Rural Health Connections
A quarterly publication of the Southera Rural Access Program
National Program Office

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August 2000

Spring Grantee Conference provided wealth of information and expertise on provider recruitment & retention

Well over 100 people attended the Spring Grantee Conference of the Southern Rural Access Program this past March in Tunica, Mississippi. Grantees and other invited guests had the opportunity to meet and mingle with **Steve Schroeder, MD**, president & CEO - The Robert Wood Johnson Foundation, during the opening evening poster display session and reception. Dr. Schroeder formally addressed the crowd again as the introductory speaker to the plenary session the following morning.

In his remarks, **Dr. Schroeder** discussed the recent reorganization of the Foundation into health and health care units and its current funding priorities. He also praised the SRAP grantees and the national program office staff for the tremendous amount of work they had accomplished since the authorization of the program. He acknowledged that the challenges that lie ahead in improving the healthcare infrastructure in the South are tremendous and said the Foundation is committed for the long-term to helping the states improve access to healthcare in these medically underserved areas.

After speaking to the early morning crowd, Dr. Schroeder embarked on a day and one half journey through the Mississippi Delta and Hill Country regions to meet with community physicians, nurse practitioners, administrators and public health advocates. He was accompanied by Mississippi Project Director **Marcus Garner**, Northwest Public Health District I Health Officer **Lovetta Brown, MD, MPH** and SRAP Director **Michael Beachler**.

In a follow-up thank you note sent to all the community representatives, Dr. Schroeder noted that he "*came away with great respect for the energy, integrity and intelligence of the many people with whom I met.*"

The plenary session, presented by two well-respected researchers, explored research findings related to recruitment and retention of health professionals in underserved rural areas. **Donald Pathman, MD, MPH**, research director - University of North Carolina (UNC) at Chapel Hill, focused his remarks on the eight principals of retaining rural physicians learned from 10 years of research at UNC. **L. Gary Hart, PhD**, professor of family medicine and researcher - University of Washington, discussed the rural environment, rural differences, physician trends and issues along with rural physician training, recruitment and retention. He shared with the group what he termed "four obvious secrets to rural training, recruitment and retention".

Key #1	Reduce the number of rural uninsured, underinsured and poor people.
Key #2	Create a stable and financially sound rural healthcare delivery system.
Key #3	No vision of the future can come to fruition, if it does not allow for its healthcare providers to have stable, rewarding and fulfilling professional and personal lives.
Key #4	Research or policy analyses, policies or regulations cannot relieve local rural residents and providers from their responsibilities to coordinate their community's available resources to provide as optimally cost effective and high quality of care as possible (Amundson, 1993).

Although most sessions related directly to recruitment and retention efforts, sessions were offered on media relations, focus groups, working with legislators, program evaluation, the 21st Century Challenge Fund and renewal applications. Specific recruitment and retention sessions included locum tenens, practice sights software, practice management and the Triple R Net. Presentations were made by 40 individuals, representing healthcare-related and government organizations, lead agencies and key partners, academics, the national program office and RWJF.

SRAP Director **Michael Beachle**r (L) and **Mike Boyd** (R), who delivered remarks on behalf of Mississippi Governor Ronnie Musgrove, listen to the upbeat remarks made by RWJF CEO & President Steve Schroeder, MD, during the opening reception.

SRAP National Program Office Staff Assistant **Sandy Rauchu**t refills the candy jar during a break at the conference. Having an NPO located in the *"Sweetest Place on Earth"* is certainly appreciated by Hershey chocolate lovers. For those of you who call the NPO, Sandy is often the first point of contact.

Principles of Retaining Rural Physicians: Lessons from UNC's Studies of the Past 10 Years

Donald Pathman, MD, MPH -- University of North Carolina at Chapel Hill

1st Principle:	Long-term retention is a realistic goal for rural physicians in virtually very location. Median rural retention duration is six years.
2nd Principle:	Recruiting and retaining rural physicians are different goals that require different initiatives.
Corollary A:	The phrase "recruitment and retention" should be avoided if it keeps us from recognizing that separate initiatives are needed for each.
3rd Principle:	When it comes to retention, rural primary care physicians demonstrate that they are "locals" at heart. Rural physicians should be approached as a local (within-state) labor force, not as national. ("Think globally, recruit locally.")
4th Principle:	Retention is not a matter of selecting the right type of individual or right type of community and practice, but is a matter of making a good match between an individual and a community and practice.
5th Principle:	Physicians who choose rural practice are not typical of physicians as a whole (think of them as "deviants"). Retention initiatives should attend to rural physicians' greater value in independence, lower attachment to technology, greater altruism and greater need to feel their impact on their community.
Corollary B:	Don't listen to what urban physicians—and especially academics—say about satisfying and retaining rural physicians, unless they have rural practice experience or speak from solid data. Urban physicians project their own needs on rural physicians.
Corollary C:	Community attachment may be the single most important factor in retaining rural physicians [see the movie "Doc Hollywood"].
6th Principle:	Retention is affected most by what physicians encounter in their rural practices and communities.
Corollary D:	Although explicit rural training during residency promotes preparedness and retention, no upbringing or training will prepare or insulate a physician from a bad situation.
7th Principle:	The role of rural practices in retention is to offer a job situation that makes physicians feel satisfied, respected, valued, professionally fulfilled and is a viable long-term employment option.
Corollary E:	Physicians are no more likely than any other human to remain in a job with stress, conflict, disrespectful coworkers, or inordinately low pay and benefits.
Corollary F:	Retention is bolstered by avoiding physician dissatisfaction, not by increasing levels of satisfaction.
8th Principle:	Rural physicians are human. Addressing physicians' human needs is more important to retention than providing professional supports.

