Practice Sights: State Primary Care Development Strategies

BY IRENE M. WIELAWSKI

Robert Wood Johnson Foundation

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Stephen L. Isaacs and
James R. Knickman
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Editor's Introduction

Since its establishment as a national philanthropy in 1972, the Robert Wood Johnson Foundation has consistently pursued the goal of increasing the access of all Americans to health care services. It has given a high priority to expanding the number of Americans having health insurance coverage–for example, by funding a series of surveys providing data on uninsured Americans, a variety of programs to make it easier for children to obtain health insurance, and a number of policy development and public education initiatives to keep health insurance coverage in the public eye.[1]

Insurance coverage is only one factor determining access to health care services, of course. Over the years, the Foundation has addressed a range of problems that hinder access. One area that has commanded particular attention is development of a health care workforce capable of providing, and willing to provide, services to people without a regular source of health care, especially those living in rural areas. The Foundation has endeavored to increase the number of physicians practicing primary care and has played an important role in developing the fields of nurse practitioner and physician assistant.[2] It has also funded programs to increase the number of minority physicians and other health practitioners, largely on the ground that they tend to serve minority patients.[3]

Beyond trying to increase the *supply* of health practitioners able to aid underserved populations, the Foundation has also sought ways to make the *distribution* of health practitioners more equitable. A major program to encourage health practitioners to work in rural areas was Practice Sights. In this chapter, Irene Wielawski, an award-winning journalist, the evaluator of the Foundation's Reach Out® program, and a frequent contributor to the Robert Wood Johnson Foundation *Anthology* series, examines this ambitious ten-state effort.

Wielawski explores why it is so difficult to recruit and retain health practitioners in rural settings and discusses other efforts–largely the federal government's National Health Service Corps–to encourage physicians and their families to move to rural areas. Focusing particularly on New Hampshire, Nebraska, and Virginia, Wielawski describes how the states participating in Practice Sights attempted to increase the availability of health care practitioners in rural areas.

Practice Sights was one of a number of Foundation programs–past and present–designed to improve health care services in rural areas. For example, the Foundation funded the Rural Infant Care program and the Rural Hospital Program of Extended-Care Services in the 1980s.[4] It currently

supports the Southern Rural Access Program, which aims at increasing access to health care services in eight largely rural southern states.

Notes

[1] Other chapters of the *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology* series on the Foundation's work to increase access to health care are Isaacs, S. L., and Knickman, J. R. "Strategies for Improving Access to Health Care–Observations from the Robert Wood Johnson Foundation Anthology Series" (vol. V, 2002); Berk, M. L., and Schur, C. L. "A Review of the National Access-to-Care Surveys" (1997); and Holloway, M. Y. "Expanding Health Insurance for Children" (2000).

[2] Other chapters of *The Robert Wood Johnson Foundation Anthology* series on the Foundation's workforce programs are Isaacs, S. L., Sandy, L. G., and Schroeder, S. A. "Improving the Health Care Workforce: Perspectives from Twenty-Four Years' Experience" (1997); and Keenan, T. "Support of Nurse-Practitioners and Physician Assistants" (1998–99).

[3] Lois Bergeisen and Joel C. Cantor examine the Minority Medical Education Program in *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology.* San Francisco: Jossey-Bass, 2000.

[4] Other chapters of *The Robert Wood Johnson Foundation Anthology* on the Foundation's rural health programs are Holloway, M. Y. "The Regionalized Perinatal Care Program" (2001); and Begley, S. "The Swing-Bed Program," Chapter Eleven in this volume.

David Adams is a recent recruit to the health care system of Fairbury, Nebraska, population four thousand. An M.D., he works with four other family practitioners at the Fairbury Clinic, which is the source of primary care for most of Jefferson County–a large, rectangular chunk of farmland on the Nebraska-Kansas border. People travel an hour or more in all kinds of weather to get to the clinic, but they rarely complain of inconvenience. You don't have to go back many generations in rural America to hear firsthand what it was like when there was no doctor.

The inconveniences, moreover, are not borne entirely by patients. Adams and his colleagues must deliver twenty-first-century medicine in a setting that lacks the backup specialists and high-tech equipment they took for granted in training. The nearest specialists are in Beatrice, about fifty minutes from Fairbury. Lincoln, the state capital, where Adams trained, is more than a two-hour drive, and Omaha is three.

"We have to be able to do just about everything–the sore throat, the heart attack, the car wreck," says Adams, who happens to relish the challenge. Rural practitioners also speak of personal rewards that come through knowing their patients as fellow members of a community rather than as strangers passing through a busy urban practice.

Yet Adams and his sort are a scarce commodity. Only 2.6 percent of medical school graduates choose practice in a small town or rural area, according to the Association of American Medical Colleges. Over the years, this has resulted in a lopsided scenario in which fifty-one million rural Americans–roughly 20 percent of the nation's population–are being cared for by less than 10 percent of the nation's practicing physicians. Poor inner-city neighborhoods are similarly underserved because of a scarcity of health care providers.

This is not a new problem. The provider imbalance has worried academicians, government leaders, and health policy experts for more than thirty years. Periodically, efforts are launched to correct it, but there has been little measurable long-term improvement. Between 1980 and 1990, the number of federally designated Health Professional Shortage Areas, or HPSA, remained constant, at 1,956. The number of HPSAs steadily rose through the 1990s, despite an overall increase in the U.S. physician supply. By 2002, they totaled 3,168, of which 2,209 (70 percent) were in "nonmetropolitan" areas, as designated by the U.S. Health Resources and Services Administration. To eliminate these rural shortages would require successful recruitment and retention of 3,327 additional primary care physicians.[1]

There are several reasons for the continuing shortage. Income potential for a physician is lower in an underserved area, and many physicians today emerge from training with significant debt. Long hours, professional isolation, and lifestyle preferences are also cited as factors. Beyond these, however, rural health experts point to the absence of a national plan to improve the geographic distribution of health care providers. Efforts to date have been largely piecemeal, with little coordination among government and private sector initiatives.

Perhaps the best known of these initiatives is the National Health Service Corps, made up of physicians who agree to be posted to underserved areas of the United States in exchange for repayment of medical education loans. The Corps has been an excellent source of physicians for localities that would have had a hard time recruiting on their own. Unfortunately, Corps physicians tend to leave when their contracts are up, sending these communities scurrying once again for what is still the most essential component of any health care system: a doctor.

