Robert Wood Johnson Foundation

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Southern Rural Access Program

An RWJF national program

SUMMARY

The *Southern Rural Access Program*, a national program of the Robert Wood Johnson Foundation (RWJF), implemented a range of activities to increase access to health care services in rural, underserved areas of eight southern states:

- Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Texas (East Texas only) and West Virginia.

From early 1999 through mid-2006, state project teams undertook initiatives to:

- Develop a cadre of students in the health professions committed to practicing in rural areas.
- Recruit primary care providers to rural communities and retain them.
- Support collaborative networks of rural health providers.
- Develop revolving loan funds to help rural health providers finance improvements in their practices.

Key Results

- The program's recruitment and retention efforts had a positive effect on the growth of the primary care physician supply in 124 targeted high-poverty rural counties in the eight states, according to a program evaluation.
- The program helped strengthen the region's health infrastructure by supporting the development of rural health networks. Twenty-three networks received funding or technical assistance through the state grantee organizations or national program office.
- Seven revolving loan funds supported by the program helped finance millions of dollars in improvements for rural health providers, including the construction of new facilities, office renovations and equipment purchases.
- The program established collaborative relationships among and within the participating states that continued to benefit the region after the program ended.

For a look at key activities and outcomes in five of the participating states, see:

- Louisiana: Responding to Hurricanes Katrina and Rita.
- Mississippi: Recruiting and Retaining Rural Primary Care Providers.
- South Carolina: Developing a Pipeline of Rural Health Providers.
- Texas: Supporting Health Care Networks in Rural Areas.
- West Virginia: Developing a Health Care Revolving Loan Fund.

Funding

RWJF's Board of Trustees authorized up to $14.5 million for the program in July 1997 and reauthorized the program in January 2002 for up to an additional $22.5 million.

THE PROBLEM

Rural Americans experience significant health disparities compared with people living in metropolitan areas. One factor is that rural residents, as a group, have different characteristics and health needs.

As noted in the Institute of Medicine's 2005 report on rural health (*Quality Through Collaboration: The Future of Rural Health*), rural populations tend to be older and have poorer health behaviors, including higher rates of smoking and obesity. They also tend to have less education, income, employment and health insurance coverage than urban residents.

Another factor is that people living in rural areas generally have less access to health care services. Isolated and with limited educational and economic opportunities, many rural communities have difficulty attracting and retaining health care professionals.

Based on data from the 1990s, researchers at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina-Chapel Hill reported that more than 20 million Americans were living in non-metropolitan areas with a shortage of primary care doctors. (See *Facts about…Rural Physicians*.)

The South

- In the 1990s, economic and health care disparities were particularly acute in the rural South. The South has a large rural population and the nation's highest poverty rate. Of the 10 poorest states in 1993, nine were in the bureau's 16-state southern region, according to a U.S. Census Bureau Statistical Brief. (The exception was New Mexico.)

In Mississippi, the state at the very bottom, an estimated 25 percent of the population had incomes below the poverty line—almost twice the national percentage and four times New Hampshire's poverty rate, the nation's lowest.

Measures of health status mirrored the region's economic data. Southern states were among the unhealthiest in the nation based on rates of infant mortality, heart disease, smoking and other measures.

- The 2002 edition of the United Health Foundation's State Health Rankings identified Louisiana as the unhealthiest state followed by Mississippi, South Carolina and Arkansas. The bottom 10 also included Alabama and West Virginia. (Although not generally associated with the South, certainly not the so-called Deep South, West Virginia is part of the region as defined by the Census Bureau.)
- A high percentage of southerners were without health insurance coverage. In 1993–1994, the region's average uninsurance rate for adults age 50–64 was 15.8 percent—the highest in the nation, according to *The Coverage Gap: A State-by-State Report on Access to Care* (April 2006, Cover the Uninsured Week); data compiled by the University of Minnesota School of Public Health).
- Despite improvement, the physicians-to-population ratio in the southern states remained below the national median, according to census data. In 1998, Mississippi had 163 physicians for every 100,000 people compared to 251 for the nation. Only Idaho's ratio—154—was lower.

Referring to the South in a 1992 *Health Affairs* article, Columbia University scholars Eli Ginzberg and Miriam Ostow wrote:

> *The shortage of physicians, low Medicaid enrollments and inadequate reimbursement for physicians who treat Medicaid patients continue to make it difficult for rural populations to gain access to health care.*

To focus on this disadvantaged region, in the mid-1990s RWJF began planning what became the *Southern Rural Access Program*.

CONTEXT

Increasing access to health care has been a core goal of RWJF since its establishment as a national philanthropy in 1972.

As part of this effort, the Foundation has been interested in developing a health care workforce to serve the nation's underserved populations—including rural Americans. Previous RWJF initiatives to improve health care in rural areas include:

- *Rural Practice Project* (1975–1984)—a $12-million effort to support administrator-physician teams engaged in building nonprofit primary care capacity in rural areas.
- *Rural Hospital Program of Extended Care Services* (1981–1987)—a $6.5-million program to use excess hospital beds in rural areas for long-term care of the frail and disabled. (For details, see Chapter 11 of the 2003 edition of the annual RWJF anthology *To Improve Health and Health Care*.)
- *Hospital-Based Rural Health Care Program* (1987–1992)—a $9-million program to strengthen the quality of care and financial stability of rural hospitals.
- *Practice Sights: State Primary Care Development Strategies* (1991–1998)—a $16.5-million program to strengthen state efforts to recruit and retain primary care providers in rural areas. (See Program Results Report on the program. Also, Chapter 3 of the 2003 edition of *To Improve Health and Health Care* discusses this program.)

Focusing on the Rural South

In addition to the exceptional health care needs of people living in the South, there was a second reason that RWJF wanted to focus on that region: in the past, the southern states had not fared well in RWJF's competitive grantmaking process.

An internal review of RWJF grants covering 1992–1996 showed that five southern states combined—Alabama, Louisiana, Mississippi, South Carolina and West Virginia—received fewer grants than the single state of Minnesota.

Southern states had either not applied for RWJF funding or applied and not been funded. In the view of RWJF program staff, the South was too busy trying to put together the basic building blocks of an effective health system to engage in cutting-edge health care demonstration projects—the kind often applying to RWJF.

RWJF leadership and staff wanted to help the region get those building blocks in place more quickly.

PROGRAM DESIGN

In July 1997, the Board of Trustees authorized spending up to $14.5-million over four years to increase access to basic health care services in underserved rural areas of eight southern states:

- Alabama
- Arkansas
- Georgia
- Louisiana
- Mississippi
- South Carolina
- Texas (38 counties in the eastern section only)
- West Virginia

Four years later, the Board authorized up to an additional $22.5 million to continue the initiative—with changes—for another four years.

This eight-year $37-million effort—the *Southern Rural Access Program*—had three major goals:

- Increase the supply of primary care providers in rural, underserved areas of the eight states.
- Strengthen the health care infrastructure in these areas.
- Build capacity at the state and community levels to address health care problems that disproportionately affect residents of those areas.

Four Intervention Strategies

The grantee organizations in the target states and their partners were to determine the specific interventions appropriate to their communities. However, RWJF identified four broad strategies—the program's core components—that each state was to implement.

This multifaceted approach was unusually complex in comparison with other RWJF initiatives, said Michael Beachler, then an RWJF program officer and chief architect of the *Southern Rural Access Program* who later became the national program director.

RWJF staff believed that no single intervention would make a difference, but that these four strategies wrapped in a coordinated effort could have a significant impact on primary care supply and ultimately on health care access.

The four strategies were:

1. **Develop a cadre of students in the health professions committed to becoming leaders in primary care in rural underserved areas.**

Called the Rural Leaders Pipeline Effort, this component focused on attracting undergraduate college students to the health professions and helping them gain admittance to medical school and other training programs.

2. **Recruit and retain primary care providers.**

   The grantee institutions were to develop strategies for attracting practitioners to—and keeping them in—rural communities.

   One strategy for retaining practitioners was to offer consultation in practice management—the term for the administrative and financial aspects of a physician office, clinic or hospital. The idea was that making providers more efficient would increase their profitability and, it was hoped, survivability.

   Another strategy was to develop a locum tenens service—a corps of substitute physicians willing to relieve rural practitioners so they could take a break for vacation or continuing education classes, for example. This had also been tried in RWJF's *Practice Sights* program, where five states (Arkansas, Idaho, Minnesota and Nebraska) had piloted such a service and one developed it (New Mexico). The links above go to the Program Results on the program and on the sites with locum tenens.

3. **Develop formal collaborative arrangements—called rural health networks.** These allow providers to pool their resources to improve and/or provide increased numbers of services to the community.

   Health networks range widely in form and purpose and can include both individual physicians and organizations, such as hospitals, social service agencies and community groups. (For a more detailed explanation, see *Principles of Rural Health Network Development and Management*, a 2002 publication of the Alpha Center.)

4. **Establish revolving loan funds to help rural communities improve their health infrastructure.**

   Historically, rural providers have had difficulty obtaining bank loans and other traditional financing at rates they could afford. Each state was to implement a loan fund that would help finance clinical equipment purchases, office expansions, clinic construction and other needs of rural providers.

   In addition to seeding the funds, RWJF grant money could support staff to market the loans, advise providers on financing issues and solicit additional fund capital.

   RWJF expected the state teams to match every RWJF loan dollar with at least six dollars from other sources.

The 21st Century Challenge Fund

In addition to supporting state teams to implement the four core components, the authorization included $2.5 million for a special grant fund—called the 21st Century Challenge Fund—to be controlled by the national program office.

The fund's purpose was to provide a flexible method to support innovative health care projects that arose within the region but outside the states' strategic project plans. The grants would "encourage creative risk-taking and solutions," said the program's *Call for Proposals.* Recipients of 21st Century Challenge Fund grants had to secure matching funds of at least one-to-one from local philanthropies or other sources.

Beachler said he made a point to confer with a number of regional foundations as he developed the program concept as the RWJF program officer—a step that he believed proved helpful later in attracting regional philanthropic support not only for 21st Century Challenge Fund projects but also for the state initiatives.

Texas and West Virginia: Special Circumstances

West Virginia

West Virginia was the only one of the eight states not contiguous with at least one other target state. The self-proclaimed "Mountain State" had the same health care access problems as the other seven, but its inclusion also resulted from a special circumstance.

Staff of the Claude Worthington Benedum Foundation—a Pittsburgh-based philanthropy that focuses much of its grantmaking on West Virginia—wanted to support the program's West Virginia activities and agreed to match RWJF's spending in that state. Throughout the program, the Benedum Foundation funded the West Virginia project in partnership with RWJF, with the exception of $500,000 in seed money for West Virginia's loan fund that the West Virginia legislature provided.

Texas

Texas was unique in that participation, from the program's outset, was limited to just one section of the state—East Texas. Some RWJF staff wanted to include the entire state, but the Foundation's leadership considered that too ambitious.

THE PROGRAM

To run the *Southern Rural Access Program*, RWJF established a national program office in Hershey, Pa., home of Pennsylvania State University College of Medicine, and selected Michael Beachler—the RWJF program officer involved in the program's design—to be program director.

An obvious question—one heard throughout the life of the program—was why an effort aimed at helping the South was headquartered in Hershey. One reason was that Beachler, a Penn State graduate, had ties with rural health experts at Penn State's medical school located there.

Another was that RWJF was interested in working with a large integrated rural health delivery system that had been formed earlier by the merger of the university's medical center and the Geisinger Health System, based in Danville, Pa.