Corollary G:	Professional supports, such as CAT scanners, telecommunication linkages and easy access to consultants, may augment the quality of care of rural physicians but they do not promote their retention...a mistaken belief of urban physicians.

RWJF awards SCSORH a nearly $1 million second round grant award

The Robert Wood Johnson Foundation (RWJF) has awarded the South Carolina State Office of Rural Health (SCSORH) a 19-month grant in the amount of $981,930 for stage two of the Southern Rural Access Program. "*South Carolina's ambitious and innovative strategy to improve access in rural underserved areas builds on the progress made during the first grant period,*" said SRAP Deputy Director **Isiah C. Lineberry**. "*Initiatives approved for the second stage include continuation of projects funded through the first grant award along with new projects.*"

The first of the four continuation initiatives is **Community Incentive for Diversity (CID)**, a leadership development program that provides scholarships to encourage minority enrollment in nurse practitioner, nurse midwifery and physician assistant programs and the selection of rural practice after graduation.

The second continuation initiative is the funding of a **Revolving Loan Fund Specialist** position, established to identify capital and coordinate loan funds for rural health facility and practice improvements. "*Having a central source for information and technical resources related to improving rural health infrastructure has been extremely helpful and long overdue,*" said **Hank Ray**, vice president - Wachovia Bank of South Carolina. "*The Foundation's administrative support of this resource has allowed for greater communication and coordination of financial vehicles available to rural health providers. I believe that the revolving loan fund program has made a difference in South Carolina and the revolving loan fund specialist has served as a catalyst to investigate new opportunities for enhancing South Carolina's healthcare loan funds.*"

The third initiative is expansion of the **Regional Locum Tenens Program** by utilizing three family medicine residency programs in Anderson, Charleston and Florence, respectively, to provide coverage for rural physicians when they take time off for personal reasons or professional development. "*This initiative will entail strategically placing locum tenens providers in underserved areas of the state,*" said **Amy Brock**, SC Rural Health Access Program Director. "*This effort should help relieve overburdened physicians and provide the opportunity for interaction with the state's medical schools making rural practice more visible to students and residents.*"

The last continuation initiative will fund a **Recruiter/Placement Coordinator** to provide recruitment and retention services to network members. Low Country Health Care Network, an emerging vertically-integrated network in the Low Country of South Carolina, will also engage consultants to assist in the development of a Clinical Pathways program for its hospital membership.

New initiatives include **Project Stay Put**, a two-prong approach to improving the recruitment and retention of primary healthcare providers in rural South Carolina. Project Stay Put will assist rural practices in improving their financial viability through practice management technical assistance and will empower small and rural communities to develop recruitment and retention strategies of health care providers. "*While many small and rural communities recognize the need, economic advantage and desirability of providing basic healthcare services, community leaders often lack the ability to develop a systematic, realistic recruitment and retention plan that will produce the results required to sustain basic health services,*" explained **William F. Mahon**, CEO - South Carolina Medical Association. "*It is anticipated that the successes of this project will be portable and replication by other communities will be an important by-product of this much needed initiative.*"

Building from a Bureau of Health Professions funded project, the second new initiative, the **South Carolina Rural Interdisciplinary Program of Training (SCRIPT) 2000**, aims to increase the likelihood that health professions students will select a rural, underserved community for practice upon graduation. Health professions students from 13 disciplines will participate in projects to improve selected aspects of health care delivery. RWJF funds will allow the expansion of SCRIPT into the Catawba-Wateree and Pee Dee regions of the state.

The final new initiative involves a collaborative effort to conduct an **investigation on issues surrounding the practice of nurse practitioners, physician assistants and certified nurse midwives in rural South Carolina**. Representatives from each of the academic programs and professional organizations in the state will participate in the study.

HRSA recognizes Commun-I-Care's "Models That Work" Program

The Health Resources and Services Administration (HRSA) honored four local health programs as "Models That Work" winners. "*Models That Work offer the best in local problem solving to meet local healthcare needs,*' said HRSA Administrator **Claude Earl Fox, MD, MPH**. "*Dedicated health professionals, community leaders and consumers have broken the cycle by finding good sense, workable solutions that promote access to quality preventative and primary health care. Showcasing these community-driven solutions gets the word out to other communities wanting to improve the health of their residents.*"

One of the programs, Commun-I-Care, is based in Columbia, SC, a Southern Rural Access Program state. The patient-friendly program, serving nearly 3,000 patients throughout the state, provides free primary care, prescription drugs and supplies, lab services and dental care to poor, uninsured South Carolinians.

More than 1,400 healthcare professionals, hospitals, labs and other providers donate their time and resources. An additional 400 pharmacies and pharmaceutical manufacturers also support the program with free prescriptions.

"*We were thrilled to learn that we were a recipient of the Models That Work awards,*" said **Ken Trogden**, executive director-Commun-I-Care. "*It should cast us onto the national stage by increasing our overall awareness and credibility.*"

By calling a toll-free number patients are referred to a nearby provider for healthcare services. At least $1.5 million have been saved through reduced emergency department visits, two million dollars through reduced hospitalizations and another $20,000 in reduced healthcare agency costs for Medicaid eligibility screening.

HRSA described the honored programs as "*innovative, effective and resourceful grassroots programs that use everything from high tech to traditional healers to break down barriers to healthcare access, lower costs and bring primary care and preventive services to local residents.*"

Cosponsors in the Models That Work campaign are The Robert Wood Johnson Foundation (RWJF) and Bristol-Myers Squibb Company. Federal partners include the Public Health Services' Office on Women's Health, Health Care Finance Administration and the Centers for Disease Control and Prevention.

The Commun-I-Care program is also a past recipient of other RWJF funding. Between 1994 and 1997 the program received $300,000 in funding from the *Reach Out* program.