Historically, states have not, until recently, paid much attention to their medically underserved areas, often considering them a federal responsibility, similar to the provision of health insurance (Medicaid and Medicare), welfare, or housing support for the very poor. Some states have experimented with homegrown solutions, such as loan repayment and *locum tenens* (substitute doctor) programs, to ease the economic and workload burden on providers. The majority, however, simply clamored for more National Health Service Corps doctors, more federally funded clinics for poor and uninsured patients, more federal response in general.

Finger-pointing at the feds may be convenient for governors, but it didn't sit well with state public health professionals. Just as poverty and a lack of insurance have measurable consequences for the health of individuals, so does a medically underserved area have consequences for population health. Population health is the means by which public health professionals measure their own performance. As the provider shortages persisted, it became apparent that medically underserved areas were dragging down population health statistics. People in these communities *are* sicker than residents of communities with sufficient doctors and health centers.[2] They also tend to have a lower immunization rate, higher infant mortality, and other measurable deficits. Smart program design, compelling health promotion campaigns, determined outreach workers–all fail without health care providers to deliver the goods.

It was against this backdrop that the Robert Wood Johnson Foundation decided to offer a challenge to states to come up with more comprehensive approaches to recruitment and retention of rural and inner-city health care providers. The $16.5 million program was called Practice Sights: State Primary Care Development Strategies. Its overriding goal was to improve access to primary health care by increasing the number of providers in underserved areas. Physicians were only one type of provider envisioned by those designing Practice Sights. The program also sought to introduce physicians' assistants, nurse practitioners, and nurse midwives into underserved communities, and to improve the regulatory climate in states that restricted these mid-level practitioners from fully using their skills.

Success in landing recruits is only half the task; the other half is, How do you get them to stay? The Foundation had more ambitious goals than to merely duplicate underserved communities' experience with the National Health Service Corps. To this end, Practice Sights challenged states to come up with ways to make medical practice in these communities economically viable and to ameliorate the conditions that lead health care providers to leave, among them professional isolation and excessive workload.

Practice Sights was authorized by the Foundation in the fall of 1991 and ran through 1998. A National Program Office, or NPO, was established at the North Carolina Foundation for Alternative Health, under the direction of James D. Bernstein. Practice Sights clearly struck a chord with state health officials eager to emancipate themselves from dependence on disparate federal programs: forty-four of the fifty states responded to the NPO's request for proposals. Of these, fifteen were successful in winning Practice Sights planning grants of up to $100,000.

The planning grant was to be used to lay the groundwork for effective recruiting and retention of physicians and midlevel practitioners. Planning activities included assembling interagency working groups; building liaison between state entities and underserved communities; developing statewide information systems to track vacancies and advertise for candidates; and removing licensing or other barriers to effective use of physician assistants, nurse practitioners, and other non-M.D. primary care providers.

Practice Sights moved into its second phase, implementation, in the summer of 1994. The Foundation authorized a new round of grants averaging $800,000 that states could use over three years to carry out ideas honed in the planning phase. Of the fifteen states that received planning grants, ten were successful

in winning implementation grants: Idaho, Kentucky, Minnesota, Nebraska, New Hampshire, New Mexico, New York, Pennsylvania, South Dakota, and Virginia. These states mostly focused on underserved rural areas, even though Practice Sights originally aimed at addressing human resource shortages in both rural and inner-city settings. As a result, the collective Practice Sights effort emphasized rural issues.

PROGRAM OVERVIEW

Practice Sights swam against the economic and cultural tide of American medicine and long-established trends among medical school graduates to head for metropolitan practices, where pay and prestige are greatest. The program set three goals for grantees:

1. To increase the number of primary care providers in underserved areas
2. To improve reimbursement levels and working conditions in underserved areas so they have a better chance of attracting and keeping providers
3. To increase the state's capacity to support primary care systems

For a single site to achieve even one of these goals in the relatively short run of the program would have been impressive. To make headway during the particular years of Practice Sights is nothing short of amazing, for there has probably been no period of greater upheaval in the history of the American health care system.

Practice Sights' debut coincided with widespread public and political concern about the plight of the medically uninsured and the unreliability of the private insurance system. Passage of some type of national health reform was considered imminent. The universal health coverage included in most proposals before Congress was especially important in the context of Practice Sights, since medically underserved areas have a relatively high proportion of uninsured or inadequately insured patients. If federal reform gave these patients a means to pay for medical treatment, health systems and providers in underserved areas would benefit as well. This could only enhance the prospects for successful recruiting and retention. No one designing Practice Sights in the early 1990s or applying for one of its grants could have anticipated the failure of President Bill Clinton's Health Security Plan in 1994, and the domino effect on all other reform proposals. The timing was particularly onerous; congressional leaders declared health reform dead only a month after Practice Sights' most adventuresome states entered the high-risk implementation phase.

There followed a dizzying period of health care system reorganization and consolidation, in anticipation of a managed care juggernaut. Rural health systems were caught up in the general frenzy. New Hampshire, for one, saw its rural hospitals scrambling to buy out physician practices, or to affiliate with neighboring hospitals. These local health systems believed their best defense against the shrewd deal making of gigantic multistate managed care companies was to array patients and other assets into a unified front. The feared alternative was to be picked off one by one and lowballed on reimbursement rates. These turned out to be costly strategies, fueled by fear. By the late 1990s, it was clear that managed care companies had little interest in rural markets. But Practice Sights was already well along by then.

"There were pluses and minuses to that period," says Jonathan Stewart, director of the Community Health Institute in Concord, New Hampshire, a collaborator on that state's Practice Sights project. Pluses included an unusual receptivity to new ideas among normally tradition-bound rural physicians and hospitals. On the other hand, with day-to-day survival a foremost concern, it was difficult to get people focused on long-term systemic improvements.