The national program office operated initially as part of this merged entity, the Penn State Geisinger Health System, and RWJF funded the work of the program office through grants to Geisinger.

In the program's third year—for reasons unrelated to the program—Penn State and Geisinger terminated their affiliation. As a result of the split, the national program office moved its financial and administrative home to the Penn State College of Medicine.

In addition to Beachler, the national program staff included a deputy director, communications officer, program coordinator and staff assistant. See Appendix 1 for the names of the staff and three consultants who provided technical assistance.

National Advisory Committee

RWJF appointed experts in health, health care policy, financing and regional philanthropy to a committee to advise the program staff. See Appendix 2 for a list of members.

Committee members—most of whom lived in the eight-state region—helped:

- Develop grant application guidelines and evaluate the applications.
- Conduct grantee site visits and provide technical assistance to the state project teams.
- Attend meetings of representatives from grantee institutions and other program functions.

The Planning Phase

The national program staff invited stakeholders in each of the eight states to come together and select an organization to lead the program in that state and apply for funding. Each state could submit only one grant application.

Thus, each state was certain to get a grant provided the interested organizations could overcome turf rivalries and agree on a lead agency. The hope at RWJF was that a consensus-selection process would encourage broad, continuing collaboration.

This approach—limiting funding to one applicant per state in a preordained region—was a first for RWJF, according to Beachler.

Stakeholder Meetings to Select Lead Agencies

To encourage a wide spectrum of participants in the selection of the lead agency, the national program staff conducted a stakeholders' meeting in each state. This was a departure for an RWJF-funded national program. Typically, the staff of a new RWJF program holds one or maybe two centrally located workshops for potential applicants.

The individual state sessions—held January–May 1998—made it possible for small, community-based groups without travel budgets to attend, said Beachler. "We leveled the playing field." The attendees included representatives of local philanthropies, banks, hospitals, provider organizations and government agencies—about 100 people per meeting on average.

The Lead Agencies: A Diverse Group

The selection process progressed at varying rates and produced a mix of private and public organizations to lead the state efforts.

For example:

- The Mississippi stakeholders took several months to iron out differences and agree on the Mississippi Primary Health Care Association, an organization of community health centers. Even so, other groups feared the association would funnel all of the RWJF money to community health centers, says Robert Pugh, the association's executive director.
- In Louisiana, two competing organizations—the Louisiana State University Health Sciences Center and state Department of Health and Hospitals—ended up agreeing to run the project as a partnership, with the university the named grantee.

Once stakeholders identified the state's lead agency, the national program staff worked with the lead agency staff and other stakeholders to develop the state's grant application. The national program office gave each lead agency $15,000 for meetings and needs assessments.

In addition to their work coordinating the grant applications, lead agencies administered the grant and supported subcontractors hired to carry out the interventions and implemented some services directly. See Appendix 3 for a full list of the lead agencies.

Core Grants and Seed Money for the Revolving Loan Funds

RWJF awarded the first grants on a staggered schedule—depending on each state's readiness—from December 1998 into March 1999.

Over the life of the program, RWJF awarded three additional rounds of program grants, called "core" grants. The grants varied in size—from $230,100 to $1.3 million—according to each state's menu of interventions for that particular round.

In addition to the core grants, the states received separate RWJF funding to seed their revolving loan funds. These grants generally went to a partnering organization experienced in financing instead of to the lead agency itself.

(One exception was Alabama, which did not implement a loan fund and, therefore, got no seed money. Another was West Virginia; in part because of the co-funding arrangement with the Benedum Foundation, RWJF built West Virginia's loan fund seed capital into the state's core grants.)

See Appendix 3 for a list of the grants each lead agency received over the course of the program as well as loan-fund grantees and the seed money they received.

The Implementation Phase: National Program Office Activities

Technical Assistance and Direction

The national program staff and consultants provided technical assistance to help the state teams plan, implement and—as the program progressed—refine their interventions. The staff:

- Convened meetings and hosted conference calls with lead agency staffs, team partners, advisory committee members and government officials.
- Conducted regular site monitoring visits to assess progress in the states and, in conjunction with the program's evaluators, reviewed periodic progress reports by the lead agencies. (See Evaluation Findings.)
- Helped the state teams develop proposals for the different funding rounds and advised the site staffs on steps to make their project activities self-sustaining—an increasingly important aspect as the program neared completion.
- Helped the state teams leverage additional resources by establishing linkages with financial institutions, philanthropies and government agencies in the region.

21st Century Challenge Fund

The national program staff developed application guidelines (the first in January 2000) and financial monitoring policies for the $2.5-million fund.

Nonprofit organizations, public agencies and universities in the eight states were eligible to apply; the emphasis was on community-based entities serving residents in underserved rural areas. Grants could support either demonstrations of innovative approaches to health care problems or analytical studies of health care issues.

Beachler worked with philanthropic, academic, community and government organizations in the region to identify potential projects, encourage co-funding arrangements and monitor the initiatives after they got underway.

The grantmaking process was more flexible and less formal than normally employed by RWJF—a major advantage, according to Beachler. On several occasions, his ability to commit funding quickly for a promising project was the catalyst that assured matching support from other philanthropies and government agencies, he said.

As an example, Beachler cited *Smile Alabama*, an oral health initiative to help underserved children. His agreement to provide a $250,000 21st Century Challenge Fund grant allowed the Alabama Medicaid Agency to secure more than $750,000 from other sources, including $500,000 in federal Medicaid funds—money needed to make the project feasible.

The membership of two southern philanthropic leaders on the program's national advisory committee helped facilitate funding partnerships with foundations in the region, the national program staff said. (The two were Joe Charles H. (Pete) McTier, president of the Robert W. Woodruff Foundation in Atlanta, Ga., and Joe Rosier, CEO of the Rapides Foundation in Alexandria, La.)

For example, the Rapides Foundation supported three 21st Century Challenge Fund projects in Louisiana, including the piloting of a transportation service that helped elderly residents of a rural southwestern parish get to non-emergency health care appointments.

In addition to regional foundations, the co-funders included national foundations (for example, the W.K Kellogg Foundation) health care organizations (for example, Blue Cross/Blue Shield of Alabama) and various local, state and federal government agencies.

From 2000 through 2004, Beachler's office received more than 60 grant proposals, which he and his staff evaluated with assistance from advisory committee members, consultants and RWJF program staff.

The national program office awarded a total of 21 grants ranging from $24,730 to $500,000. See Appendix 4 for a list of the funded projects and their sponsors.

Communications

The national program staff took numerous steps to disseminate information about the program, including activities of the individual states and the funding opportunities offered through the 21st Century Challenge Fund. For an overview, see Appendix 5. For details, see National Program Office Bibliography.

In addition to the program staff's own communications activities, RWJF awarded a $125,000 grant (ID# 051405) to the Benton Foundation to include three southern public

radio stations in a separate RWJF national program, *Sound Partners for Community Health* (for more information see Program Results Report).

Sound Partners supports efforts by public radio stations across the nation to increase awareness of health issues. See Appendix 6 for information on the three stations that participated.

The Implementation Phase: Site Activities

To implement the program's four core components, the lead agencies and their partners undertook a wide range of activities. While the specifics differed from state to state—and also within each state over the eight years—almost all of the eight states took steps to:

- Develop a cadre of students in the health professions committed to practicing in rural areas.
- Recruit primary care providers to rural communities and retain them.
- Support collaborative networks of rural health providers.
- Develop revolving loan funds to help rural health providers finance improvements.

For a look at overall results from the eight state projects, see the Key Site Results.

For a look at key activities and outcomes in five of the participating states, see the sidebars.

PROGRAM EVALUATION

RWJF selected the Cecil G. Sheps Center for Health Services Research at the University of North Carolina-Chapel Hill to evaluate the program's impact.

RWJF awarded the university a grant to plan the evaluation followed by two grants to implement the evaluation and disseminate the results. The evaluation team worked closely with both the national program office and state project staffs.

Thomas C. Ricketts, PhD, deputy director of the Sheps Center, initially directed the work. In 2001, evaluation team member Donald Pathman, MD, MPH, research director for the university's department of family medicine, assumed the leadership.

The evaluation had two research objectives:

- **To monitor changes in the supply of primary care providers in the eight-state region.**

  The evaluation team used American Medical Association (AMA) and census data to compare the increase in the number of physicians in rural counties targeted for

intervention in the eight states with the increase in rural counties that were not targeted.

- **To track changes in how residents of the targeted areas assessed their access to health care.**

  The evaluation team commissioned a telephone survey of residents of the states' targeted rural counties to learn about their use of outpatient services, barriers to care and opinions on access issues.

  The team planned to conduct a second survey to track changes.

  RWJF staff decided not to fund the follow-up survey, however, believing that program activities were too "long term and diffuse" to warrant the expense of a second survey.

See Appendix 7 for an explanation of the team's research methodologies. See Evaluation Findings and Appendix 8 for the key findings.

In addition, the evaluators helped the state teams create project logic models—diagrams that specified the activities, objectives and timelines of the projects, and thereby set benchmarks for gauging progress. The models served as the basis for regular progress reports by the state teams.

Evaluation Team Communications

The evaluation team disseminated its research findings in nine articles published in professional journals. It also issued more than a dozen reports on the state projects and their outcomes.

In addition, the Sheps Center published a monograph, *Helping One and One Yield Three in Grant-Funded Programs: Promoting Synergy in the Robert Wood Johnson Foundation's Southern Rural Access Program*, which examined the role that collaboration and synergy played in the *Southern Rural Access Program* and identified lessons learned.

See the Evaluation Bibliography for citations.

PROGRAM EVOLUTION: NARROWING THE FOCUS

The Mid-Program Assessment

As the program neared the end of its first authorization, RWJF commissioned the Edmund S. Muskie School of Public Service at the University of Southern Maine in Portland to assess the program's implementation and the appropriateness of the program strategy.

RWJF staff engaged a different organization to conduct this short-term appraisal because of the close, ongoing involvement in the program of the Sheps center evaluators.

A four-member team of experts in rural health policy—led by Andrew Coburn, PhD, director of the Muskie School's Institute for Health Policy—reviewed program documents, visited four of the states and conducted telephone interviews with project staff in all of the states.

Team members also interviewed a range of stakeholders and policy-makers in the region, including state health department personnel, health agency representatives and university officials.

Assessment Findings

In October 2001, the assessment team reported to RWJF: "We observed numerous examples of exemplary and exciting program components."

However, in their 42-page report, the team expressed doubt that the program as constituted would have a significant effect on health care access in the eight states. The report said:

- While various state projects were likely to affect the local availability of health care resources, the initiatives were relatively small and geographically and programmatically dispersed.
- "The likelihood is small that these demonstration-type programs alone can change the complexion of statewide trends in primary care access and infrastructure capacity" given the large role that insurance coverage, employment and other economic and fiscal factors play in determining access.
- Although "interesting and worthy," the projects funded by the 21st Century Challenge Fund "contribute to the 'ad-hoc' nature of the program strategy and do little to add critical mass or synergy to the program as a whole."
- The effort to recruit primary care providers is unlikely to succeed without "a more intensive community development strategy…it is impossible to have effective primary care recruitment and retention without focusing on community capacity."

The following were among the recommendations made by the four assessment team members to RWJF in an October 15, 2001, report:

- RWJF should recast the program's goals to focus on "capacity-building as a building block toward improved access rather than access improvement per se."
- Existing program components should place a greater emphasis on community development activities. Grantees should have more flexibility to address this priority,

and the national program office should deploy technical assistance in community development.