William A. MacBain: SRAP Consultant

Program consultant Bill MacBain spent his childhood living in rural America. "*My understanding of the impact of health care in the rural community goes back to my childhood,*" explained MacBain. "*I grew up in a small rural community and know what it's like to not have healthcare services or enough doctors. I also know that, even today, it takes a very special type of person to work in rural health. Although most healthcare providers could make more money elsewhere, it usually isn't as personally rewarding.*"

In 1997 when The Robert Wood Johnson Foundation authorized the Southern Rural Access Program, the Geisinger Health System (Danville, PA) and The Milton S. Hershey Medical Center (Hershey, PA) were in the process of merging into an integrated delivery system with a 1,000-physician medical group, an academic health center, a rural tertiary teaching hospital, a community hospital and a health plan with 250,000 members. The new entity, the Penn State Geisinger Health System, was chosen to administer the Southern Rural Access Program through its newly formed Rural Health Policy Center. Before, during and after the health system merger MacBain held a variety of key executive positions with the organization. This experience played a key role in his being asked to serve as a program consultant.

At the time of the merger, he was senior VP/executive director of Penn State Geisinger Health Plan's Southern New York operations where he directed the development of an IPA-model HMO covering seven counties, including recruitment of core staff, project planning, provider con-tract negotiations and licensure and government relations. For eight years prior to this position, MacBain was senior vice president - Health Plans Operations for the Geisinger Health System. His division operated the nation's largest rural-based HMO, a 25,000-member preferred provider organization, an indemnity health insurance company and a third party administrator. During his tenure the division grew from a small subsidiary to Geisinger's primary business strategy, increasing its revenue to more than 50% of Geisinger's patient service revenue.

"*Once the merger with Hershey was complete, the emphasis shifted south and the northern expansion into New York didn't make sense,*" explained MacBain. What did make sense was for him to take his 25+ years of experience in healthcare delivery and apply it elsewhere. When the New York project was cancelled he left the health system to co-found along with his wife, Lisa, MacBain & MacBain, LLC, a management consulting firm specializing in strategic planning, project support and financial analysis for healthcare providers and managed care organizations.

"*Most of my career has been spent in rural communities trying to improve access to care*" said MacBain. "*My areas of greatest concentration have been in rural practice management, managed care and network development. As a consultant to the Southern Rural Access Program I am able to apply that expertise to analyze funding proposals and make recommendations on how projects can be improved.*"

Some of his recent projects include:

- preliminary "due diligence" review and valuation estimate of several HMOs
- design of an HMO key indicator report package
- analysis of a large HMO's experience rating methodology

- financial plan and capital needs assessment for a proposed provider-sponsored health plan
- Development of financial models to forecast performance of individual HMOs and a multiple-plan holding company
- Development of managed care contracting recommendations for a provider trade association.

MacBain cites three major challenges of the Southern Rural Access Program. "*First, the problem in rural areas isn't cost-containment, it's lack of funding. There's just never enough funding in rural areas for access-related projects. It's also important that community leaders come together beyond just sitting on the same boards so they can develop true systems of care. And last, there must be a proper balance maintained between public and private enterprises such as local networks, hospitals and public health agencies, if access to care is going to be improved.*"

MacBain knows the impact public and private partnerships can achieve when they work together. He recalled a bit of history he learned while chief operating officer of the HMO of Western Pennsylvania, when he said, "*In the 1950s the United Mine Workers (UMW) set-up clinics in the coal mining region of western Pennsylvania to provide care for their workers' and their families. The UMW contracted with a medical group to provide care and fought some tough battles with local doctors to get established. The successful management of the Miner's Clinics served as the basis for the development of HMO of Western Pennsylvania, an independent not-for-profit health plan.*

"*The UMW was very effective in coping with changes in the economy. In the 1970s the UMW began contracting with standard Blue Cross/Blue Shield plans. In the 1980s during my tenure as COO we used capitation to support health groups in Appalachia to provide access to care for populations who wouldn't have been served otherwise.*"

MacBain graduated from Cornell University and after completing a tour in Vietnam, he began his career as a public health investigator for the New York State Health Department. He later earned his Master of Hospital and Health Service Administration from Cornell University. MacBain also served as a commissioner on the Medicare Payment Advisory Commission, the successor to the Prospective Payment Assessment Commission, from 1996 through April 2000.

His vision for the Southern Rural Access Program is "*to see the program funded on a long-term basis, as ongoing funding will be necessary to see projects through to maturity. To see measurable results and successful outcomes the program will need to be sustained beyond seed money. Significant fruit will be borne by the efforts of this program and we will need to spread the word through formal academic articles. I envision that more states may be added and others will imitate our success.*"

REAP program develops leaders as catalysts for change

Georgia's Rural Enrichment and Access Program (REAP) along with the University of Georgia JW Fanning Institute for Leadership developed a ***Rural Health Leadership Academy*** to raise awareness of rural healthcare trends and develop leadership skills among healthcare professionals and community members in a nine-county area of east-central Georgia. The program, which concluded its inaugural session June 16 with a graduation ceremony, opened with a two-day orientation session last December. Fifteen community leaders from East Georgia participated.

"*The objectives of the Leadership Academy fit well with the anticipated outcomes and program logic of the Rural Enrichment and Access Program. The vision statement of REAP encompasses the core principals of the Leadership Academy,*" said **Becky Ryles**, REAP Director. "*The mission embraced by the REAP Advisory Board assertively advocates on behalf of rural communities. It's aim is to increase healthcare access and mold public policy reflective of rural health systems that are economically viable, culturally competent and supportive of improved health status.*"

The Academy, one of REAP's four major components, is committed to improving the region's healthcare system through a series of population-based tools to develop leadership, team building, problem solving and new skills development. The Academy welcomes individuals with backgrounds in marketing, nursing, education, medicine, public health administration, mortuarial science and management who work in hospitals, rural health clinics, physician offices, health centers or hospice care centers.