Another wild card in Practice Sights was the character of rural medicine in each of the participating states. It is a running joke among rural providers that the only people who can comfortably generalize about their working conditions are researchers studying them from the climate-controlled comfort of an urban think tank. That said, rural providers themselves tend to generalize from their own experience, which may not be the norm for others. The Practice Sights states exemplified this variation in functional definitions of rural and medically needy. New Hampshire, for example, has a hospital every thirty miles or so in its underserved North Country. Providers and patients in larger states such as South Dakota and Nebraska would consider this pure luxury (that is, until they tried driving New Hampshire's twisty North Country roads in January). As for the needs of Virginia's rural communities, well, it depends upon which part of the state you're talking about. Says Deborah D. Oswalt, executive director of the Virginia Health Care Foundation and a Practice Sights collaborator:

> Our southwest tail–that's Appalachia–has such difficult terrain that it can take you an hour to go ten miles, especially if you get behind a coal truck. We've got Southside Virginia, which is a very different place with very different people. It is still very agricultural. More than a third of the population over age twenty-five in Southside has not completed high school. There is still housing in some places with dirt floors and no indoor plumbing. Then we have the Northern Neck, which is in eastern Virginia near Chesapeake Bay. We have a lot of watermen there who make their living by fishing and crabbing and oystering, and their health issues and travel issues

> are very different from those of the mountain and Southside people. You simply cannot generalize about rural health needs, not even in a single state.

Practice Sights had a final twist. In addition to traditional grant funding, the Foundation offered participating states a highly atypical business deal. Essentially, the Foundation took on the role of a bank, sending seed money to grantees so that they in turn could create a loan fund to give rural providers access to low-interest capital. The Foundation loans—called Program-Related Investments, or PRIs—ranged from $700,000 to $1.5 million.[3] Payback with interest was required within ten years. Only four of the ten Practice Sights grantees took the PRI option, and it proved to be a rocky experiment for all concerned, with mixed results.

A SHOWCASE OF LESSONS FROM THREE STATES

The lessons of Practice Sights found their best showcases in three states: New Hampshire, Nebraska, and Virginia. These states exemplify the rural diversity that characterized the program, and their experiences underscore the importance of local fine-tuning if a national workforce strategy ever materializes. These states also emerged as unusually illustrative of how the Practice Sights program played out. New Hampshire used Practice Sights to build a strong statewide provider recruitment system, but it did not develop a loan program and had limited success in other areas of the project, such as improved working conditions. Nebraska's greatest accomplishments came in organizing balkanized rural providers into mutually supportive hospital and physician networks, thereby reducing professional isolation and improving economic stability. But its PRI loan program was a colossal failure. Virginia made little progress in moving recruiting to the state level; the rural physician workforce continues to be replenished through direct recruiting by local practices. However, the Virginia project took a $700,000 seed loan from the Foundation and leveraged it into a successful revolving fund that to date has issued nearly $6 million in low-interest financing for health-related investments in underserved communities.

Recruiting

Why would your average debt-laden medical school graduate choose to work in a setting with limited income potential, long hours, and gravely compromised social options? This was the challenge to Practice Sights leaders. In New Hampshire, the sales job belongs to Stephanie Pagliuca.

Pagliuca is program manager of the New Hampshire Recruitment Center. Located in Concord, the state capital, the Recruitment Center is a not-for-profit enterprise created through Practice Sights. Its track record is impressive. By the end of 2001, the state had filled just about every vacancy in its medically

underserved areas, including the North Country, a sparsely populated region that borders Canada. Overall, since the inception of Practice Sights, a total of 131 physicians and nurse practitioners have been successfully recruited in New Hampshire. Twenty-six percent of those recruited went to HPSAs, a federal designation for regions where the ratio of patients to physicians is greater than 3,500:1. Twenty-nine percent went to Medically Underserved Areas, so-called because population and health demographics–including age, poverty, and a high rate of low-birth-weight babies–show a need for more doctors. The remaining 45 percent went to practices elsewhere in the state.

The Recruitment Center was part of a broad Practice Sights–fueled effort to address a patchwork health care infrastructure in New Hampshire, especially in its North Country. Population and the lion's share of health care professionals and facilities were concentrated in the southern half of the state. Public health workers were scattered and poorly coordinated. The state used the umbrella of Practice Sights to join forces with local community health care organizations. Besides the Recruitment Center, New Hampshire's Practice Sights leaders created the Community Health Institute, which provided consulting services to medically needy communities, administered a state loan repayment fund to enhance recruiting of health care providers with sizeable school debt, and developed preceptor programs with local colleges and universities, through which medical and nursing students were placed in underserved areas. The Institute, in collaboration with the state health department, gained new federal support for New Hampshire by qualifying communities for community health center grants.

The standout legacy of Practice Sights in New Hampshire, however, is the Recruitment Center. Initially supported by Practice Sights grant money and state contributions, the Recruitment Center today is largely self-sustaining. It operates on a fee-for-service basis, charging hospitals, clinics, and physician practices about half what they would pay for commercial recruiting assistance.

Ironically, one of New Hampshire's strongest assets is the relative weakness of what Practice Sights architects thought would be the program's anchor: state health departments. New Hampshire's history is one of decentralized government; its state agencies are bare-bones, and the electorate consistently votes against anything that would expand the power of state government over local community rule.

"The basic social and decision-making unit in New Hampshire is the town–the community," says James W. Squires, a surgeon and former state senator. He currently heads the Endowment for Health, a foundation working to improve health care access in New Hampshire. "It is not the county; it is not a

hospital cachement area; it is not a demographic unit; and it is certainly not state government. Every town has its own police force; every one has its own ambulance, fire department, and education system."

A single town is not the ideal unit for advancing statewide improvements in health systems or workforce, but state officials in New Hampshire are used to modest stature and are adept at getting around the handicap.

"We know right off that we will never have the expertise in state government to guide each community to fulfill its health care needs," says John Bonds, a state health services planner and a Practice Sights project director. "So we are very good at creating community and statewide coalitions to help formulate and carry out programs. Everything is done under contract to existing community-based agencies: visiting nurses, home health care agencies, and the rest."

As a result, Practice Sights in New Hampshire spent almost no time bottled up in health department bureaucracy; instead it immediately began to work with mostly private sector coalitions with established credibility in the health care community. (By contrast, Nebraska's project lacked staff for more than two years because of a statewide hiring freeze that barred health officials from filling the grant-funded position.) Bonds, Pagliuca, and other Practice Sights leaders were able to turn to these community-based coalitions for ideas and practical assistance in implementing the goals of Practice Sights.