- RWJF and the national program office should consider creating a regional center to facilitate collective action to improve access across the eight states. The Southern States Center on Healthcare Access—the name suggested by the team—would create an ongoing regional capacity to carry on the work started by the program.

A Similar Caution from the Sheps Evaluation Team

Separately, as part of its ongoing evaluation, the Sheps Center team also cautioned RWJF about the program's "diffuse targeting."

In internal reports in 2000 and 2001, the evaluators told RWJF that although the program's literature and guidance to grantees was that the program should be geographically targeted, most initiatives were directed statewide, with little targeting to specific areas within states.

Reauthorization: Program Changes

In January 2002 the Board reauthorized the program for another four years—called Phase II—and provided up to an additional $22.5 million. Reflecting the advice of the assessment and evaluation teams, the reauthorization proposal made a number of changes in the program's design and operation.

Most significantly, while the state teams would continue to pursue the same four broad strategies, each was to choose a specific geographic area and target its work there—instead of at rural communities statewide.

Also, the Phase II funding guidelines emphasized the importance of undertaking activities with concrete, measurable objectives and a community development orientation.

The Target Counties

In response to the new directive, the eight state teams chose a total of 150 rural counties (parishes in Louisiana) and eight urban counties on which to concentrate their Phase II activities—leaving 457 rural counties outside the target areas. The teams made their choices based largely on what they perceived to be the severity of the counties' health and socioeconomic needs. (The Shep Center evaluation team left out the eight metropolitan counties when choosing counties because including them would have muddied the comparison of selected and non-selected counties.)

The 150 target counties became the focus for much of the research conducted by the evaluation team from that point on.

RWJF's decision to limit Phase II interventions to specific areas was an unhappy surprise to many state team members. It meant cutting out some partners and beneficiaries previously involved in the teams' efforts.

Exit Strategy

The advice of the assessment and evaluation teams was not the only factor responsible for the decision to target specific areas. Another was a tentative decision by RWJF to not renew the program at the end of the authorization.

The RWJF staff believed that narrowing the geographic and programmatic focus increased the likelihood that the targeted counties would be able to produce measurable results within the remaining four years. Measurable results, in turn, would help attract resources to sustain the interventions.

As part of this exit strategy, RWJF structured the Phase II funding to gradually decline—by about 17 percent in each of the last three years. By the program's final year, the states were to be funding about 50 percent of their core activities with non-RWJF resources.

This approach forced the state teams to begin seeking support to sustain projects before their RWJF funding ended instead of waiting until the end of the RWJF grant period.

Although the weaning process was challenging and resulted in the phasing out of some activities, state teams secured state and local funding and implemented user fees to continue a number of their initiatives.

The national program office reported at the program's conclusion that a majority of the rural health networks, recruitment services and pipeline efforts had sufficient resources to continue. (See Program Results.)

Ending the 21st Century Challenge Fund

Another Phase II change was that RWJF eliminated the 21st Century Challenge Fund. The move was not specific to this one program but rather part of an RWJF-wide effort to cut back special initiative funds of this kind, said Anne Weiss, the program officer who oversaw the *Southern Rural Access Program* from 2000 to its end.

Independent expenditures generally—not just those of the 21st Century Challenge Fund—tended to lack sufficient focus and impact, she said.

PROGRAM CHALLENGES

Among the challenges affecting the program were the following:

- Two major hurricanes in 2005—Katrina in August and Rita in September—caused significant damage in Louisiana and Mississippi and disruption of project activities.

In Louisiana, where the impact of the two hurricanes was particularly severe, the project director, Marsha Broussard, and the project coordinator, Ruth Landis, had to work out of their homes and cars for nine months, communicating with outlying team members by cell phone.

The staffs in both states were resilient and continued to provide leadership despite hardships, said Beachler. Nevertheless, the hurricanes had a severe effect on program activities and health care resources generally in those two states.

As just one example, the hurricane recovery effort generated large construction cost increases that stopped some planned health care projects.

The cost estimate for one proposed health center in Mississippi soared from $472,000 to $900,000, putting the plans on indefinite hold, according to the administrator of the state's revolving loan fund.

- A tightening of federal and state budgets during the program period placed increased financial pressures on rural health care providers and education programs for health professions students.

  The Balanced Budget Act of 1997—passed in part to control the growth in Medicare spending—was a major factor. In addition, some states also faced a difficult fiscal environment that affected their ability to increase or even maintain health services.

- The elimination of funding for the Quentin N. Burdick Rural Program for Interdisciplinary Training-a federal program that supported health careers training for students in rural underserved communities affected the program. Before the cut-off, Burdick money supported several Rural Leaders Pipeline projects.

- A continuing decline in the number of medical students entering family medicine and other primary care residency programs was a problem particularly for two of the target states, Louisiana and Mississippi, the program staff reported.

- Professionals with the expertise to provide effective practice management services were difficult to come by. Individuals experienced in the business side of health care tend to work for large, well-paying consulting firms. That was a barrier to recruiting practice management specialists, the Louisiana project staff found.

PROGRAM RESULTS

Overall Results

The following were among the key results of the *Southern Rural Access Program*, under each of the program's strategies, as reported by the program staff to RWJF following the program's closure on September 30, 2006:

Strategy: Develop a cadre of students in the health professions committed to becoming leaders in primary care in rural underserved areas.

- **Although several states implemented and sustained summer enrichment programs for college students interested in health careers, the Rural Leaders Pipeline Effort did not achieve the outcomes anticipated, Beachler reported.** He cited two main factors:

  — The program guidelines for the pipeline component were not prescriptive enough. As a result, the states implemented a wide range of interventions—too wide for the project teams to learn from each other's' experiences and make improvements accordingly.

  — Funding for the pipeline activities was insufficient—both RWJF grant funding and, more importantly, funding from outside sources.

  The cutback in federal and state support for health professions training in rural areas during the program period reduced the opportunity for the state teams to leverage their RWJF resources into pipeline programs of significant scale.

Strategy: Recruit and retain primary care providers.

- **Efforts to recruit and retain rural health care providers had a positive effect on the supply of primary care physicians in 124 of the highest poverty rural counties targeted by the program, as shown by the findings of the evaluation team.** (See Evaluation Findings for details.)

  These efforts included:

  — Six of the eight states supported staff at the regional or community level to recruit providers to rural communities.

  — All eight states launched practice management services—through either the lead agency or a collaborating partner, such as an Area Health Education Center (AHEC) or medical society.

  As of the program's conclusion in 2006, all states except West Virginia had secured resources to continue their practice management services, according to the program director.

  (However, in some states the scope and operation of the practice management service underwent change after the RWJF funding ended. For an example, see Mississippi: Recruiting and Retaining Rural Primary Care Providers.)

Strategy: Develop formal collaborative arrangements—called rural health networks—that allow providers to pool their resources to improve and/or provide increased numbers of services to the community.

- **The program helped strengthen the region's health infrastructure by supporting the development of rural health networks.**
  - Some 23 networks—representing more than half of the networks created in the eight states during the program period—received funding or technical assistance through the state grantees or the national program office, the national program staff reported.
  - Health screenings and reduced-cost pharmaceuticals for the medically indigent were among the services that the networks provided—often across multiple counties. Many networks also provided disease management services to patients with chronic conditions.
  - Networks in the region successfully competed for federal funding. Of 13 grants made to rural health networks by the U.S. Office of Rural Health Policy in 2006, five went to networks in program states.
  - Although new networks proved difficult to sustain once they exhausted their initial grant funding, a number kept going after the program ended. For examples of networks supported by the program, see the Key Site Results.

Strategy: Establish revolving loan funds to help rural communities improve their health infrastructure.

- **Seven revolving loan funds supported by the program helped finance millions of dollars in improvements for rural health care providers, including the construction of new facilities, office renovations and equipment purchases.** (Alabama did not establish a fund.)

  In addition to $5,591,850 in loan capital, approximately $1.4 million in RWJF funding supported loan fund staff members to market the loans, raise more seed money and help providers secure additional financing from other sources. (Often, a low-interest loan from the RWJF fund did not finance an entire project but helped make an otherwise marginal proposal attractive to commercial lenders.)
  - As of March 2006, the seven loan funds had made or facilitated 100 loans to help finance projects costing a total of $131 million. (The commercial sector, government agencies and other philanthropies covered the remainder of the project costs.)
  - When calculated against RWJF's approximate $7-million investment in the funds and support for their marketing, etc., the $131-million total represented an 18:1 leveraging ratio.

- All seven funds established loan-monitoring procedures, and as of late 2006, none had experienced a default.
- Among loans closed as of June 2005, 30 percent financed equipment, 17 percent construction and 14 percent a line of credit, according to an analysis by national program office staff, *A Clean, Well-Lighted Space: The Experience of the Revolving Loan Funds of the Southern Rural Access Program*. Other purposes included working capital, facility purchases, renovation and debt restructure.
- All seven funds appeared likely to continue without RWJF support, although obtaining additional seed money remained a continuing challenge. As of early 2007, a lack of capital had forced at least two of the funds—those in Georgia and Texas—to suspend new loan activity until more capital became available.

In addition, the program had other accomplishments:

- **Some 21 grants from the 21st Century Challenge Fund totaled $2.6 million and leveraged an additional $6.8 million in philanthropic, state and federal matching resources.** The grants supported 19 demonstrations and two research projects.
  - In the publication *21st Century Challenge Fund*, the national program staff reported on 16 grants that had closed by late 2004:
    - Five of the 16 funded projects (31%) had expanded services and were developing a source of continuing support. For example, a mobile dentistry van in Louisiana's Catahoula Parish—co-funded with the Rapides Foundation—expanded dental services from two to four days a week and experienced a 200 percent increase in clinic encounters.
    - Eight of the 16 projects (50%) were continuing at "moderate" capacity, three (19%) at "minimum" capacity, and none had terminated services completely, the publication said.
- **The *Southern Rural Access Program* stimulated other government and non-government organizations to support recruitment and practice management initiatives, according to Beachler, the national program director.** He reported:
  - As a result of the program, the U.S. Office of Rural Health Policy developed plans to make practice management technical assistance eligible for funding under the Delta States Rural Development Program.
  - An increasing number of rural health networks funded by the Office of Rural Health Policy included recruitment components.
  - The Physicians' Foundation for Health Systems Excellence—a private grantmaking foundation in Boston that supports initiatives to improve physician care—funded three practice management efforts modeled after the South Carolina and Arkansas initiatives.

- **The program established collaborative relationships and synergies among and within the participating states that continued to benefit the region after the program ended.**

  The evaluators at the Sheps Center published a report on the role of synergy in the program, *Helping One and One Yield Three in Grant-Funded Programs: Promoting Synergy in the Robert Wood Johnson Foundation's Southern Rural Access Program*, in December 2006. Based on interviews with program participants, the report states:

  — "Synergies played a prominent role in the *Southern Rural Access Program* and its successes."

  — "With less sharing of information and know how, grantees felt that their initiatives would more often have relied on trial and error and thereby developed more slowly, and more initiatives would have failed."

  — Strategies used in the program that are broadly applicable to other grant programs pursuing synergies include:

    - Requiring collaboration in order to be eligible for funding.
    - Creating a variety of venues where participants can meet.
    - Encouraging partnerships with other funding agencies.
    - Using technical assistance to help participants recognize and act on opportunities for collaboration.