In support of its mission to prepare participants to work together as catalysts for developing plans and implementing solutions for improved health status, two major goals have been identified:

1. Foster individual self-examination and serve as a tool to encourage growth in community leadership and empowerment.
2. Examine the unique role that each participating community member has in planning for health community outcomes, setting community goals, managing healthcare related projects and working with others to build solid, sustainable leadership.

According to **Andre' Thomas**, REAP Leadership Coordinator, anticipated outcomes include "*shared services and personnel across county lines; an increase in local primary care services and dollars; proactive approaches to helping local communities develop strategic healthcare delivery plans; more integrated communication; an increase in the availability of technical information and effective advocacy to improve rural health policy.*"

Written evaluations of the Leadership Academy included the following comments:

"*This is worthwhile. The participants are not people I ordinarily see a lot; they are the plusses – good facilitators, too.*"

"*I'm enjoying this group immensely – every session promises to lead to greater professional and personal growth.*"

"Stretching ourselves to actually define things and come up with ideas and solutions to part of the problem."

"(The Academy) needs more private practitioners involved in future academies."

According to Thomas, the participants are now using some of their newly acquired skills and knowledge to implement in their communities ideas they learned at the Academy. He said he is eager to see the results of their efforts and measure the impact on improving healthcare in rural portions of Georgia.

ARVRHC develops multi-faceted access improvement strategy

The Arkansas River Valley Rural Health Cooperative (ARVRHC) is using start-up support from local, state, federal and philanthropic resources to launch an ambitious three-pronged access improvement strategy. The Cooperative, formed in 1999 by leaders of four small rural hospitals, 18 primary care physicians and two surgeons, serves three small poor rural counties (Franklin, Logan and Scott) in Northwest Arkansas. Current funding sources include a federal rural health network planning grant, net- work membership dues, state health department resources and grants from SRAP and the Sister of Mercy Catherine's Legacy Fund. ARVRHC's strategies include a community health plan, a prescription drug assistance program and a health education/disease management initiative.

Community Health Plan Development

ARVRHC is in the early stages of designing a community-based health plan to provide low-income uninsured and underinsured adults an affordable means of obtaining access to needed healthcare services. A fourth of the adult population in the three-county service area with a population of 45,000 has no health insurance. According to Bob Redford, ARVRHC executive director, "a key feature of the plan involves extended partnering agreements with federal and state government agencies and local communities to share the responsibility, cost burden, risk and benefits associated with membership in the plan."

Healthcare services rendered by an ARVRHC provider will be discounted and require a small co-payment at the time of service. Monthly membership dues will include enrollment in a group insurance plan to cover major medical services not available in the tri-county rural service area.

For members with family incomes 200% above the federal poverty level membership dues are expected to cover the full cost of the plan. The monthly dues of low-income members will be discounted on a sliding-fee scale based on income level. *"It's estimated that 60% to 70% of the cost of these services will be subsidized,"* explained Redford. *"These subsidies will be funded by monies raised though organizational membership programs, a trust fund and private and corporate donations, as well as funds received from charitable and government organizations. We anticipate this program becoming a Medicaid expansion pilot program, in which local funds will be combined with federal-state matching dollars."*

Prescription Drug Assistance Program

ARVRHC also recently completed a pilot program to assist low-income individuals with chronic health problems in obtaining medications they otherwise couldn't afford. The program was offered to patients in Paris, Franklin County. ARVRHC's **Kendall Poe** completed the required paperwork for the patients and submitted it directly to the pharmaceutical companies for processing. The prescription drugs then were sent to the prescribing physician for dispensing.

Data from the pilot program, which ended June 30, is now being compiled and analyzed by ARVRHC staff. Once the scope of the problem has been defined, recommendations can be made to expand or modify the program and additional sources of administrative and financial support can be pursued.

Health Education/Disease Management Program

Earlier this year ARVRHC contracted with **Rick Guyton, PhD,** Director - UAMS AHEC-Northwest Regional Medical Program, to develop a model health promotion, disease prevention and chronic disease management program. Program components will include identification of patient health risk behavior profiles, health promotion and screening programs and development of personal assessment profiles.

The disease management effort will provide patients with appropriate medication, as well as individualized education and counseling on their chronic disease. ARVRHC also plans to establish a Health Education & Counseling Center at each of the four community hospitals in its network. The centers will provide health education resources printed materials, as well as, computer and interactive video equipment for telemedicine consultations by local physicians.

NGA convenes meeting of southern policymakers

The National Governor's Association Center for Best Practices convened a meeting of southern policymakers and grantees of the Southern Rural Access Program (SRAP) in Atlanta this past April to discuss rural health and primary care access issues. Issues addressed included funding opportunities, coverage and access, coordination of data systems, services and funding and overviews of model state programs.

In his keynote address, Georgia **Governor Roy Barnes** discussed the challenges and his vision for healthcare in the southeastern United States. He said that the lack of education and healthcare resources hold back rural America. The Governor also stated that if a state is pro-business, it needs to be pro-health, as evidenced by his tobacco settlement proposal that calls for business tax incentives, if employee health coverage if provided. Barnes also emphasized the need for regional planning and cross-county communication and said he favors public-private partnerships.