For example, at the outset of the 1990s, New Hampshire had only one federally funded community health center, even though numerous localities met the criteria to qualify for federal assistance. What they lacked was the leadership necessary to mount a successful application. This was the genesis of the New Hampshire Practice Sights' consulting arm, the Community Health Institute. State and private sector health leaders saw an opportunity to mobilize communities under the aegis of Practice Sights, since new health centers with funded staff positions for underserved communities would be consistent with the program's goals. The applications were carefully timed to prevent one New Hampshire community from knocking another out of contention. The collaborative approach resulted in nine new health centers–a significant accomplishment for a small state in a competitive federal program.

In building the recruitment center's capacity, Pagliuca and her colleagues took a similarly collaborative approach. She recalls:

> We started out simply responding to requests for candidates to fill vacancies. We did some educating of practices to think about using nurse practitioners, because the University of New Hampshire had an emerging training program. Then we started to link up with other organizations in New Hampshire that were getting similar calls: the medical society, the hospital association. Then we got the nurse practitioner and physician assistant societies joining. Then we linked up to our state loan repayment program, and strengthened our relationship with the National Health Service Corps. That gave us a more comprehensive package to offer candidates.
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> We also helped create marketing materials for the practices, advertisements for publications read by physicians such as *The New England Journal of Medicine*, *Family Physician Recruiter* newsletter, *OBG Management,* and so on.

Gavin Muir was one of the recruiting successes. Muir graduated from Temple University's medical school in 1995 and trained in family practice in a Pueblo, Colorado, residency program strongly oriented to rural practice. He began talking to Pagliuca about job possibilities in August 1997, which was eleven months before he completed training.

"I had some very specific requirements and after that I was flexible," Muir says. "Number one, I wanted to work some place where I could practice obstetrics because I put so much blood, sweat, and tears into the advanced obstetrics program in Pueblo. Number two, I wanted some place that would help me with my loans. I had $160,000 in medical school debt. Number three, my wife and I wanted to be reasonably close to our families–she's from Buffalo. Number four, I wanted a decent quality of life."

All of these criteria were met by the Manchester Community Health Center, where Muir is currently medical director. The health center is one of New Hampshire's new ones, located in a rare pocket of urban need. A manufacturing city of about one hundred thousand residents, Manchester is home to a large immigrant community, with a recent influx of Bosnian and Sudanese refugees. Muir is delighted with his job for professional, practical, and personal reasons.

"I work a four-day week," he says, which enables him to spend time with his wife and four-year-old daughter. "I'm in the fourth year of federal loan repayment because I work in a federally designated underserved area. This means $120,000 in loans paid off so far by the feds. I love what I am doing; I enjoy living where I am. All my friends who did National Health Service Corps got out as soon as they

could because their spouses were ready to kill them. But this is a place where people would love to live. An hour from the beach, an hour from the mountains, a couple of hours from Boston."

Pagliuca acknowledges recruiting advantages for New Hampshire in the state's natural beauty and its relative proximity to a major city like Boston. The Recruiting Center's Website emphasizes these attributes on each informational screen, with luscious photographs of lakes, mountains, and majestic forests. Of course, the appeal is not universal.

Pagliuca recalls a deluge of job seekers from 1996 to 1997, all foreign-born and looking to bypass immigration requirements that they return to their own country after training. A loophole was the J-1 visa program, which exempted foreign physicians working in medically underserved areas of the United States. Pagliuca's experience with one of these physicians illustrates another recruiting responsibility: screening out an unqualified applicant or, simply, a poor fit. As she recalls:

> Many of them I could barely understand over the phone, their English was so poor. How could they practice in our rural areas? We were recruiting for retention, and the lack of cultural outlets for these physicians really didn't make it realistic. There were no appropriate places of worship, no ethnic food stores, that sort of thing.
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> I had one physician from a Middle Eastern country who was interested in a position in our North Country. But he was a vegetarian. There is a real problem getting fresh produce up there in winter. That's a genuine concern, although a lot of times the physicians don't really think about these things. It is our job to bring up these lifestyle and cultural issues with every candidate. Think about this: "You are going to a rural town. What does that mean in terms of social outlets? Does your spouse want to work? Are there opportunities there?"
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> Initially, I felt a little uncomfortable asking these questions about spouses, or dealing with issues of same-sex couples or racial and cultural issues. How many of these questions are discriminatory? We worry about this, but then we realize that the physicians are just as interested in going to a community that will be a good fit for them. We do an awful lot of handholding on both sides.

In the case of the Middle Eastern physician, a site visit helped clarify realities for all concerned. What Pagliuca could not convey during the office interview was amply demonstrated during the visit, which included a stop at the local grocery store. The physician was dismayed by the skimpy produce section,

which his family would depend upon to uphold cultural and religious dietary practices. In subsequent interviews with local physicians and hospital officials, he brought this up as a concern. Eager for help with the patient load, the physicians assured him that he and his family would soon love meat. They even offered to supply his wife with recipes and take him on moose hunting trips.

"He came back to Concord and withdrew his application," Pagliuca recalls. "He told me, 'I am not going to change my beliefs and practices just for a job.' It was a satisfactory conclusion. It wasn't going to be a good fit for anyone."

In Nebraska and Virginia, recruiting continues to be a function of local practices, although Practice Sights did help to establish statewide databanks cataloguing the characteristics of locales, provider needs, and other considerations. Unlike New Hampshire, which is a relatively small state, Nebraska and Virginia must contend with significant distance and diversity in their health systems. The experience of Practice Sights leaders there suggests that a regional approach to recruiting might work better in a larger state, or even that several states with common geography and demographics might collaborate in recruiting. In Nebraska, for example, practices like the one David Adams joined in Fairbury are the easiest to recruit for because the community has a full-service local hospital, urban centers are relatively close, and the Fairbury practice has enough doctors for collegiality and a reasonable work schedule. It is more difficult to sell physicians on a remote community such as Benkelman, six hours' drive from Lincoln, or Calloway, where the district hospital's medical staff consists of a single doctor—a 24/7 job if there ever was one. "I wouldn't say Benkelman is exactly the end of the world," says Dennis Berens of Nebraska's Office of Rural Health. "But you can see it from there."

Even to recruit someone who is as ideal on paper as David Adams was takes creativity. The body of research on rural physicians suggests that those who work out best grow up in a small town; marry someone from a small town; and have a self-confident, take-charge personality. David Adams is all of these. But he brought requirements to the table that typify expectations of the newest medical school graduates—a reality for rural recruiting no less than for a large group practice. His negotiations with the Fairbury Clinic underscore the personal and highly individualized dynamic that Stephanie Pagliuca has found essential to success in New Hampshire.