  Through meetings, conference calls and cooperative services, individuals and organizations that had previously been distant or even at odds established lasting professional and personal ties. Program Director Beachler considered these new connections a key result of the program and cited these examples:

  — Staff of the **Arkansas** loan fund grantee, Southern Financial Partners, traveled to Mississippi to provide in-depth technical assistance to that state's loan fund grantee, Enterprise Corporation of the Delta.

    Subsequently, the Enterprise Corporation of the Delta used some of its non-RWJF funding to sponsor a conference in Little Rock, Ark., on practice management interventions for program grantees. Also, the Enterprise Corporation helped community health centers in Louisiana learn to be more effective in accessing capital sources.

  — The **West Virginia** lead agency staff and consultants helped the Louisiana loan fund grantee, Southeastern Louisiana AHEC, secure certification and funding as a community development institution from the U.S. Treasury Department—benefits that the West Virginia staff had achieved earlier for its own fund.

— Recruiters supported by the program in one state mentored newly hired recruiters in other program states. For example, the Arkansas recruiter helped train a new Texas recruiter, who later went to Louisiana to work with a newcomer there.

— Similarly, the **Mississippi** practice management staff provided technical assistance to the Louisiana and Arkansas projects during the start-up phase of their practice management initiatives.

— Within the individual states there was also greater collaboration as a result of the program. In **Arkansas,** the lead agency staff cited as an example the partnership they developed with the Arkansas Medical Society to provide practice management assistance.

— In **South Carolina,** before the program began, people working on rural health issues were isolated from one another, according to Nela Gibbons, director of the Office on Aging within the South Carolina lieutenant governor's office.

The program brought these scattered individuals into a network that is able to have a greater impact on rural health, Gibbons, a member of the program advisory committee, told the grantees at their last meeting in February 2006.

Key Site Results

The following are examples of the major site results from the eight projects as reported to RWJF by the national program staff and lead state agencies. For fuller descriptions of key activities and their results in five state projects, see the sidebars.

Developing Rural Health Providers

- **College students from rural communities—including many from economically disadvantaged families—received special assistance at summer enrichment sessions that state teams designed to encourage entry into the health professions.**

— In **Mississippi,** for example, a total of 162 community college and university students participated in a six-week summer program organized and supported by the state project team from 2000 through 2006. Sessions included classroom work in math, sciences and test-taking skills. Students also observed activities in local hospitals and health care centers.

One Mississippi nursing student, Pamalia Fleming, who attended the 2005 summer session at Delta State University in Cleveland, Miss., spent the mornings in a biology class and lab and afternoons shadowing workers at a Cleveland hospital and a health center in the nearby African-American community of Mound Bayou.

"It made me want to be a nurse more-especially in the Mount Bayou area," she said in an interview after the session ended. The experience showed her that some uninsured African Americans were not getting the care they needed, she added.

The six-week session at Delta State also entailed a research paper. For her subject, Fleming chose the increasing incidence of AIDS among African-American females. As part of her research, she administered a questionnaire to other students, faculty and community residents on condom use.

Another student who participated in Mississippi's summer programs was Stanita Jackson, a biology major from Greenville, Miss., who started thinking about becoming a pediatrician when she was eight years old. To find out how Stanita's program helped her shape her future plans, click here.

— The **Alabama project** supported a summer program at the University of Alabama at Tuscaloosa that helped 58 minority pre-med college students from rural backgrounds develop academic and test-taking skills necessary for the Medical College Admission Test.

Of the 11 Alabama participants who had graduated from college by the end of 2006:

- Three were in medical school.
- One was to enter medical school in 2007.
- Two were preparing for medical school as part of the university's Rural Medical Scholars program.

- **The state teams initiated other efforts to develop a pipeline of rural health providers including workshops to help prepare undergraduates for the graduate school application process, mentoring programs that matched students with physicians and field trips to visit medical schools and other postgraduate programs.**

— The **Georgia project** supported a pipeline program during the academic year at Albany State University, a historically black institution in southwestern Georgia. Albany State students who were the first in their families to go to college were a key target.

The effort included providing consultants to help students develop the interviewing and writing skills necessary for successful medical, dental or nursing school application.

- Five Albany State students who participated in the program were accepted at medical school.
- Three others got into dental school.
- Eight family nurse practitioner students who participated obtained certification and entered practice in rural southwest Georgia.

The program received federal support through the Health Careers Opportunity Program. However, the RWJF funds permitted inclusion of students who did not meet federal eligibility guidelines and yet were interested in returning to rural southwest Georgia after medical, dental or nursing school.

Recruiting and Retention

- **Many of the state teams sponsored a regional recruiter to identify physicians and other health care providers interested in practicing in rural areas and match them with job openings and practice opportunities.** Recruiters also advised communities in recruitment strategies.

  — Recruiters supported by the **Arkansas project,** which targeted underserved Mississippi Delta counties in Arkansas, helped attract 12 primary care physicians, five specialist physicians, four nurse practitioners and two dentists during the program period, the state's lead agency reported.

  As part of their services, the recruiters helped communities develop medical staffing plans and design communications strategies.

  — The **Mississippi project,** which focused on 31 delta counties in that state, partnered with the state Office of Primary Care Liaison to support a recruiting effort that placed 134 primary care providers in rural areas statewide over the life of the program, according to the lead agency's report to RWJF. For more details see Mississippi: Recruiting and Retaining Rural Health Providers.

  — **Throughout the eight states,** recruiters used online interactive recruitment software to track potential recruits and match them with job openings and practice opportunities. Recruiters also visited colleges and attended job fairs to promote rural practice opportunities.

- **Practice management consultation was the most frequent retention strategy employed by the states.** Practice management specialists found ways to increase the financial viability of rural hospitals, clinics and doctors' offices, for example, by updating billing systems to increase reimbursements.

  — The **Mississippi Hospital Association** hired three practice management specialists who assisted a total of 39 hospitals and 31 other providers during the project period.

  Four rural Mississippi hospitals that underwent a master charge review—the term for a comprehensive review and updating of coding and billing data—increased their charges an average of $1.2 million per hospital, the Mississippi project team reported. For more details see Mississippi: Recruiting and Retaining Rural Health Providers.

  The experience of Mary Curtis, administrator of the community hospital in Prentiss, Miss., illustrates how the practice management service worked. To find out how Sally Harrison, a registered nurse experienced in the business side of health care, helped Mary Curtis find ways to increase the community hospital's charges, click here.

  — In **Georgia,** the program supported practice management specialists at three AHEC organizations. Together, they assisted 218 rural primary care practices in the state.

  "I can tell you we have found lots of money left on the table," said Peggy LaMee, a practice management specialist at the Three Rivers AHEC in Columbus, Ga., referring to uncollected reimbursements.

  — The **South Carolina Office of Rural Health,** that state's lead agency, developed a service to help rural health clinics improve their reimbursement methodologies. The organization also helped primary care providers become designated rural health clinics—a status that increases reimbursement. The service coordinator visited 63 rural clinics to help with these issues.

  — The **East Texas AHEC staff** developed a curriculum to train other AHEC personnel in practice management and the organization used state and federal funding to expand the service throughout the organization's full 111-county area.

  However, the practice management service was unable to generate sufficient fees to sustain itself. The lowest fee for the neediest clients was $250, but some clinics were reluctant to pay even that for the service, the staff reported.

- **West Virginia took a community development approach to recruitment.** Multidisciplinary teams of professionals from West Virginia University—including experts in engineering, landscape architecture and historic preservation—advised rural communities on ways to increase their potential for attracting and retaining practitioners.

  In intensive two-day visits to 11 communities, team members worked with local leaders to plan beautification projects, new recreational opportunities, school system improvements and other steps to make their town a more attractive place to live and work.

  "It is felt that community revitalization assists in the recruitment and retention of health care professionals," said Nancy Melton, the Recruitable Community coordinator in the state Division of Rural Health.

  "We don't bring our hammers and saws….[Instead] we give them (local leaders) the plans and tools" necessary to take action, Melton added. Team members might help plan a new swimming pool, park or soccer field or enhance a town square.

  — Eleven communities that went through the team process in the period 1999–2005 subsequently recruited a total of 53 health care providers, including physicians, nurse practitioners and physician assistants, according to C. Kennard Shannon, MD, PhD, research director of the West Virginia University department of family medicine and the originator of the Recruitable Community concept.

  — The Recruitable Community Program, implemented in 1998 by the university's family medicine department, became a state program when the *Southern Rural Access Program* ended.

- **The West Virginia state team also initiated a fellowship program in collaboration with two West Virginia AHEC centers and provided 13 rural doctors an opportunity for additional education and experience conducive to a rural practice.**

  For example, one fellow partnered with a professor to learn how to use a piece of medical equipment available in her rural community. Another learned about adolescent sports injuries and then worked with a school football team in his community.

  Participants received a $2,000 stipend—half from the RWJF grant and half from AHEC funds. The fellowships generally lasted about a year.

  Although the fellowship continued immediately after the RWJF program ended, a cutback in AHEC funding put its future in doubt at the time this report was written.

- South Carolina was the only one of the eight states to successfully develop a locum tenens service. (See Lessons Learned.) The South Carolina lead agency contracted with three family practice residency programs to make faculty members available as

substitutes for rural physicians. As of 2006, the service had provided a total of 320 weeks of relief coverage.

The service—run by the Medical University of South Carolina in Charleston—continued with AHEC funding after the RWJF program ended.

Rural Health Network Development

- **The state teams established and supported cooperative efforts by providers, social service agencies and other organizations to link medically indigent residents with health care services.**

  — The **East Texas Health Access Network** was a collaborative effort by health care, faith-based and other organizations to improve care in five rural southeastern Texas counties: Jasper, Tyler, Newton, Sabine and San Augustine.

  The network grew into a full-time operation with paid staff and dozens of volunteers and not only helped link thousands of people to health services by project end but also provided relief services to thousands of victims of hurricane Rita in 2005. For more details, see Texas: Supporting Health Networks in Rural Areas.

  One beneficiary of the network was William Hewitt, a 68-year-old resident of Center, Texas, with numerous health problems, including cancer, emphysema and a bad heart. Until 2006, he also had painful, diseased teeth. To find out how the network helped this retired manager of a chicken processing plant find the dental care he needed and could afford, click here.

  — The **Arkansas project** fostered multicounty networks of providers. For example, in three poor, rural west-central counties (Franklin, Logan and Scott), the project team helped providers and community leaders successfully apply for funding from the federal Office of Rural Health Policy.

  The network that emerged—the Arkansas River Valley Rural Health Cooperative—designed a program to provide affordable health care services to the uninsured in the three counties. An article in the *Journal of Rural Health* (19 Suppl: 384–390, 2003) describes the cooperative. The abstract is available online.

  — In **Georgia,** nine rural health networks supported by the state team and the 21st Century Challenge Fund served thousands of underserved residents. As of 2006, six of the nine networks remained in operation, according to reports to RWJF.

Among them was the Spring Creek Health Cooperative, a multicounty network in southwest Georgia, the project's target area. Two Spring Creek case managers coordinated medical care, preventive care, health education and monitoring services for indigent, chronically ill patients.

As of June 2006, the Spring Creek cooperative was providing case management services to 479 clients. Because of this assistance, emergency room visits at one local hospital declined by 82 percent, the project team told RWJF. Because of their own savings, three rural hospitals provided some $250,000 to Spring Creek to support its case management work.

