to the University of Arizona and we came to Tucson together. Tucson was "love at first sight" for me. I thought it was breathtakingly beautiful and didn't want to leave. That appreciation still stands.

Before I got my graduate degree, I worked as a Congressional Aide for then-Congressman James McNulty of Arizona's Fifth District. Previous to that, I served as Executive Director of the Tucson Women's Commission. We held hearings that dealt with discrimination against disabled women and elderly women. Before that, I worked as the grant writer at Pima Community College. Prior to coming to Tucson I worked for the U.S. Commission on Civil Rights in Washington. That experience raised my consciousness immensely about the injustices that needed to be righted.

What prompted you to get a graduate degree in public administration?

The degree was a natural extension of what I had been doing professionally. The training simply gave me a better academic perspective on decision-making principles.

Despite your other political and work involvements, you've been active in art organizations. Is art important to you?

I come from a family of artistic folks with solid working class roots. My father and mother both painted; my sister is a potter. They all had other jobs to earn survival money. I am the family workaholic who pours her lifeblood into making a difference in the rural health arena.

What first sparked your interest in rural health? Did an interest in health policy gradually become focused on rural or were you always interested in rural health?

None of the above.

When I completed graduate school and returned to Tucson in 1985 I was offered two different positions at the University of Arizona. The one I knew the least about was at the Rural Health Office. One of my former professors, Dr. Richard Neustadt, used to say, "Play to your weakness." I remembered that advice when I was struggling with which position to accept. I chose rural health, and have never regretted that decision. I have not stopped learning in over two decades.

It is wonderful to get up in the morning and look forward to going to work. A lot of working people don't have that luxury.

What do you think are some of the biggest challenges facing your office?

In Arizona big city legislators dominate the legislature. Legislators who represent rural residents often can't get the votes to pass legislation that is responsive to constituent needs. I love it when rural legislators call on our office for assistance.

Have the issues changed much in the last 20 years?

Some challenges have not changed much. Recruitment and retention of the rural health care workforce is just as challenging today as it was in 1986. Rural residents still can't get adequate dental or eye care. Access to orthopedic devices is another challenge for them.

There have been positive changes though. We see more efforts nowadays to build a healthier America through nutrition education and exercise promotion. In Indian country, I see lots of walking clubs sprouting up. The inscription on my favorite coffee mug is "Hopi Wellness 100 Mile Club." If people get healthier they won't need to depend as much on a broken health system. Insurance companies don't reward prevention activities by covering exercise club memberships. If they did they would save a lot of hospital costs.

One of our critical access hospitals was financially forced to close its long-term care wing as the reimbursement was much less than what it cost to provide the service. The hospital CEO got community funding support to turn that hospital wing into a community exercise program. They did some remodeling and bought work-out equipment. I visited the hospital recently and that exercise room was packed!

What would you like to see happen with health care—particularly rural health care in the West—in the next five to 10 years?

I would like to see individuals taking control of their own electronic patient records that they can use regardless of what system of care they are using. A nutritionist friend of mine was once a missionary in Africa. Many of the people were nomadic and if they showed up at a clinic there was no record of patient histories. My friend created a little book for each patient. It was a personal health record. They were asked to carry the record with them at all times. These books became very precious to the villagers. They treated them like identification cards and took them everywhere. Eventually the concept spread and everyone started to create the books for villagers in other areas. Today we can do this electronically. When people take control of their own electronic health record, it will be like a super high-end version of the Hopi 100 Mile Club!

Technology is not the solution, but it can be used to lift us to the next level of health care. We must remember, however, that lots of rural residents don't have computers in their homes, or access to high speed Internet services. There is a lot yet to be done.

What are the some of the other potential problems with expanding the use of technology in rural areas?

Telemedicine is supposed to give rural residents better access to specialty care and in many cases succeeds. Telepsychiatry works well, for example, and is a reimbursable telemedicine specialty.

Not all payers, however, reimburse the rural practitioner for providing care using telemedicine technology. The problem is most specialists are usually located in urban locations. The rural practitioner who takes time to be with her or his patient during the telemedicine consultation with a specialist is not reimbursed. Consequently they don't want to take time away from seeing another patient for whom they can be reimbursed. Although there is no requirement for an eligible telehealth patient to be presented by a licensed physician or practitioner at the originating site unless it is medically necessary, all presenters must have received appropriate training to present the patient. If a presenter is different from the referring clinician, the designated presenter should be sufficiently familiar with the patient's medical condition and have appropriate clinical training to present the case accurately. This means they need training and that costs money.

A few years ago there was a noticeable decrease in telemedicine utilization numbers coming from one of our community health centers. When I visited with the CEO of that center to ask why, his response was honest and direct. "Our doctors are spending too much time in the telemedicine room. During that same time they could have seen three more patients, and we could have billed for that time."

If you had to put your energy into only one effort, what would it be?

We need to change the country's complicated, multiple-layered, many-payer health reimbursement system. When you think of it, there are many payer and provider systems: private insurance carriers, fiscal intermediaries for Medicare and Medicaid, the profit and non-profit hospitals, clinics, pharmacies, mental health institutions and mental health clinics, physician practice offices, the prison health system, the military system, the veterans' system, the tribal systems and the Indian Health Care system. People can be in and out of more than one of these systems at a given time in their lives and there is no real continuity of care record exchanged among them. We have to find a way to make this less complicated. A few years ago one of the Arizona payers with a managed care contract pulled its services out of the rural areas of our state leaving everyone high and dry. That should not be allowed to happen.

Today's progressive health care leaders have a similar mantra: "Operate health care like a business." The approach makes sense but it can be detrimental to the patient's need for more education during the consultation. Physicians should not have to hurry through a consultation with a patient so they can meet their billable quota.

People who live in rural areas should have a right to receive the best possible health care within the best possible system of care. They often have to travel long distances for health care, and when they seek care, they should get as long as they need with the practitioner. They produce most of our food. We can't live without them.

Opinions expressed are those of the interviewee and do not necessarily reflect the views of the Rural Health Information Hub.