Jerry Coopey, director of legislative affairs - Office of Rural Health Policy, led a discussion on approaches southeastern states are taking to implement their Critical Access Hospital Programs. He noted that Georgia's Department of Community Health has crafted an innovative reimbursement policy for hospital's that secure Critical Access Hospital status. The Department-administered Georgia State Health Benefit (state employees) and Board of Regent's Health Plans (university employees) will pay 100 percent of **charge** reimbursement for outpatient services provided by Critical Access Hospitals. In addition, the Department also provides 100 percent reimbursement for outpatient services delivered to Medicaid enrollees at Critical Access Hospitals. In return for this enhanced payment, participating hospitals commit to developing regionally coordinated systems of care. This unified payment policy has the potential to help stabilize the rural health infrastructure in underserved communities, according to Coopey.

Many SRAP lead agency project directors made presentations on their respective rural access programs. (SRAP state project summaries can be found by visiting the SRAP website at www.hmc.psu.edu/rhpc and clicking on Lead Agencies/Contacts.) SRAP Director **Michael Beachler** also gave an overview of philanthropic funding sources available in the Southeast.

The meeting was funded by two federal agencies, Office of Rural Health Policy and Bureau of Primary Health Care, and the SRAP National Program Office.

National Governor's Association meeting at a glance

Wil Baker, EdD, Alabama SRAP co-director (left), discusses the state's healthcare climate with **Don Weaver, MD**, Director - National Health Services Corp, during the National Governor's Association meeting in Atlanta. In his remarks to the group Dr. Weaver discussed coordinating data systems, services and funding -- emphasizing that states can't achieve 100% Access/0% Health Disparities without these three elements.

Enjoying some light after-lunch conversation at the NGA meeting are **Keya Jordan**, NGA (standing), **Steve Dorage**, Region IV, HRSA Atlanta Field Office consultant (rear left); **Robert Pugh**, MS Primary Health Care Association (front left); **Jerry Coopey**, Office of Rural Health Policy (rear right); **Perelia Taylor**, Office of Primary Care Liaison - MS State Department of Health (center right); and **David Lightwine**, Office of Rural Health - MS Department of Health (front right).

Mississippi Delta Beyond 2000 Conference

(L-R) **Deborah Slayton**, VP - Arkansas Enterprise Group; **Wilbur Peer**, associate administrator - USDA Rural Business - Cooperative Service; and **Bill Brandon**, National Advisory Committee Chairman and president - Southern Bancorporation, take some time for R&R during the Mississippi Delta Beyond 2000 National Conference held this past May in Arlington, Virginia

Policy Briefs

Mississippi – Governor Ronnie Musgrove signed HB 846 into law April 24, paving the way for physician assistants (PA) to seek licensure from the MS State Board of Medical Licensure. Mississippi is the last state to license PAs. Earlier this year the MS Nurses Association and the MS Academy of Physician Assistants agreed on the wording of this legislation after years of haggling over the issue of minimal educational requirements. The new law, which took effect July 1, requires that applicants for PA licensure on or after December 31, 2004 must hold a minimum of a master's degree in a health-related or science field. Currently practicing PAs are eligible for licensure, if they submit an application before December 31. Graduates of accredited PA educational programs between now and December 31, 2004 must possess a minimum of a baccalaureate degree and pass the National Commission on Certification of Physician Assistants certification exam.

Another piece of legislation adopted this past session, HB 729, established a medical education scholarship program to provide 20 full scholarships for students attending the University Of Mississippi School Of Medicine. In return for the free medical school education, the recipient must agree to practice family medicine for at least 10 years in a critical needs area of the state. The program will be funded from monies appropriated from the state's Health Care Expendable Fund.

First 21st Century Challenge Fund grant made

Southern Rural Access Program Director **Michael Beachler** announced the approval of a two-year $285,258 grant to The Center for Rural Health Development, Inc., the lead agency for the West Virginia SRAP initiative. The Center was the first applicant to be awarded a grant from the 21st Century Challenge Fund, a new grant program funded by The Robert Wood Johnson Foundation (see story below). The Southern Rural Access Program awarded the grant to support the West Virginia Community Health Transportation Initiative. *"The initiative will assist five communities in addressing transportation barriers to healthcare by better coordinating existing resources and developing collaborative relationships to address other transportation needs,"* explained Beachler.

Data indicate 81% of the rural population in West Virginia lives in areas that are either not served by public transportation or have below-average service. Over 67,000 rural households are without cars. Beyond this data little information exists about the problems of accessing healthcare due to transportation difficulties.

"Communities are in the best position to identify their needs and develop and implement solutions," said **Ken Stone**, program manager - WV Rural Health Access Program. *"While a number of transportation resources may be available to a community, they are often managed by programs that address the needs of specific population groups such as senior citizens, disabled persons, Medicaid recipients or specific facilities such as transportation vehicles operated by hospitals, primary care centers or mental health facilities. Service providers, whether they represent health care organizations, social services agencies, or transit authorities, have indicated that some of the transportation resources that currently exist may not be used to full capacity because of restrictions placed on them by funding sources."*

The WV Rural Health Access Program Transportation Workgroup developed a strategic plan consisting of two initiatives. The first, the Community Health Transportation Initiative, will assist selected communities in addressing transportation barriers to accessing health care services. The second initiative, a state-level effort, addresses policy-related barriers that inhibit communities from implementing improvements designed to address their transportation needs. The goal of the plan is for a sustainable state-level program to be developed based on lessons learned from the community-based initiative.

Description of Program

The Community Health Transportation Initiative assists select communities in reducing transportation barriers to healthcare by better coordinating the resources that currently exist in their communities and developing collaborative relationships to leverage additional resources. The initiative focuses on finding ways to use scarce resources for the greatest good and to maximize the use of available transportation resources. It is not intended to focus on any specific healthcare organization or facility. It encourages activities designed to improve access to healthcare and quality of life for community residents.