The cooperative, based in the town of Blakely near the Alabama border, also operated a pharmaceutical assistance program, which served 655 patients as of 2006.

— **South Carolina's** Low Country Health Care Network, a collaboration of small hospitals, community health centers and other providers in four rural underserved counties, initiated a patient advocacy system that employed nurses and other dedicated staff to identify clinic patients needing preventive screenings.

Advocates hired by the network went to rural health clinics and read the charts of patients scheduled for appointments, looking for factors indicating risks for disease.

For example, identifying an individual with a family history of colon cancer, the advocate might suggest to the primary care doctor a colonoscopy referral. In addition to informing the doctor, the advocate would educate the patient on the procedure and insurance coverage issues and assist in making the appointment.

At the conclusion of the network's advocacy initiative, the clinics incorporated the advocacy function into their own staffs' work, according to Kathy Schwarting, the network's executive director.

Revolving Loan Funds

- **Seven of the eight states (Alabama was the exception) launched loan funds.**

— The **Arkansas** fund—managed by Southern Financial Partners, a nonprofit affiliate of the Southern Bancorp—leveraged $1 million in RWJF seed money into loans totaling $16 million, as of the end of 2005.

The financed projects included construction of a $4.2-million health and wellness center in the Mississippi River town of Helena. The 25,000-square-foot facility includes classrooms, a library, exercise facilities and offices for the Delta AHEC.

Southern Financial Partners provided $2 million and helped the borrower, the Helena Health Foundation, obtain an additional $2-million guaranteed loan from the U.S. Department of Agriculture.

In addition to the RWJF money, staff at the Arkansas fund raised capital from government and other philanthropic sources, including $1 million from the Walton Family Foundation in Bentonville.

— The **West Virginia** loan fund—managed by the Center for Rural Health Development, the lead state agency—made more than 20 loans to finance health care projects costing a total of $16 million.

RWJF built $1 million into West Virginia's first two "core" grants to seed the loan fund ($500,000 per grant). The Claude Worthington Benedum Foundation in Pittsburgh provided a match of $500,000 for the loan fund during the first RWJF grant period. Because the West Virginia legislature gave $500,000 to the loan fund during the second grant period, Benedum did not match the second round of RWJF's loan fund money.

At the conclusion of the RWJF program, the fund had almost $1.5 million in uncommitted capital and was continuing to seek additional funding. There had been no loan defaults.

For more details, see West Virginia: Developing a Health Care Revolving Loan Fund.

— From its inception in 1999 to 2006, the **Louisiana** loan fund, funded with $500,000 from RWJF, facilitated or closed 35 loans that financed projects with a total investment of more than $52 million, according to the fund's managing organization, the Southeast Louisiana AHEC in Hammond, La.

As of 2006, the Louisiana fund had raised $2.6 million, counting funding from all sources, including a special Katrina-relief grant from RWJF in 2005 (ID# 055911). That was sufficient to sustain the fund, although the AHEC continued to seek additional capital.

Linda Sharpless, MSN, JD, a nurse practitioner and a lawyer, got $40,000 in low-interest operating funds from the Louisiana health care loan fund to open a clinic in Independence, a town of about 1,700 in the state's southeast.

Several years later, ready to expand, Sharpless got a $160,800 low-interest loan from the fund to purchase and renovate a vacant store building in town. "We couldn't do it without the lower rate," she said. "We're a fee-for-

service clinic. We have to make every penny count to provide these services."

She and her staff see patients-the majority of whom are African American-regardless of coverage and ability to pay, she said. Because the rural area has no public transportation or taxi system, the clinics has two vans that pick up patients and return them to their homes.

In 2007, Sharpless was planning a further expansion of clinic operations-into a second building, this one just for mental health services. Richard Blouin, senior loan coordinator for the Louisiana fund, said he was hopeful that this time Sharpless would be able to obtain commercial financing.

Another beneficiary of the Louisiana loan fund was Tina Monlezun, RN, MSN, a nurse practitioner who opened a clinic in Lake Arthur, a town of 2,900 in southwest Louisiana sustained by shrimping, oil production and farming-occupations that typically provide minimal pay and no health benefits. To find out how a start-up loan helped her clinic survive a tough first year—and serve patients after Hurricane Katrina—click here.

— For some of the other funds, securing enough new seed money to permit continued lending was more of a challenge. For example, the **Georgia** fund made five loans and, as of early 2007, lacked the money to make any more.

EVALUATION FINDINGS

Supply of Primary Care Physicians

The Sheps Center evaluation team reported its findings on physician supply in an August 16, 2006 report to RWJF (*Assessment of Physician Growth in Counties Targeted in the Robert Wood Johnson Foundation's Southern Rural Access Program*: December 2001 through October 2005). The report said:

- **When examining all 150 SRAP-target and 457 non-target rural counties as two large groups, the number of primary care physicians per 100,000 population were found to grow at comparable rates.** In targeted counties, the number of physicians per 100,000 population changed from 58.5 to 61.6, increasing by 3.08 per 100,000. In non-targeted counties the number of physicians per 100,000 population changed from 61.7 to 65.2, increasing by 3.57 per 100,000. Thus, the data indicates the program did not affect primary care physician availability in the target counties examined as a group.

- **However, in 124 *high-poverty* counties targeted by the program, numbers of primary care physicians per 100,000 population improved more than they did in 202 non-target *high-poverty* counties.** The number of physicians per 100,000 in the high-poverty target counties changed from 57.1 to 60.3, increasing by 3.21 per 100,000. In the non-target, high-poverty counties, the number of physicians per 100,000 population changed from 54.9 to 55.4, increasing by 0.05 per 100,000. High-poverty counties were those with 18 percent or more of the population living below the federal poverty line. (See Appendix 7 for a full explanation of the methodology.)

- **Similarly, in the high-poverty target counties, primary care physician numbers grew at a faster rate than in the high-poverty non-target counties** (the numbers grew by 4.4 percent compared to 1.7%).

- **If the physicians-to-population ratio had grown only "proportionately the same amount over the four years" within the high-poverty counties targeted by the program as within the high-poverty non-target counties, there would have been 73 fewer primary care physicians working in the high-poverty target counties in 2005 than there actually were.**

- **Analysis indicates that the greater growth in the primary care physician supply in the high-poverty target counties resulted principally from lower out-migration rates in those counties.** Out-migration was 28.9 percent of physicians in the high-poverty target counties over the four years compared to 32.1 percent in the high-poverty non-target. The in-migration rates of the two groups were virtually identical.

  Conclusion: "We estimate that as of October 31, 2005, the SRAP was responsible for recruiting and/or retaining 73 of the primary care physicians who were then practicing in the SRAP's 124 high-poverty counties."

  Limitations: The evaluation team said the changes in physician supply could be due in part or entirely to forces and trends other than the state projects. For example, rising malpractice insurance costs could affect where some doctors practice.

  Also, the AMA physician data are not perfect, and inaccuracies would likely affect the practitioner counts, the team said.

Additional Findings and Conclusions

A series of journal articles analyzed the results of the evaluation team's 2002–2003 telephone survey of target county residents on access issues. See Appendix 8 for those survey findings.

Appendix 8 also includes key findings from the evaluators' reports on progress by the state grantees in implementing their planned interventions.

See Appendix 7 for an explanation of the evaluation methodologies.

LESSONS LEARNED

1. **When targeting a region for intervention, work closely with local funders in the area—including soliciting their input during the design stage.** A collaborative approach is likely to elicit local involvement and support, as it did for this program. (Program Director/Beachler)

2. **National philanthropies should continue to work with their local funding partners after a grant is awarded and the project is underway.** In administering the 21st Century Challenge Fund grants, the program staff learned that the local co-funder is often in the best position to identify problems early in a project and to craft appropriate solutions. (National Program Staff/the program publication *21st Century Challenge Fund*)

3. **Be patient when developing a health care loan fund.** Funds of this type are complex and take time to plan and implement. Five of the seven revolving loan funds developed under the *Southern Rural Access Program* took one to two years to plan. Four needed an additional 15–24 months to close their first loans.

   Health agencies and the banking/economic development community use different languages and have different cultures. Building credibility between the two can be time-consuming. (National Program Staff/the program publication *A Clean, Well-Lighted Place*)

4. **When developing a health care loan fund, dedicate staff to that purpose.** Loan funds that hired staff with the primary or sole job responsibility of developing the loan fund were more likely to become productive in less time than those that did not hire dedicated staff.

   Dedicated staff people were able to develop the critical professional relationships with providers and banking partners that permitted successful loan negotiations. (National Program Staff/the program publication *A Clean, Well-Lighted Place*)

5. **Don't limit the search for capital when starting up a health care loan fund.** For most of the *Southern Rural Access Program* sites, the revolving loan fund was a vital

element, and the key was finding a blend of state, federal and philanthropic resources to provide seed money. (Program Director/Beachler)

6. **Don't underestimate the importance of strategic communications when initiating a health care loan fund.** Various *Southern Rural Access Program* loan fund administrators found that disseminating information about the first one or two successful loan negotiations built credibility and created momentum for the fund.

   The Louisiana and West Virginia funds included strategic communications in their plans and found that once awareness was established, the pace and volume of loans increased markedly. (National Program Staff/the national program publication *A Clean, Well-Lighted Place*)

7. **Don't discount the potential value of geographic proximity when designing a multisite grant program.** The regional makeup of the *Southern Rural Access Program* enhanced the ability of the project staffs to learn from each other and adopt useful strategies.

   Geographic proximity encouraged loan fund representatives to visit each other and exchange information. (National Program Staff/the program publication *A Clean, Well-Lighted Place*)

8. **Be realistic about Locum tenens projects; they are difficult to develop and sustain.** One problem is finding physicians willing to travel and substitute. Another is marketing the service so rural practitioners know of the opportunity.

   Also, many doctors are workaholics; they either don't want to take vacation or are afraid of losing their patients to competitors. (Program Director/Beachler)

9. **Consider charging fees for a service at the outset instead of initially offering the service for free and then putting it on a fee basis.** The Georgia project team reported that demand for its previously free practice management service declined when fees were assessed.

   A better way to assure sustainability may be to start off with a sliding-fee schedule with significant subsidies for the most needy users. (Georgia project staff)

10. **To achieve synergy across multiple organizations, consider adopting one or more of the strategies used by this program.** For example, the stakeholders had to collaborate in order for their state to be eligible for funding. (Evaluation Team)

AFTERWARD

The Southern Rural Health Consortium

As part of RWJF's exit strategy from the program, the $22.5-million reauthorization included $600,000 to initiate a regional forum to continue the effort to increase health care access in the eight states.

The RWJF staff viewed the ability of the state teams to collaborate and learn from each other as one of the strongest features of the *Southern Rural Access Program* and hoped this new entity—subsequently named the Southern Rural Health Consortium—would keep that aspect intact, said Anne Weiss, the program officer. Creating a mechanism of this type was also among the recommendations of the University of Southern Maine assessment team.

This new organization was to help the states share best practices, analyze data and policy issues and develop technical assistance resources.

In January 2004—while the *Southern Rural Access Program* was still underway—RWJF awarded the $600,000 planning grant (ID# 049849) to the South Carolina Office of Rural Health, which served as the consortium's fiscal agent.

The grant—initially for two years but extended through December 2006—was to support the state project leaders as they organized the consortium, determined its specific mission and reached out to regional and national funders for long-term support.