Adams didn't want to work the twelve-hour days that his seniors in the Fairbury practice considered routine, and he was equally tough-minded about night and weekend duty. He wanted an income

sufficient to meet lifestyle and financial goals. Indeed, most states are finding they cannot recruit rural physicians without a guaranteed first-year income of $100,000 to $125,000. And though it's true that Adams has a spouse to help in his transition to small-town America, that's not her complete job description, as it might have been a generation ago. Mrs. David Adams also happens to be a physician. Any practice hoping to recruit David Adams, M.D., had to come up with an equally appealing position for Kari Adams, M.D. The physician partners in the Fairbury Clinic decided it was worth it to go up to five doctors from four to accommodate both Adamses.

Virginia's rural areas are experimenting with private recruiting on a larger scale. In its southwestern Appalachia region, the not-for-profit Carilion Medical Group handles recruiting for forty-four affiliated private practices. The group has 175 physician members and is a subsidiary of the Carilion Health System, the largest hospital network in western Virginia. The health system provides income subsidies for new physician recruits and for members of the medical group working in extreme poverty areas. For its part, the medical group runs educational workshops and has linked the practices to computerized information systems to keep its members up to date on the latest developments in medical science.

This last element is critical, says James G. Nuckolls, a rural physician in Galax, who is the group's medical director. He emphasizes what so often is left out of the numbers discussion dominating conventional thinking on rural recruitment: rural populations need *good* doctors, not just warm bodies.

"We do our best to recruit the people that seem to be good, but then we watch them real close during the first year," Nuckolls says. "We want to make sure they are real doctors, not just playing at being a doctor to fulfill lifestyle needs. It's like that saying: 'He ain't no cowboy till you seen him ride.' We support them every way we can, but we've got to see that they are hard workers and team players."

Landing quality recruits, however, is only the first step. Keeping them sharp is as much a part of the retention formula as income and lifestyle support, according to Nuckolls. "The thing that happens to rural doctors is that they get isolated and can no longer measure the true quality of their work," he says. "They start to measure themselves by the compliments they receive from patients. Pretty soon, the doctor's head gets so swelled that he's a walking deity. The fact is, medical quality is best judged by one's peers. You've got to be in contact with peers, challenged on the science and so forth, to keep yourself sharp and interested."

Improving Economic Conditions

The dream of Nebraska's rural health planners is to have a dozen networks scattered about the state, mimicking the Carilion system in southwest Virginia. But with Practice Sights they were starting from scratch, and with two strikes against them. First, the historic evolution of the state's rural health system had left individual hospitals and physicians unusually isolated from one another, compared with smaller and more populous states. Second, many of them were struggling financially at the launch of Practice Sights and had little capital to invest in systems change.

Nebraska is very rural. Its two urban centers, Lincoln and Omaha, are on the eastern edge, about an hour apart. These cities are also the center of tertiary care medicine and medical education. As you head west toward the Panhandle region, bordering Wyoming, towns become smaller and farther apart. Large sections of the state don't even qualify as rural, falling instead into the public health definition of *frontier.* No statewide entity–no health department, hospital association, or medical society–can generalize about the characteristics and needs of Nebraska's rural health systems. They pretty much operate as a collection of local fiefdoms, some good, some less so, all fiercely independent in character. This defining ethos goes back to pioneer times, when an isolated community had to develop self-sufficiency or perish. It continues today for remarkably similar reasons. Of 534 incorporated communities in Nebraska, 90 percent have fewer than twenty-five hundred people. But with an area of 77,355 square miles, Nebraska is more than eight times the size of New Hampshire. The one-on-one handholding that Stephanie Pagliuca can do from Concord is not possible from Lincoln. Just to sit down with physicians in the Panhandle means an eight-hour drive.

"You do not come in as a state person in Nebraska and say, 'This is how it is going to be,'" says David Palm of the state Department of Health and Human Services, who led the Practice Sights project in Nebraska and has folded his lanky 6' 6" frame into state cars for many such trips. "You have to soft-pedal everything, and be very respectful of how the communities have traditionally done things, and think carefully about what we at the state level can do to help them accomplish *their* goals."

Dennis Berens, who heads Nebraska's Office of Rural Health and was the mild-mannered Palm's colleague on Practice Sights, adds, "People here don't like outsiders coming in and telling them what to do–not from Lincoln, not from Washington, and not from some big foundation in Princeton. If we tried to do that, it would be 'Just put the money in a bag and leave it at the outskirts of town. …'"

Nebraska's health officials used the Practice Sights grant to organize the state's diverse and far-flung

regions into five provider networks. With varying degrees of success, the networks worked collaboratively to recruit additional health care providers and to provide educational forums for members–both goals of Practice Sights. The networks also joined forces with the University of Nebraska and various state agencies to expand scholarship, loan repayment, and *locum tenens* programs for health care providers willing to work in an underserved area. Practice Sights leaders were also successful in spurring legislative action to eliminate certain practice restrictions on physicians' assistants so they could help alleviate the provider shortage.

As in New Hampshire, Nebraska's Practice Sights leaders got unexpected momentum from rural providers' panic over managed care, which spurred interest in collaborative action. In southeast Nebraska, physicians had already formed the Southeast Rural Physicians Alliance to negotiate managed care contracts and explore other business-oriented group activities such as bulk purchasing of supplies and better rates for malpractice insurance. Similarly, the hospitals in that region had formed the Blue River Valley Hospital Network. Seeing an opportunity for fully integrating the health care delivery system, Palm suggested that the organizations take the next step of collaborating with one another. This led to formation of the Rural Comprehensive Care Network, a physician and hospital alliance made up of local health systems in seventeen counties in Nebraska's southeastern corner.

The southeast network–which today remains the strongest of those organized under Practice Sights–undertakes a variety of projects for its members, including negotiating lower-cost bulk purchase of supplies and better rates on malpractice insurance. It has also started some medical quality-improvement projects. But there is no mistaking the driving force behind these activities: the economic survival of local hospitals and physicians. Even the medical quality-improvement projects are oriented to the bottom line; one purpose is to prove to local residents that they needn't drive all the way to Lincoln for first-rate primary medical care.