The five community projects selected were Senior Life Services of Morgan County, Inc., Preston County Senior Citizens, Inc., Eastern Regional Family Resource Network, Plateau Medical Center and Kanawha Valley Senior Services, Inc. Each organization developed a business plan outlining

ways to improve access to healthcare through improved coordination of transportation resources that currently exist and collaborations to address gaps that exist after coordination has taken place in the community.

The communities were competitively selected based on the following criteria:

- potential to make sustainable improvements in access to healthcare by addressing transportation needs
- strong partnerships that include representation from healthcare organizations, transportation providers, underserved populations and communities, social service agencies and public officials
- financial and resource commitment of partners
- effective use of grant resources
- strong linkages to other access-improvement efforts
- quantifiable improvements in reducing transportation barriers that result in improved access to healthcare services.

Other funding sources are a one-year $150,000 grant from the Claude Worthington Benedum Foundation, a $14,000 grant from the Greater Kanawha Valley Foundation and in-kind support from the lead agencies and their partners. The Center and the five communities will approach these Foundations in 2001 to seek continuation funding for the second year of the project.

More information on the project can be obtained by calling **Ken Stone** at 304-766-1591.

21st Century Challenge Fund seeks proposals

The Southern Rural Access Program national program office is accepting grant applications on an ongoing basis for innovative pilot demonstrations or small analytical projects that address specific healthcare problems and increase access to basic healthcare within the eight states served by SRAP. The 21st Century Challenge Fund encourages creative risk-taking and finding viable solutions to the challenges faced by medically underserved rural communities in Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Texas and West Virginia. Proposals must include matching funding sources from other philanthropic, public or private sources to be eligible for the program.

To date, 16 proposals have been submitted for review. Of the three proposals that were submitted before the first review deadline of April 14 only one, the West Virginia Transportation project, was approved. Another 15 proposals are currently under review. Award discussions are anticipated within the next several months.

"*Applications can be submitted at any time; however, approximately every three months – April, July, October and January – we will begin reviewing about mid-month those applications that have been received since the last deadline,*" explained NPO Deputy Director **Isiah Lineberry**. "*We anticipate that the review process will take between two and four months. During the review process we will send applicants letters of acknowledgement and once a decision has been rendered by the review committee, we will notify applicants of our decision.*"

This 30-month $2.5 million innovative grantmaking initiative is funded by The Robert Wood Johnson Foundation. Individual grant awards are expected to range between $50,000 and $250,000 generally.

AEG approves three loans totaling nearly $2.2 million

The Arkansas Enterprise Group (AEG), the lending administrator for the Arkansas Revolving Loan Fund Program, has facilitated the processing of three loans since the program's inception. In October 1999, AEG received a $500,000 grant from The Robert Wood Johnson Foundation to provide start-up seed capital for the loan fund. As a result of AEG's efforts, funds have been distributed to Helena Hospital Association, Corning Area Health Care, Inc. and Crosset Health Foundation. To date, the loans disbursed total $2,197,000.

"Loans are available for physicians, community health centers, rural health clinics, emergency medical services, healthcare network development, wellness initiatives, dentists, pharmacists and hospitals," explained **Rodney O. Parks,** loan fund program director. *"Funds can be used for start-up, working capital, practice management services, rent, equipment, training systems or other infrastructure such as transportation or computerized information systems. By working to maintain and improve the healthcare infrastructure we should be able to increase the economic viability of healthcare in Arkansas."*

Helena Hospital Association received a loan of $450,000 from First National Bank of Phillips County to attract new physicians to the area, including the hospital's only surgeon. A new federally funded community health center in rural Arkansas, Corning Area Health Care, Inc., received a $1.1 million loan, including funds from Arkansas Capital Corporation and the US Department of Agriculture (USDA). The Crosset Health Foundation received a loan of $642,000 from funds secured from the USDA and AEG to build a new multi-specialty physician office building adjacent to Ashley County Medical Center.

Meet Our NAC Member

Doris M. Barnette, MS

Principal Advisor to the Administrator, Health Resources and Services Administration
US Department of Health & Human Services

Doris Barnette hasn't veered very far from her course of study since she graduated cum laude from Northeast Louisiana University with a BA in social work. While completing her masters of social work at the University of Southern Mississippi, she worked as a graduate research assistant. She began her lengthy career in public health as a medical social worker for the Mississippi band of Choctaw Indians at the Choctaw Health Center Reservation and then as a social worker with the National Health Services Corp in the Mississippi Delta. "*Having worked in these two extremely depressed areas made it very clear to me that access to care was a major and critical need,*" said Barnette of those experiences.

"*I was born and grew-up in Louisiana and have worked there as a consultant. I have strong personal stakes to several other states – Mississippi, Alabama and Arkansas – and I have working knowledge of South Carolina, West Virginia and Georgia,*" explained Barnette. "*I take great pleasure in serving on the NAC and my ties to the deep south are probably one of the reasons I was asked to serve.*" Currently, Barnette serves the US Department of Health and Human Services as the principal advisor to the administrator - Health Resources and Services Administration (HRSA). She said that many of the nation's safety net services are provided by HRSA-funded entities, such as community health centers, Ryan White providers, Area Health Education Centers and others. "*The efforts The Robert Wood Johnson Foundation is trying to capitalize on are very similar to those of HRSA.*"

Barnette said she views her role on the NAC as more than just overseeing the use of funds. "*I enjoy dialoguing with the grantees and sometimes can't refrain from giving advice when I should be asking questions. I'm a problem solver, mentor and listener. There's nothing more exciting than sitting around a table and figuring out how we can get the most out of a program. I am amazed at the ability of the Foundation to take seed money and use it to call people to the table that don't usually come together. I commend the national program office and RWJ for their expertise in facilitating this. It's a lesson in coordination and collaboration.*"