The Consortium: Development Activities

To govern the consortium, the state project leaders formed a 16-member board with two representatives from each of the eight states. The chair was Steven R. Shelton, director of the Texas project and executive director of the East Texas AHEC.

With support from the planning grant, the consortium:

- Hired an executive director, who was housed at the South Carolina Office of Rural Health.
- Contracted the Georgia Center for Health Policy to facilitate the planning process by providing policy guidance and research, including a literature review of the causes of health disparities.
- Created a website to provide information on the group's purpose and activities plus the results of any studies undertaken. (The site, *www.srhc.info*, is no longer active.)

The board members decided the consortium should focus on the entire southern region. They also discussed broadening the consortium's overall mission to address not just health care access but also the root causes of health disparities, such basic problems as poverty, racism and poor education.

The board identified the following three areas as the consortium's highest priorities and submitted 14 proposals and letters of interest to five potential funding sources:

- Obesity prevention and reduction.
- Preparation of vulnerable populations to survive natural disasters.

- Establishment of a revolving loan fund technical assistance resource center—a consulting service to help other states develop rural health care loan funds.

Consortium: Interim Results

Shortly after the December 31, 2006, conclusion of the planning grant, the consortium reported the following to RWJF:

- **None of the funding requests received a favorable response.** The report cited two reasons for the lack of fund-raising success:
  - The consortium's "mission is very broad and potential funding sources had difficulty in comprehending the breadth of the mission."
  - Board members were employees of organizations that were targeting some of the same foundations, compromising the members' ability to solicit funds for the consortium.
- **The consortium experienced staffing difficulties.** The initial executive director did not remain in the position, and a second served only briefly before moving to another job. As a result, functions normally performed by an executive director fell to the board's executive committee and individual board members. As of early 2007, the consortium had no staff.
- **The consortium's "evolution in thought"—the recognition that health disparities are rooted in social conditions—"produced a communication vacuum with many of its stakeholders."** The report added:

  "A more comprehensive approach was necessary, but the SRHC (the consortium) did not have the answer on how to do so—or how to communicate its conclusions."

In an interview April 10, 2007, Shelton, the chair, said the consortium continued to function, with board members meeting regularly via telephone conference calls. A regional conference on combating childhood obesity was held in August 2007 in Little Rock, Ark., and attracted close to 200 participants.

Health disparities and their root causes remain a central focus of the consortium, he said, expressing optimism that funding would become available.

RWJF Grantmaking

RWJF has continued to fund individual health and health care projects in the South. For example, the Foundation awarded multiple grants to support Arkansas' ambitious effort to combat childhood obesity. In addition, RWJF has made a large commitment to help the Gulf region's public health infrastructure recover from Hurricane Katrina.

As of early 2007, however, RWJF had no plans to initiate another national program focused specifically on the region, according to Weiss, the program officer.

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Sidebars

LOUISIANA: RESPONDING TO HURRICANES KATRINA AND RITA

The ability of the Louisiana project to help people after the 2005 hurricanes Katrina and Rita added to its value, according to Michael Beachler, the national program director of the *Southern Rural Access Program.*

In Louisiana, two institutions—the Louisiana State University Health Sciences Center and the state Department of Health and Hospitals—ran the Louisiana Rural Access Program in partnership, with the university as RWJF's grantee.

After Katrina's devastation of their region, project director Marsha Broussard and project coordinator Ruth Landis had to work out of their homes and cars for nine months, communicating with outlying team members by cell phone.

Health Care Networks and Collaborations Facilitate Relief Efforts

Early in the *Southern Rural Access Program* project—before either hurricane struck—the Louisiana team contracted the Southwest Louisiana AHEC in Lafayette to create health networks in about a dozen rural parishes (counties) in the state's southwestern section.

Parish by parish, the AHEC staff initiated a community-planning process to identify and address gaps in local primary care services—a process designed to produce ongoing collaboration among local health, social service and civic organizations.

Five Health Networks Created or Enhanced

Three parishes in the state's southwestern target area—Vermilion, St. Landry and Iberia—ended up creating formal health networks as a result of the planning process and RWJF project support. Between them, the three parishes accessed a total of nearly $10 million in new community grant dollars as a result of the project, the state team reported.

Most of the new grant dollars came from the federal Bureau of Primary Care. Both St. Landry and Vermilion Parishes received network outreach grants from the bureau. Iberia Parish obtained a large grant from the federal Department of Education. It came about as a result of the community planning and collaboration that was initiated through the program, according to the project director Martha Broussard.

- In Vermilion Parish, RWJF funding supported a market analysis to assess health needs and determine the best location for a primary care clinic. The resulting data and recommendations helped guide the community as it planned activities for the new network. Some 70 individuals participated in the planning.

- The Vermilion network obtained a federal Rural Network Development Grant, established a volunteer clinic and set up a pharmacy access program.

Two previously existing networks—the Bayou Teche Community Health Network in St. Mary Parish and Health Enrichment Network in Allen Parish—increased funding and expanded services as a result of the planning assistance provided by project staff.

- The Allen network, for example, reopened a local hospital emergency room and developed grant funding to start a school-based health center.

When Southwest Louisiana was hit particularly hard by Katrina and Rita, Broussard cited the parish-level health networks and other collaborative groups as an important resource in the storms' aftermath. The parish collaboratives also provided a local contact point amid the post-hurricane chaos for state relief agencies, Broussard said.

Pharmacy Networks Add Benefit

At least three parishes (Cameron, Jefferson Davis and Acadia) developed pharmaceutical access programs as a result of the project.

Because so many of the health networks and collaborations were attempting to develop better access to pharmaceuticals, the AHEC staff initiated a regional network of nonprofit organizations to secure and distribute medications at affordable prices.

The AHEC obtained a federal grant to further develop the pharmacy access network—named *Informed*—and as of mid-2007, eight organizations had joined, according to AHEC staff. In addition to obtaining pharmaceuticals, the network worked to encourage people to enroll for the Medicare drug benefit.

Once again, after the storms, the pharmacy access programs set up by the networks were particularly valuable in helping evacuees from New Orleans obtain medicines to replace those left behind, according to Broussard.

Other Project Interventions Also Help Hurricane Response Efforts

A Loan Fund

From its beginning in 1999 to 2006, the Louisiana loan fund facilitated—with technical assistance or direct lending—35 loans that financed clinics and other health care projects with a total investment of more than $52 million.

Initiated in 1999 with capital from the Louisiana Public Facilities Authority and the U.S. Department of Agriculture, the loan fund received $500,000 from RWJF in 2003 as part of the state's *Southern Rural Access Program* project.

During the RWJF grant period—October 2003 through December 2005—the fund closed nine loans that, together with an additional loan closed in early 2006, totaled $1,055,346 and financed projects worth $2.2 million.

Counting funding from all sources, including a special Katrina-relief grant from RWJF in 2005 (ID# 055911), the fund raised $2.6 million as of 2006.

When the hurricanes struck, facilities assisted by the loan fund enhanced the state's response, Broussard said. For example, the Lake Arthur Health Clinic—which opened in 2001 with financing from the revolving loan fund—set up a satellite clinic to serve the influx of hurricane refugees into the Lake Arthur community and surrounding Jefferson Davis Parish.

> *Tina Monlezun, RN, MSN, is the nurse practitioner who opened the clinic in Lake Arthur, a town of 2,900 in southwest Louisiana sustained by shrimping, oil production and farming—occupations that typically provide minimal pay and no health benefits. To find out how the start-up financing from the revolving loan fund helped her clinic survive a tough first year—and serve patients after Hurricane Katrina—click here.*

A Regional Recruiter

By supporting a regional recruiter based at the Southwest Louisiana AHEC, the project stimulated development of a provider recruitment system that helped bring health care personnel into the state after the two hurricanes, says Broussard.

The system also helped Louisiana physicians disrupted by the storms find new practice opportunities in the state, according to Jeanne Solis, AHEC's executive director.

Sustaining the Networks Proves Difficult

By early 2006, only one of the three health networks—St. Landry—continued to function, according to AHEC staff.

The networks "faced significant sustainability challenges," Beachler, the national program director, told RWJF. Once their outside funding ended, the networks had trouble securing replacement resources, according to Solis.

Nevertheless, although establishing formal, permanent networks proved difficult, the collaborative process left communities more organized and better able to respond to the

needs of Katrina and Rita victims, according to Broussard. "It was really the grass roots folks that provided the relief to evacuees," she says.

MISSISSIPPI: RECRUITING AND RETAINING RURAL PRIMARY CARE PROVIDERS

The Mississippi Primary Health Care Association, an organization of community health centers and other community-based providers, led the Mississippi project.

"It was kind of a breech birth," Robert M. Pugh, MPH, the association's executive director, said of the process that led to his organization's selection. "We had to do some real negotiating to build the trust" among Mississippi's other health care interests.

The concern was that with the primary care association in the driver's seat, community health centers would get the bulk of the state's *Southern Rural Access Program* funding, Pugh explained. In response, the association took pains to give the project a separate identity, including its own advisory board, staff and name: Mississippi Access to Rural Care (MARC).

Efforts to recruit and retain primary care physicians in some of Mississippi's most remote and impoverished areas proved to be a major focus of MARC.

Attracting Licensed Primary Care Providers to Rural Mississippi

The Mississippi project staff partnered with the state Office of Primary Care Liaison to support a recruiter to attract licensed primary care providers to rural areas. The recruitment effort focused on 31 western Mississippi counties, the project's target area.

The effort helped recruit and place 134 primary care providers over the life of the project:

- The recruiter advised rural hospitals and health centers on recruiting strategies. An online, interactive recruitment service accessible through the project Web site (no longer maintained) allowed health care facilities to list their employment opportunities and health workers looking for positions to post their resumes.
- Aided by software, the recruiter tracked 225 Mississippi medical students during their training-both students at the University of Mississippi medical school and Mississippians enrolled out-of-state.
- The recruiter attended 50 career and health fairs and visited 25 medical and dental schools.

The recruitment service continued at the conclusion of the RWJF funding with state and federal support.

A Practice Management Service Helps Providers Thrive

Mastering the arcane but critical details of practice management—including coding and billing, reimbursement and personnel procedures—was a particular need among small Mississippi clinics and hospitals. According to one estimate, rural Mississippi providers had lost $30 million because their billing departments undercharged.

The Mississippi Hospital Association used project support to hire Sally Harrison, a registered nurse experienced in the business side of health care, to assist rural health care facilities with practice management issues.

Harrison explained that hospitals are entitled to charge for their facilities costs—everything from suture kits to intangible overhead—as well as for physician services. Some hospitals, however, fail to charge for both and, as a result, lose a lot of revenue, she said.

Among four rural hospitals that underwent a master charge review—the term for a review and updating of coding and pricing data—charges increased an average of $1.2 million per hospital, the project team reported.

> *The experience of Mary Curtis, administrator of the community hospital in Prentiss, Miss., illustrates the practice management service's value. To find out how Sally Harrison, RN, helped Mary Curtis find ways to increase the community hospital's charges, click here.*

The hospital association eventually hired additional personnel to expand the practice management service. During the project period, the service assisted 39 hospitals and 31 other providers.

When the RWJF funding ended, the practice management service continued for a short period with fee income and hospital association support. In August 2006, however, Harrison and Ann Morris, another practice manager, left the association and formed their own for-profit practice management business.

Harrison said she and Morris would continue to assist only rural hospitals, and they would work in collaboration with the hospital association, for example, taking referrals.