Palm, Berens, and other Practice Sights leaders sought to sell the program's goals–improved recruiting, better use of midlevel practitioners, and so on–in the context of these overtly financial concerns. Indeed, Practice Sights stripped down was very much about economic survival. At some point in the program's five-year course, every grantee realized the need to meld principle–improving health care access for rural populations–with the practical: ensuring the financial viability of rural physicians and hospitals. In Nebraska, however, cold reality was a companion from Day One. Consider:

- Pushed to explore the possibility of expanding the capacity of his solo practice with a nurse practitioner, an older rural physician was shocked to discover that the going rate for a salary–

about $60,000 a year–exceeded his own income. He gave up, unable to imagine how to fund the position, given the general poverty of his community.

- In the Panhandle, where state health officials hoped to stimulate formation of a rural health coalition similar to the one in southeast Nebraska, nine of the region's thirteen hospital administrators turned over in two years, a leadership instability related to the very conditions Practice Sights sought to alleviate for physicians.
- Reimbursement rates set by Medicare, the dominant payer in rural Nebraska, were among the worst in the country because of historically low fees charged by physicians and hospitals.

"We had older physicians who were still charging five, eight, and ten dollars a visit," Palm says. "That was going to be a real problem if managed care came in and tried to negotiate on the basis of that rate. We realized we needed to lay some building blocks for improving recruiting and many other aspects of rural health in Nebraska. You can't look just at recruitment and retention as a single issue. The solutions really have to be multifaceted, and you can't attribute them to one program or one set of goals."

Just about everything Nebraska experimented with under Practice Sights came down to money–mostly the lack of it. In its effort to lay building blocks, the health department, as Practice Sights' lead agency, brought in a variety of partners, including the Nebraska Economic Development Corporation, the medical school at the University of Nebraska, the Office of Rural Health, and even private community entities such as the Saint Elizabeth's Foundation. The latter was asked to develop a *locum tenens* program, through which medical residents and emergency room or retired physicians in Lincoln and Omaha would cover for rural physicians who needed a break. Surveys of doctors and potential recruits showed enthusiasm for such a program, but Nebraska's rural health systems could pay only twenty to thirty dollars an hour, which was about fifteen dollars under market. Moonlighters could earn more–and conveniently–by filling openings in the cities or suburbs. "Fifty miles was about the limit of what they wanted to travel," says Donna K. Hammack, of the Saint Elizabeth's Foundation. "Our rural areas were a lot farther than that."

The failure of the experiment convinced Practice Sights leaders of the necessity of locally based human resource solutions. But human resources could not be bolstered without significant improvement in rural health's bottom line–exactly the focus of the program's constituents. Practice Sights leaders redirected their efforts from the specific goals articulated by the grant program to Palm's building blocks. Specifically, they set out to help rural hospitals take advantage of federal programs–designation as a Critical Access Hospital or Rural Health Clinic–that would vastly improve the revenue stream for

providers. Both programs afford an opportunity for qualified providers to secure higher reimbursement under Medicare and Medicaid.

The strategy had remarkable success, similar to New Hampshire's with gaining federally funded health centers. The number of physician practices earning Rural Health Clinic status went from five to seventy-seven in Nebraska; the number of Critical Access Hospitals went from zero to fifty-five, largely as a result of the momentum gained from Practice Sights.

Other building blocks include the startup of three additional hospital/physician networks modeled on southeast Nebraska's Rural Comprehensive Care Network. Practice Sights leaders also gave support to University of Nebraska efforts aimed at creating a supply of health professionals. As it is, the majority of physicians practicing in Nebraska are graduates of the University of Nebraska or its medical school. But to build a supply of *rural* physicians, the university's medical center now sponsors an eighth grade science fair to identify talented students in rural areas. These youngsters become eligible for scholarships to state colleges and, if successful there, are guaranteed admission to a health profession graduate program at the University, including medicine, pharmacy, dentistry, physical therapy, and occupational therapy. The medical school has a special Rural Health Opportunities Program, which rotates students through rural practices to give them hands-on experience. An added benefit is courtesy faculty status for the students' physician mentors, giving these relatively isolated practitioners a connection to the university.

The Loan Program

Virginia was one of only four Practice Sights grantees that dared to tango with the Robert Wood Johnson Foundation's Program-Related Investment idea. The Virginia project was ultimately successful, but only after protracted and dizzying negotiations that left other Practice Sights grantees badly winded. Nebraska had the worst experience and ended up returning the Foundation's money.

The PRI was a relatively new undertaking for the Foundation when program officers made it part of Practice Sights, though conceptually it had been a recognized vehicle for charitable funding since the Tax Reform Act of 1969. Instead of a grant, the Foundation proposed to lend seed money to Practice Sights grantees for a revolving loan fund that would give health care providers access to capital at a favorable interest rate. Unlike a grant, whose use is restricted to project personnel and operating costs, a loan fund could legitimately finance bricks-and-mortar-type investment consistent with program goals. In Practice Sights, one could imagine many such uses, from upgrading a rural physician's office equipment to rehabilitating a Main Street storefront for use as a primary care clinic. The Foundation expected grantees

to round up local partners to match the seed loan, five to one. It also required payback of the Foundation's loan plus 3 percent interest within ten years.

The loan arrangement was the problem. It saddled Practice Sights grantees with an unusual and intimidating management task. Most of their experience was with grants, which, once you land them, can be freely spent for defined purposes. About the only way you can get into trouble is if you take a Hawaiian vacation or otherwise abuse a funder's trust. The essence of successful grant management is prudence and integrity. Practice Sights leaders were confident that they could manage the grants part of the program.

The PRI requirements, however, challenged their financial acumen, of which they were less confident. Among several noteworthy consequences was unusual timidity in this area of Practice Sights. The grantees stuck the loan money in bank certificates of deposit, the most conservative form of investment. Their primary concern was safeguarding the Foundation's money and earning the required interest before even a penny went out into the field. In this, the PRI experiment contrasted sharply with the Robert Wood Johnson Foundation's long-avowed mission of stimulating innovation and risk taking in the field, which unquestionably occurred in Practice Sights grant-funded areas.