She acknowledges that while collaboration and coordination are essential, in some places it's harder to gain collaboration. "**Bringing together people around a common interest is a hard thing to do, but very rewarding. On site visits when various groups representing multiple organizations present a joint idea, we know a lot of blood, sweat and tears went into it. We learn and grow from each other. It's the best way to serve the people.**"

Barnette has spent her entire career directly helping those in need or working to find solutions to the different challenges facing the medically underserved. Her experience includes several adjunct faculty and university staff appointments, plus a variety of public health management positions. She also has provided consultative services at various times throughout her career. She

began working for Earl Fox, her present boss and HRSA administrator while working with an Improved Child Health Project in the Mississippi Delta. She jokingly admits that she has been following Earl ever since and has had a *"strong partnership with him since 1980."*

She says she knows the least about the revolving loan fund component of SRAP, but has learned quite a bit about the development of these funds since becoming a NAC member. Because she works with the agency that administers the National Health Services Corp, she probably knows most about provider recruitment and retention efforts. She says she is deeply interested in the capacity of CHIP (Children's Health Insurance Program). Her vision for CHIP is that *"every child can access care, not just have a card to obtain it."*

Barnette said that access is more than just having a provider. *"There needs to be diversity and distribution of the healthcare workforce. People should be cared by providers who understand their culture and their healthcare challenges. HRSA has undertaken initiatives to address this issue and SRAP also has a collection of activities designed to address this issue. Ensuring access to healthcare for all Americans includes a whole array of activities."*

She said she feels the program is on track. *"I grew up in the system and understand that it's a long way from conceptualization to funding and implementation. Some states are farther ahead than others are, but every state is running as fast as it can. I can't point to any one state and say they have done a poor job, but I can point to every state and say they have done a good job with what they have been dealt."*

An improvement in the service delivery system is something Barnette hopes can be accomplished through the Southern Rural Access Program. *"We need to see an increase in leadership and a more stable workforce within the states. More people need to speak out for vulnerable populations. The revolving loan fund is a supporting activity that will allow for better capital expansion and improvements in our existing systems."*

Despite her bright visions for the future, Barnette cited several challenges. *"The states will need to maintain their momentum, vibrancy and enthusiasm. They will need to keep their interest and energy flowing by constantly tweaking and improving whatever they are doing. When they run into a brick wall, they will need to find another avenue to accomplish the task.*

"The Foundation did a good job identifying some of the most depressed areas of the country with this program. Now, I would like to see the Foundation expand the program into remoted areas of the West where it's expensive to give care because of the dearth of providers. I envision the program to be similar in concept, but different in its strategy and program components."

SRAP state tobacco settlement updates

Editor's Note: *In the October 1999 issue of Rural Health Connections we provided an update on the tobacco settlements for each of the eight states participating in the Southern Rural Access Program. At that time no major legislative action had been taken in Arkansas, Georgia and South Carolina. Since that time key policy decisions have been made in these three states. The following brief reports summarize those actions.*

Arkansas – On July 7 Governor Michael Huckabee announced that enough signatures had been secured to place a referendum on the November electoral ballot for voters to have a say in how the state would spend the anticipated $1.6 billion from the state's settlement with the tobacco industry. Gov. Huckabee supports a plan drafted by the Coalition for a Healthy Arkansas Today (CHART), a group comprised of health professional organizations, healthcare institutions and citizen groups, that emphasizes long-term solutions, expansion of Medicaid benefits, smoking prevention and cessation programs, construction of research facilities at two state universities and development of a School of Public Health. The CHART plan would not spend any of the settlement money on programs until the trust fund containing all the settlement proceeds totaled $100 million.

Georgia – Governor Roy Barnes recently signed the new state budget allocating $86.9 million of the state's tobacco settlement funds (58% of the state's $150 million first year payment) for healthcare related programs. The remaining $63.1 million will be used to initiate the One Georgia Fund for rural economic development. Specific programs to benefit from the settlement include Medicaid, PeachCare for Kids (expansion to cover pregnant women and children up to 235% of the poverty level), Independent Care Waiver and Traumatic Brain Injury Waiver, Chronic Disease Prevention, Mental Retardation Waiver, AIDS Drug Assistance and smoking prevention and cessation programs. Funds also will be used for rural health system development ($3.5 million); implementation of an infant universal hearing screening program; expansion of community based services for senior citizens; development of a new early intervention program to provide intensive outreach services for at-risk families in conjunction with state and federal TANF funds; implementation of a program to provide a nurse in each public school; and expansion of community-based services for mentally handicapped clients.

South Carolina – As part of its master settlement agreement with the tobacco industry South Carolina received an initial payment of $165 million. These dollars were spent on a variety of "one time projects", including a prescription drug program for seniors, a sexual predator program, funding for hospitals and other health and human services programs. The state has agreed to securitize, or take the lion's share of, its $700 million to one billion dollar settlement as a lump sum payment. It's anticipated that 73 percent will be used for healthcare initiatives, a relatively high proportion for a tobacco-growing state; 10 percent for rural economic development and two percent for water and sewer improvements. The remaining 15 percent will be shared among tobacco farmers and allotment holders.

A message from the program director

A real town has a Dairy Queen, a food store, a Ford or Chevy dealer and healthcare. – Steve Shelton, CEO - East Texas AHEC, during a "sweet tooth" moment on a September 1999 site visit to East Texas and the state capital in Austin.

-- Michael P. Beachler

Well, maybe every "*real town*" doesn't have a Dairy Queen, but it sure should have access to basic health care.