Adding Practice Management Skills to the Rural Workforce

In a separate effort, the Mississippi Board for Community and Junior Colleges developed a billing and coding curriculum with support from a 21st Century Challenge Fund grant of $60,141.

The purpose was to train residents of rural, underserved Mississippi—individuals who most likely could not afford a commercial course—to be hospital billing clerks.

The Enterprise Corporation of the Delta and the Bower Foundation of Ridgeland, Miss., also supported the training effort.

Some 125 students took the course at community colleges during the project period.

SOUTH CAROLINA: DEVELOPING A PIPELINE OF RURAL HEALTH PROVIDERS

The nonprofit South Carolina Office of Rural Health led the state's *Southern Rural Access Program.* Established in 1991 to improve South Carolina's rural health infrastructure, the organization was initially part of the state health department but became independent in 1994.

Even before the RWJF program started, the South Carolina Office of Rural Health was working to help students in the health professions and had a loan fund and recruiting program in place. So the organization was an obvious choice to take on the leadership role for the project.

The activities of the South Carolina project were initially statewide, but in the second four years the project targeted 17 rural counties along the state's I-95 corridor and in the Low Country region south of Charleston and Columbia.

Nurturing future health professionals likely to practice in rural areas was a strong focus of the South Carolina project. The team developed two different pipeline initiatives: a scholarship program and summer enrichment sessions.

A Scholarship Program

To generate a rural primary care workforce in tune with the population being served, the South Carolina team developed a scholarship program for minority students in nurse practitioner, nurse midwifery and physician assistant training programs.

This initiative—called *Community Incentive for Diversity*—provided minority students with leadership training and mentoring as well as two-year scholarships worth, initially, $10,000 per year.

A loss of federal support—from Washington's decision to zero out certain funding for the National Health Service Corps—forced a reduction in the scholarships part way through the project to $6,000 per year.

The rules initially required scholarship recipients to be from Health Professional Shortage Areas or Medically Underserved Areas and agree to return to practice for two years after graduation.

However, finding students who met those criteria proved difficult. As a result, the Office of Rural Health broadened the criteria to include students regardless of residency provided they agreed to practice in an underserved area.

- A total of 29 minority students in the health professions received scholarships through Community Incentive for Diversity.
- Of those, 20 had graduated by early 2006 and an additional eight expected to graduate later in the year. Of the graduates, 14 were working in underserved areas of the state.

One scholarship recipient was John Panguntalan, a native of the Philippines who came to the United States in 1990 and, with his American bride, settled in South Carolina.

His skills as a business administrator did not transfer to the highly computerized American work place, he explained. He decided to switch gears and go into nursing, earning first an R.N. through a two-year program and later a bachelor's degree at Lander University in Greenwood, S.C.

Panguntalan wanted to go still further-to become a family nurse practitioner. He learned of the Community Incentive for Diversity scholarship program, applied to and entered Clemson University's two-year family nurse practitioner program with money from the scholarship program.

"Without the financial assistance, I don't think I could have finished the program in two years," says Panguntalan, who worked part-time as a staff nurse while at Clemson.

During the program, he met twice yearly with other participants for presentations on such subjects as communications skills and conflict resolution. For a mentor, the program paired him with a family nurse practitioner of Asian descent.

After graduating from Clemson, Panguntalan was a family nurse practitioner for two and a half years in Abbeville, S.C. at a rural clinic with a large Medicaid clientele.

Funding to sustain the *Community Incentive for Diversity* initiative did not develop, so the scholarship program ended with the RWJF program.

A Summer Training Program

Separately, the South Carolina project supported a five-week summer training program for students in 12 health disciplines, including family medicine, dentistry and occupational therapy. Six South Carolina universities participated.

The purpose was to introduce future health care professionals to rural health care issues and interest them in working in small communities. The Low Country AHEC office administered the program-known as SCRIPT for South Carolina Rural Interdisciplinary Program of Training.

This program started in the early 1990s but grew as a result of the RWJF support.

The summer sessions took place in rural communities throughout the state and included 16 days of clinical practice or field work designed to give the students face-to-face contact with local residents. For example, a project might entail a student surveying shoppers at a grocery store about their knowledge of diabetes, high blood pressure or other health conditions.

Students also participated in workshops, conferences, field trips and team-based health promotion activities. They lived in the community and received a $1,000 stipend.

- Some 420 students participated in the five-week summer training program during the RWJF-funded period.
- A 2004 survey of former SCRIPT participants indicated 61 percent were motivated to seek work in rural areas, and 35 percent were actually working in rural areas at that point.

As well as losing RWJF funding when the *Southern Rural Access Program* ended, SCRIPT lost federal support when the federal government eliminated its Quentin N. Burdick Rural Program for Interdisciplinary Training.

However, the Low Country AHEC secured funds from the South Carolina legislature to continue the program in 2007.

TEXAS: SUPPORTING HEALTH CARE NETWORKS IN RURAL AREAS

The East Texas AHEC at the University of Texas Medical Branch at Galveston led the *Southern Rural Access Program* project. The AHEC has nine regional offices and serves a population of 15 million across 111 counties.

The *Southern Rural Access Program's* Texas project targeted 38 eastern counties along the Louisiana and Arkansas borders. The health disparity data for this area resembled those for the rest of the South.

In the program's second half, the focus narrowed further—to 16 counties along the Louisiana line.

A stakeholders' consortium of some 200 organizations and individuals helped develop, implement and refine the project's various activities. A 12-member governance council representing private and public health-related organizations met quarterly to provide oversight.

Development of the East Texas Health Access Network—known as ETHAN—was one of the Texas team's major activities.

A Health Care Network for the Southeast Corner of Texas

Established in 2000 with RWJF funds, ETHAN comprised 40 organizations—including hospitals, social services agencies and faith-based ministries—across five rural counties in the state's southeast corner: Jasper, Tyler, Newton, Sabine and San Augustine.

The network provided no medical care but conducted a patient referral service, health screenings for such conditions as diabetes and cardiovascular disease, health education sessions and a low-cost pharmacy program. Community health workers—local residents trained to assist their peers access health resources—delivered many of the services.

A forceful driver for the creation of the East Texas network was Carlene Womack, a businesswoman in Jasper, Texas, before her husband's death in 1998 during heart transplant surgery.

Seared by her personal experience with the health care system—including devastating medical bills—she saw the need for a way to link people experiencing health problems with health resources. She became the network's executive director.

Over the course of the project, the network developed into a multiple-service nonprofit organization with 10 full-time and two part-time nonmedical employees plus two full-time nurses and one part-time nurse.

In addition to the main office in Jasper, five satellite offices opened one to two days a week. Fifty volunteers—half of them medical professionals—assisted.

Many Residents Benefit from the Network

"ETHAN staff's primary focus is on health; however, we have learned that you cannot address health issues without addressing housing, employment, food, etc.," says Womack. "Network members serve as the conduit for accomplishing this."

> *One beneficiary of the network was William Hewitt, a 68-year-old Center, Texas, resident with numerous health problems, including cancer, emphysema and a bad heart. Until 2006, he also had painful, diseased teeth. To find out how the network helped this retired manager of a chicken processing plant find the dental care he needed and could afford, click here.*

At the end of the RWJF program, the Texas project team reported ETHAN accomplished the following:

- The pharmacy assistance program enrolled 504 individuals, who paid a $15 monthly fee for help getting reduced-price medications. The network also referred 332 people to other pharmacy programs for which they were eligible.

  The number of pharmacy program participants later declined, a development that Womack attributes to implementation of the Medicare drug benefit. As of early 2007, the program had 183 participants, she said.

- The network participated in or facilitated 48 health fairs and the screening of 2,166 individuals for diabetes, hypertension and/or cardiovascular disease. It reported hosting 28 public programs on health services and issues that drew 720 people.

- A community health worker (CHW) training series drew 15 individuals, five of whom gained CHW certification by the Texas Department of State Health Services and provided 40 hours of services monthly.

ETHAN staff and volunteers also helped in the relief efforts after hurricanes Katrina and Rita. In particular, hurricane Rita caused widespread destruction and disruption in southeast Texas in September 2005.

- Although record-keeping in the aftermath of the storms was minimal, Womack estimated that the network—with other hurricane relief grants in addition to the support provided by RWJF—provided relief services to as many as 10,000 people.

Sustaining the Network

By the end of the *Southern Rural Access Program,* only 10 percent of the network's support came from the project's RWJF grant. From federal agencies, regional

philanthropies, community donations and fee income, the network secured $2.1 million and was able to continue without RWJF funding.

Still, over the long run, the fact that the project focused on just one section of Texas—instead of statewide—made fund-raising among some state agencies and organizations difficult, said Ingrid Bowden, the project director at East Texas AHEC, following the project's conclusion.

WEST VIRGINIA: DEVELOPING A HEALTH CARE REVOLVING LOAN FUND

The West Virginia lead agency was the Center for Rural Health Development, a nonprofit organization created in 1994 to provide leadership in the state on rural health issues. (Located in Dunbar, W.Va., at the time of the program, the Center moved to Hurricane, W.Va., in May 2007.)

The project team's principal effort was setting up and operating a health care revolving loan fund. After briefly using an outside financial company, the Center for Rural Health Development took over all fund administration and loan servicing functions.

A Funding Partnership

The Claude Worthington Benedum Foundation in Pittsburgh supported the project's planning phase and matched RWJF's implementation funding.

A large share—$500,000—of the state's first core grant from RWJF went into the loan fund, accompanied by an equal amount from the Benedum foundation. The second RWJF core grant included another $500,000 in seed money. Because the state legislature gave $500,000 in seed capital to the loan fund during the second grant period, Benedum did not add loan fund seed money to its matching grant during the second grant period.

Marketing the Fund

Staff of the center worked to raise additional capital from public sources and to market the fund to bankers as well as providers. The promotional effort included communicating early loan successes to the news media and policy-makers.

Also as part of the effort to develop visibility and support for the fund, staff ensured that state legislators and local leaders received invitations to the groundbreaking ceremonies for financed projects.

A Loan Fund Clinic Gains Commercial Loans

The fund helped at least one clinic become eligible for commercial loans. Sharon Lansdale, the West Virginia project director, pointed to a clinic—the only clinic—in Wirt County in the state's northeast corner. The sponsors were unable to get commercial financing. "They were turned down by everybody, including USDA [the U. S. Department of Agriculture's community facilities loan programs]," said Lansdale.

In addition to providing mortgage financing, her organization helped the clinic become a federally qualified health center—status that ensured higher Medicare reimbursements and made a construction loan attractive to commercial lenders.

"The people in Wirt County wouldn't have a facility without the fund," said Lansdale. Subsequently, the sponsors embarked on an expansion of the clinic and were able to finance the work entirely in the commercial market—evidence of the facility's success, she said.

Loan Fund Helps Build Health Infrastructure

During the project period, the loan fund made more than 20 loans to finance health care projects costing a total of $16 million. By project end, the fund secured sufficient capital to continue without RWJF support.

- In addition to the RWJF and Benedum contributions ($1.5 million), the fund raised more than $5.2 million, including $1.5 million from the state legislature, $1.53 million from the USDA and $1.4 million from the U.S. Department of Treasury.
- At the conclusion of the RWJF program, the fund had almost $1.5 million in uncommitted capital from such sources as the Benedum Foundation, the West Virginia Legislature and federal agencies including the U.S. Departments of Treasury and Agriculture and was continuing to seek additional funding. There had been no loan defaults.