Peter Goodwin, the Foundation's vice president for finance, acknowledges conceptual miscalculations with the PRI. "It was a new business for us, and at the time we weren't very good at it," he says. Among other things, Foundation staff members did not think through the operational difficulties conferred by the loan repayment conditions. The staff members thought the loan would be educational for grantees, stimulating greater financial sophistication than a grant could about how to use money to greatest effect. But neither the Foundation nor the grantees joining in this experiment realized the complexity of the world they were entering. Fluctuating interest rates during Practice Sights' tenure were only one problem. There was also the surprising naïveté of the loan program's intended beneficiaries: rural health care providers. The PRI experience was instructive for the Foundation and grantees alike, but its structural complexity interfered with program goals.

In Nebraska's case, it utterly defeated them. "We probably spent eight or nine months negotiating the terms with Robert Wood Johnson, the legal and finance people," recalls George Frye, executive vice president of the Nebraska Economic Development Corporation, or NEDCO, which handled the rollout of the loan fund. By the time agreement was reached, in December 1996, interest rates had dropped too

low for NEDCO to offer a competitive rate and still make the money necessary to pay back the Foundation. Moreover, Nebraska found that it needed to sell the idea of borrowing to rural providers and then walk them through the loan process. They needed much more help than NEDCO's usual business customers did.

"We basically were trying to do this in a place as big as Nebraska with the existing NEDCO staff, which is pretty small," Frye said. "It's me, and I'm part-time, one full-time loan packager, and one portfolio manager. There was no money for marketing or extra staff. If we could have just had one person dedicated to going around and acquainting people with this program, I think we could have done better."

In the end, Nebraska's Community Primary Care Loan Program made only two loans. The first one ended in default; the second one financed a bailout of the first one. At that point, Practice Sights leaders concluded that the experiment was too high-risk, especially with only a ten-year loan cycle. They retrenched to priority number one: paying back the Foundation. In December 2000, their investments succeeded in restoring the full loan amount plus 3 percent. Nebraska promptly cut a check to the Foundation and withdrew from the experiment.

Virginia encountered many of the same structural problems but overcame them. The loan program established under Practice Sights, called the Healthy Communities Loan Fund, continues to grow in volume and scope. It is run under the auspices of a private philanthropy, the Virginia Health Care Foundation, which was a collaborator with the Virginia Department of Health in Practice Sights. The fund surpassed the $4 million mark in late 2001 and recently extended eligibility for a loan to mental health professionals and pharmacists. Ironically, at $700,000, Virginia's seed loan was the smallest in the program. Nebraska, by contrast, got $1.5 million.

Why was Virginia's experience so different from Nebraska's? Deborah D. Oswalt, of the Virginia Health Care Foundation, has a quick answer: "We had real bankers with commercial lending experience helping us every step of the way." Getting "real bankers" on board was an idea forged by Oswalt's concern over the PRI's complexity, which also raised eyebrows on her governing board.

"The fact that it was a loan and that we had to repay it and pay interest and so on definitely influenced how we handled the $700,000," Oswalt says. "It is not as if we were some banking gurus. We're a nonprofit foundation. What did we know about any of that sophisticated high-finance stuff? My board

wanted to be sure I wasn't sitting there making loan decisions. This helped us develop a real working partnership with the banking community."

Oswalt and her staff came up with an ingenious method of identifying the best bank for their purposes. They superimposed a map of Virginia's underserved areas on the branch networks of Virginia-based banks and found that First Virginia Banks had 310 branches in Virginia, many of them in the areas Practice Sights deemed eligible for lending. Says Oswalt:

> I can't overemphasize the importance of the relationship with the bank to our success. We learned so much from them and got help in ways we never expected. When we ran into declining interest rates, we actually questioned whether we should continue. It was getting impossible to offer the favorable loan terms we wanted: prime rate, no points, no prepayment penalties to make this a really good deal for our rural providers. But the bank was able to come through with special package deals like free checking and all those other extras banks offer good customers. So, yes, maybe the doctors could go elsewhere and get a better rate, but they wouldn't get the individual attention and help they get from us.

The bank also prints and mails the health care foundation's informational brochures, subsidizes other marketing costs, and works closely with Lilia Mayer, the Healthy Communities Loan Fund's indispensable point person. As in Nebraska, Virginia found that it needed a dedicated staff person to promote the project and respond to inquiries. The expertise that they assumed highly educated people such as doctors would bring to the transaction simply wasn't there.

"We learned to our surprise that some physicians are poor businessmen," Oswalt says. "Their bookkeeping was very rudimentary. They just wanted to treat patients, and they really did not know how to assess their assets or how much of a loan they could handle or how to develop a business plan. So Lilia began to incorporate the literature of the Small Business Administration in our mailings to help them out. It was never envisioned that we would be a technical assistance program in addition to a loan program, but that is how it turned out."

First Virginia Banks has reaped rewards as well. Tentative at first, the bank has steadily ramped up its support, recognizing the loan program's benefit to core business. First Virginia competes with larger banks by cultivating grassroots customers as opposed to major national corporations, according to John P. Salop, a senior vice president and liaison to the Healthy Communities Loan Fund. The bank recently

received the American Bankers Association's ACTION Award in recognition of its Practice Sights contributions. Still, Salop admits to some early qualms.

"This was new, it was different, so, sure, there were people at the bank with reservations," he says. "The biggest fear was that you would be spinning your wheels, that it would never get going because the underpinnings were weak. You don't want to waste your time. We said we would be willing to accept less"–in the way of interest and collateral, for instance–"but they still had to be profitable loans if this was going to be a long-term thing. Everything has to make economic sense."

With the experience of Practice Sights as a guide, the Robert Wood Johnson Foundation took another look at the economic sense of requiring loan repayment plus interest. Specifically, in the case of Virginia's Healthy Communities Loan Fund, the Foundation decided in early 2002 to forgive the 3 percent interest requirement entirely. Bank interest rates had dropped so precipitously during 2001 that the loan fund barely earned enough to cover program operating costs, never mind the Foundation's fee. Recognizing this difficulty, the Foundation essentially converted the terms of the PRI agreement to those of an interest-free loan.

Current Foundation programs are experimenting with PRIs whose seed money comes in the form of grants, not loans. The term of the grant may also be indefinitely extended, eliminating the inflexibility of a short loan cycle.

CONCLUSIONS

Practice Sights aimed at improving health care by easing conditions that discourage health care providers from working in underserved rural or inner city settings. The program also sought to build capacity at the state level to address workforce issues, thus reducing states' dependence upon federal initiatives.