Since the beginning of 1999, three small rural hospitals have closed in East Texas and many others are existing week to week or month to month. The Texas Organization of Rural and Community Hospitals is predicting the closure of **up to** two thirds of Texas' small rural hospitals as a result of the cumulative affect of the Balanced Budget Act of 1997 and changes in Medicare's hospital outpatient payment system. Four hospitals in rural Georgia and at least one in Alabama (Perry County) have closed in the past 15 months, an indication that this may becoming a regional, if not national trend. (These eight hospital closures in three SRAP states are greater than the **national** average of seven closures/year that this country experienced over the 1994-1997 period, as reported by Tom Ricketts and Paige Heaphy in "Rural Health in the United States.")

Virtually all the Southern Rural Access Program sites are focusing their efforts on underserved communities that are having difficulty maintaining the existing primary care, hospital and other components of their healthcare infrastructure. Defining what level of basic healthcare their community "needs" or can afford is one of the major challenges faced by rural communities involved in the SRAP effort. Many of the funded network efforts are using a strong community development approach to engage a broad spectrum of community leaders in counties that have recently lost their inpatient hospitals. In some places, like Hardin County, Texas, community leaders have voiced little political will to raise the revenues to reopen the hospital or look at a more regional approach to rebuild their health care infrastructure. In two communities (Franklin and Vermillion) in the pilot South Central region of Louisiana, the voters recently approved increased tax levies to maintain their hospitals and Vermillion leaders are also considering using local resources to expand their primary care infrastructure.

The communities involved in the Arkansas River Valley Rural Health Cooperative (see pg. 5 article) are using a variety of approaches including Critical Access Hospital designation for three of their inpatient facilities, local tax levies (one passed and one proposed) for two of the hospitals, a pilot pharmaceutical drug assistance and disease management program and an innovative, but high risk community health plan designed to create an improved care financing arrangement for the medically indigent. The Arkansas River Valley Rural Health Cooperative has and/or plans to combine philanthropic, private, federal, state and local public resources to sustain and increase access in this very challenging time.

State policy makers in other SRAP states are also taking innovative approaches to help improve or sustain the rural health infrastructure. Georgia, under the leadership of Gov. Roy Barnes and Department of Community Health Commissioner Russ Toal, has recently implemented creative

hospital reimbursement reforms for Critical Access Hospitals and a novel linkage of economic tax credits to insurance coverage package. (NGA article).

Both of these community-driven models and state policy actions bear watching. Some will be successful and serve as important models for their state, the region and possibly the nation. Others will face significant implementation challenges and will either fail or will need to be significantly modified.

At the national program office we look forward to our continued work with community and state stakeholders to improve the SRAP funded models' chances for success, as well as actively promoting and disseminating information about other promising approaches taken by state and community leaders. In this way, the program can be a powerful catalyst to helping "*real people in real towns get real healthcare.*"

Newsmakers

Congratulations to **Doris Barnette**, SRAP National Advisory Committee, on receipt of the John McQueen Award at the Association of Maternal and Child Health Programs annual meeting.

Frances Henderson, EdD, RN, SRAP National Advisory Committee, has been appointed Vice Chair - Collegiate Council of Nursing Education. The Collegiate Council is an 18-state regional body that helps guide the development of nursing education in the Southeastern Region of the country.

An article, *AHECs and Philanthropy: Demystifying the Rubik's Cube of Foundation Funding*, by **Michael Beachler**, SRAP Director, was published in the Autumn/Winter 2000 issue of the National AHEC Bulletin. Another article published in this issue, *Louisiana AHEC Center Serves as a Financial Resource Center,* was co-authored by **Susan C. Dollar, PhD**, senior rural health development specialist on the AHEC portion of Louisiana's SRAP grant, and **Brian P. Jakes**, CEO - Southeast Louisiana AHEC and Rural Loan Development Fund.

Congratulations to **Sandra Pope**, Director - West Virginia State Office of Rural Health, who graduated in June from the Public Health Service Primary Care Policy Fellowship in Washington, DC.

John "Buddy" Watkins, Executive Director - South Carolina State Office of Rural Health, has joined the National Rural Health Association Board of Directors and also serves as the chair of the State Office Council.

Around the States

Graham L. Adams, has been promoted to director - SC State Office of Rural Health (SCSORH). Succeeding him as SCSORH associate director and project director of the SC Rural Health Access Program (SCRHAP) is **Amy Brock**. **Cynthia Frazier** has been promoted to Amy's former position as SCRHAP project coordinator. **Jennifer Kennedy** joined the staff as program assistant. All four can be reached by calling 803-771-2810.

Ingrid Bowden, East Texas Rural Access Program, was promoted to Project Director, replacing **Sam Tessen**, Center for Rural Health Initiatives, who will remain as a consultant to the Texas program. Ingrid can be reached at 409-772-7882.

Nichole M. Dupree has joined the staff of the Louisiana Rural Health Access Program as program coordinator. Nichole can be reached at 504-680-9352.

Additions to the WV Center for Rural Health Development staff are **Ken Stone**, program manager, **Jim Toney**, revolving loan fund manager, and **Ginger Thompson**, communications director. Ken, Jim and Ginger can be reached at 304-766-1591.

Calendar of Events

August 25-30
31st Annual Convention & Community Health Institute
Sponsored by the National Association of Community Health Centers
The Palmer House Hilton, Chicago, IL
For information contact Jennifer Shehan at 202-659-8008, ext. 125 or e-mail her at JShehan@NACHC.com.

November 1-3
Rural Health Leaders Development
Southern Rural Access Program Grantee Conference
Charleston, South Carolina
For more information call the SRAP National Program Office at 717-531-2090.

December 7-9
"Involving Youth in the Future of Rural Minority Care"
6th Annual Rural Minority Health Conference
Hyatt Regency Hotel, Savannah, GA
For more information contact the HRHA at 816-756-3140 or mail@NRHArural.org.