Collectively, grantees succeeded in recruiting 867 health care providers; the total includes physicians, nurse midwives, nurse practitioners, and physician assistants. New Hampshire had a net increase in physicians. Nebraska, by contrast, finished the project with exactly the same number of rural physicians as when Practice Sights started. But the state's success in shoring up the financial underpinnings of rural health systems via Critical Access Hospital and Rural Health Clinic designations resulted in hiring a significant number of midlevel providers, where before there had been none.

To the numerical scorecard, Practice Sights added valuable insights into the alchemy of successful recruiting and retention of health care providers. Notably, it illustrated the links between the rural health care workforce and larger economic, political, and workforce trends in the United States. If a local hospital is too cash-strapped to hire a midlevel health professional to help with night and weekend emergency room coverage, there isn't much hope for improving the physician's call schedule. Similarly, a revolving door of providers and administrators bodes ill for any health system's ability to meet community needs. As Nebraska's David Palm observed, no single program or initiative can tackle all of the factors that discourage providers from working in certain areas. But Practice Sights shed new light on the dimensions of the problem and challenged conventional thinking in some areas.

The connection between health care and the larger environment plays out daily in recruiting. Success depends upon nimbly tailoring a pitch to current market demands. However, recruiters seasoned by Practice Sights learned to take the stated expectations of today's medical school graduates with more of a grain of salt than health systems researchers or senior physicians seem to. This last group is uniformly exasperated by recent candidates' determined negotiation of limits to night and weekend duty, privately grumbling about a declining work ethic in their profession. Some researchers echo this sentiment. Practice Sights recruiters, by contrast, attributed the focus on perks and work schedules to be a combination of naïveté and of competing opportunities in the larger job market. Anyone starting a career brings to it the hopes of Gavin Muir: good location, comfortable hours, challenging work, nice life. Those who succeed professionally usually do so because, at some level, they love the work and commit what it takes to do it well. His four-day workweek notwithstanding, Muir ended up being interviewed for this chapter at 11:00 P.M., after medical emergencies had forced him to cancel several earlier appointments. He still loves his job.

As for the larger job market, its influence was palpable during Practice Sights. Recruiters saw in many candidates a reflection of the expectations of their generational peers during a period of record-breaking prosperity in the United States. During the mid-1990s, many of the so-called best and brightest of college-educated young people flocked to quick wealth on Wall Street or in a dot com startup. The number of economics and business majors at the undergraduate level soared, while medical schools saw a precipitous drop in applicants, from a high of 46,965 in 1996 to 34,859 in 2001, according to the Association of American Medical Colleges. In this context, the emphasis on perks as opposed to the "working where I can make a difference" ethos of a previous era is less surprising–and also less predictive of future trends. It's worth noting that since Practice Sights, the dot com bubble has burst, Wall Street is

laying off, and recent college graduates are beating the bushes for jobs. This is the sobering reality of today's medical school students: a context that could make job security in a medically underserved area sound very nice indeed.

That said, Practice Sights leaders identified workforce changes that are more likely to be long-term. The single-breadwinner family is becoming a rarity. Time and again, grantees found that success in recruiting and retaining providers required attention to a spouse's career or avocational interests. Married physicians are not necessarily a doctor-and-doctor package, as with David and Kari Adams. In Littleton, New Hampshire, Jessica Thibodeau, a nurse practitioner recruited from Boston, had to be sold on the area's opportunities for her husband, Scott Brumenschenkel, a self-employed furniture maker and designer of custom cabinetry. Her job would provide the family's steady income, but for the relocation to work in the long run he needed a market for his high-end skills. Although the immediate area is poor, Thibodeau reports that Brumenschenkel was able to find customers among those with seasonal vacation homes in New Hampshire, and by way of local galleries. The couple's final concern was whether Littleton would be a good match for their school-aged daughter. The quality of the local school system was a significant draw, illustrating yet again the importance of the larger community infrastructure to health care improvements.

Another insight from Practice Sights is the need for more up-to-date and integrated national databases to guide recruiting strategies for underserved areas. The enthusiastic response of state health departments to Practice Sights stemmed in part from frustration with the disjointed status quo in health care workforce initiatives. The research field reflects this history. Much of the published data fall into isolated niches of inquiry and significantly lag behind the conditions driving decision making on the front line of recruitment and retention. The most comprehensive data sets–compiled by the federal Office of Rural Health and the Council on Graduate Medical Education–date to 1997. Any wisdom that researchers can offer a front-line recruiter is accordingly handicapped by lack of timeliness. During Practice Sights, the NPO developed computer software to assist states or small agencies in accomplishing recruiting tasks. The National Health Service Corps subsequently provided funding to make the software available to all fifty states. Similar coordination in updating and integrating disparate data sets would be helpful to those on the front line.

A final observation from the platform of Practice Sights is that there's no such thing as recruiting for permanence. Television dramas depict the silver-haired rural practitioner, beloved by his community,

delivering the babies of babies he helped into the world at the start of his career. This romantic scenario is not borne out statistically. The average stay for a rural practitioner is six years. Some leave because of the specific hardships that Practice Sights sought to alleviate: long hours, isolation, and inadequate income. But others leave for the reasons that lead other professionals to jump from company to company or to move about the country: a better opportunity, family needs, or perhaps just to try something different. This mobility–part of a general workforce trend that took hold in the later years of the twentieth century–can work both ways. Rural areas occasionally benefit from providers' disenchantment with urban practice. During the 1990s, for example, California physicians left the state by the thousands rather than accept changes in practice conditions and reimbursement imposed by managed care plans. How to capitalize on the many intersecting trends and crosscurrents illustrated by Practice Sights remains a challenge for those seeking to improve access to health care in underserved communities.

Notes

[1] Health Research and Services Administration, U.S. Department of Health and Human Services, "Health Professional Shortage Areas by Metropolitan/Non-Metropolitan Classification as of March 31, 2002," Table 2.

[2] Rabinowitz, H., and others. "Critical Factors for Designing Programs to Increase the Supply and Retention of Rural Primary Care Physicians." *Journal of the American Medical Association,* 2001, vol. 286.

[3] Marco Navarro and Peter Goodwin discuss the Foundation's PRIs in "Program-Related Investments." In *To Improve Health and Health Care. Vol. V: The Robert Wood Johnson Foundation Anthology.* San Francisco: Jossey-Bass, 2002.