"We've helped build eight new [health care] facilities across the state," said Lansdale.

As a next step, Lansdale hoped to develop a special lending pool to help rural providers incorporate health information technology. However, she acknowledged that was a long-term plan dependent on raising additional capital.

Since the RWJF funding ended, raising capital had become more difficult. The fact that RWJF had money in the fund encouraged other organizations to invest, she explained.

STANITA JACKSON

One student that Mississippi's six-week summer enrichment program inspired was Stanita Jackson, a biology major from Greenville, Miss., who started thinking about becoming a pediatrician when she was 8 years old. "I love helping people," she says.

Jackson, an undergrad at Delta State University in Cleveland, Miss., attended the 2004 summer session at Copiah-Lincoln Community College in Natchez. She spent half of each day in the classroom for courses in English, medical terminology and first aid.

She spent the other half-day at the Natchez Regional Medical Center, shadowing staff in a different department each week. In physical therapy, she worked with patients, throwing exercise balls to them and helping them walk the hallway. In the pathology laboratory, she saw a hernia, colon and stillborn child.

During the six weeks, Jackson and her colleagues took an overnight field trip to Atlanta, where they toured Morehouse School of Medicine and learned about jobs at the Centers for Disease Control and Prevention.

The following year, Jackson graduated from Delta State and entered the university's master's program in biological sciences, still thinking about becoming a physician but also entertaining a competing dream: getting a PhD and going into research.

MARY CURTIS AND SALLY HARRISON

When Mary Curtis became administrator of the community hospital in Prentiss, Miss., in 2000, she found serious billing problems. Incorrect billing information—resulting in numerous reimbursement denials—was one.

Another was undercharging; hospital departments were failing to seek reimbursement for supplies, personnel and other legitimate facility costs. Basically, the billing operation was out of date and disorganized, according to Curtis. "When I came in, it was all in a drawer," she says. "So I called Sally and said, 'Help.'"

That was Sally Harrison, a registered nurse experienced in the business side of health care. With RWJF funding through the *Southern Rural Access Program,* the Mississippi Hospital Association hired Harrison to assist rural health care facilities with coding and billing and other financial aspects.

Harrison spent the better part of two months straightening out the Prentiss operation, and the results were impressive: The hospital's charges increased from $9 million to $11

million a year initially and eventually went up to $14 million, says Curtis, adding. "That's the bottom line."

The hospital association charged for Harrison's services but below the standard commercial rate. When the RWJF funding ended, the practice management service continued with fee income and hospital association support until August 2006—when Harrison and a colleague left the association and formed their own practice management firm.

WILLIAM HEWITT

One client of the East Texas Health Access Network was William Hewitt, a 68-year-old Center, Texas, resident with numerous health problems, including cancer, emphysema and a bad heart. Until 2006, he also had painful, diseased teeth. They all had to come out, a dental surgeon told him.

But how could this retired manager of a chicken processing plant possibly pay for the procedure? It was dental work, so Medicare wouldn't help, he was told. He and his wife had no private dental coverage, and he certainly couldn't pay out of pocket.

Because of his overall poor health, his teeth had to be removed in a hospital setting; performing the procedure in a dental office would be too risky, the dental surgeon told him.

Facing a big hospital bill on top of the surgeon's fee, Hewitt called every organization he could think of for help and got none—until someone told him to try the East Texas Health Access Network.

The response there was quick and positive, he says. The network staff made arrangements for him to have his teeth removed at a Houston hospital by University of Texas dental students under the supervision of a dentist.

That's what he did, his cost—including dentures and two fittings—totaling just over $1,000. "I still don't know what would have happened without their help," Hewitt says, referring to the network. "They've done something for me that no one else in the country would do, not even the government."

TINA MONLEZUN

One beneficiary of Louisiana's revolving loan fund was Tina Monlezun, RN, MSN, a nurse practitioner who wanted to open a clinic in Lake Arthur, a town of 2,900 in

southwest Louisiana. The community previously had a clinic, but it closed down. Monlezun, a native of that section of the state, thought she could make a go of it and acquired the vacant clinic building.

However, she still needed capital to cover personnel, equipment and other costs while the operation got underway—and into the black.

A basic rule, says Richard Blouin, senior loan coordinator for the loan fund, is that it takes nine to 14 months before a new clinic can generate enough revenue to meet expenses. "We try to make it easy for them to get over the hump-that first year," Blouin says.

That is exactly what the loan fund did for Tina Monlezun. She got a $34,400 line of credit to draw on until income outpaced costs.

The Lake Arthur Health Clinic opened in September 2001, and demand was immediately strong—and got stronger—fueled in part by an influx of refugees from hurricanes Katrina and Rita in late 2005.

By 2006, the staff had grown to 10 (five full-time and five part-time) and the number of patient charts to almost 3,700, says Monlezun. Meanwhile, with the clinic safely in the black, Blouin converted Monlezun's line of credit to a low-interest five-year loan.

Five years gets the money back into the fund in a relatively short period so it can be re-loaned to another provider, Blouin explains. However, he and Brian Jakes, the AHEC CEO, emphasize that they are not just about making loans.

They want to make sure that a potential recipient has a realistic business plan, takes a course in practice management and knows how to market the new services. "What we want are success stories," says Blouin—stories like Monlezun's. Indeed, she subsequently got additional help to finance improvements to her clinic building and parking lot, Blouin says.

In an interview, Monlezun explained that her clinic is in a rural area where shrimping, oil production and farming are the principal sources of employment—employment that typically provides minimal pay and no health benefits.

As a result, many of her patients are uninsured, and for some, the clinic is providing the first health care they have had for years. "Had it not been for that start-up loan, we would have had to close the doors," she says.

APPENDIX 1

National Program Office Staff and Consultants, as of April 2006

Staff

Director: Michael P. Beachler, MPH

Deputy Director: Curtis E. Holloman *(Isiah Lineberry, the initial deputy director, left the staff in September 2000.)*

Communications Manager: Crystal L. Hull

Program Coordinator: Jeannie Nye

Staff Assistant: Todd Hobe

Consultants

James M. Herman, MD

Associate Dean for Primary Care

Pennsylvania State University College of Medicine

Served as the program's senior medical consultant and assisted with the Rural Leaders Pipeline Effort.

William A. McBain

MacBain and MacBain, LLC

Assisted with issues related to rural health plans and provider networks.

James D. Bernstein

President, North Carolina Foundation for Advanced Health Programs

National Program Director, *Practice Sights: State Primary Care Development Strategies*
Consulted on state health care financing and policy issues.

APPENDIX 2

Members of the National Advisory Committee, as of April 2002

William H. Brandon, Chair
President, Southern Development Corporation
First National Bank of Phillips County
Helena, Ark.

Doris Barnette
Consultant
Brandon, Miss.

Regina Benjamin, MD, MBA
Family Physician
Spanish Fort, Ala.

Cornelia (Nela) D. Gibbons
Director
Lieutenant Governor's Office on Aging
Columbia, S.C.

Debra L. Griffin, MHS
CEO
Humphreys County Memorial Hospital
Belzoni, Miss.

Frances Henderson, EdD, RN
Dean, School of Nursing
Alcorn State University
Natchez, Miss.

James Hotz, MD
Director of Clinical Services
Albany Area Primary Health Care
Albany, Ga.

Michael McKinney, MD
Chief of Staff
Office of the Governor
Austin, Texas

Tom McRae
Mountain Association for Community
Economic Development
Berea, Ky.

Charles H. (Pete) McTier
President
Robert W. Woodruff Foundation
Atlanta, Ga.

Sandra B. Nichols, MD
Senior Medical Director
United Health Care of Alabama
Birmingham, Ala.

Joe Rosier
CEO
Rapides Foundation
Alexandria, La.

Gary Wiltz, MD
Medical Director
Teche Action Clinic
Franklin, La.

APPENDIX 3

Lead Organizations in the Eight Program States and the RWJF Grants Received by Each State

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Alabama

- ***Lead Agencies***
  - **West Alabama Health Services:** A community health center headquartered in Eutaw, Ala. In response to financial and management issues, RWJF terminated the organization's grant effective May 15, 2001.
  - **Alabama Primary Health Care Association:** A professional association of federally qualified health centers serving the state's underserved population. Alabama stakeholders selected the association, based in Montgomery, to replace West Alabama Health Services as lead agency.
- ***Core Grants***
  - **West Alabama Health Services** (Eutaw, Ala.)
    - ID# 036051, $230,100 (February 1999–July 2000)
    - ID# 039517, $236,272 (August 2000–January 2002)
  - **Alabama Primary Health Care Association** (Montgomery, Ala.)
    - ID# 043088, $356,379 (August 2001–July 2002)
    - ID# 045364, $989,465 (April 2002–September 2004)
    - ID# 050635, $667,555 (April 2004–March 2006)
- ***Revolving Loan Fund Grants***
  - Alabama did not implement a revolving loan fund.

Arkansas

- ***Lead Agencies***
  - **Arkansas Center for Health Improvement:** A health policy organization in Little Rock established in 1998 under the auspices of the University of Arkansas for Medical Sciences and the Arkansas Department of Health and Human Services.

— **College of Public Health of the University of Arkansas for Medical Sciences in Little Rock:** In the program's second half, Kate Stewart, MD, MPH—director of the state's *Southern Rural Access Program* project—moved her base of operations from the Arkansas Center for Health Improvement to another university-related entity, the College of Public Health. As a result, the lead agency changed.

- ***Core Grants***

  — **University of Arkansas Foundation** (Little Rock, Ark.)

  - ID# 035761, $511,519 (February 1999–July 2000)
  - ID# 039338, $837,105 (August 2000–March 2002)
  - ID# 045359, $973,273 (April 2002–September 2004)

  — **University of Arkansas for Medical Sciences** (Little Rock, Ark.)

  - ID# 050641, $745,864 (April 2004–June 2006)

- ***Revolving Loan Fund Grants***

  — **Southern Financial Partners** (Arkadelphia, Ark.)

  - ID# 038123, $500,000 (October 1999–October 2002)
  - ID# 045358, $500,000 (April 2002–March 2005)

- ***General Program Expense Grant***

  — **Developing Policy Initiatives to Address Community Health Worker Sustainability**

  Arkansas Department of Health and Human Services (Little Rock, Ark.)

  - ID# 050226, $482,892 (August 2004–August 2008)

Georgia

- ***Lead Agency***

  — **Georgia Office of Rural Health Services:** A division of the Georgia Department of Community Health beginning in 2000, previously a division of the Department of Human Resources.

- ***Core Grants***

  — **Georgia Department of Human Resources** (Atlanta, Ga.)

  - ID# 036049, $383,522 (March 1999–December 2000)

— **Georgia Department of Community Health** (Atlanta, Ga.)

- ID# 040310, $715,689 (December 2000–September 2002)
- ID# 045803, $807,750 (July 2002–September 2004)
- ID# 050634, $696,220 (April 2004–June 2006)

- ***Revolving Loan Fund Grants***

— **Georgia Small Business Lender Inc.** (Macon, Ga.)

- ID# 049636, $500,000 (October 2003–September 2006)

Louisiana

- ***Lead Agency***

— **Louisiana State University Health Sciences Center,** New Orleans, in partnership with the **Louisiana Department of Health and Hospitals,** Baton Rouge.

- ***Core Grants***

— **Louisiana State University Health Sciences Center** (New Orleans)

- ID# 036166, $465,059 (March 1999–December 2000)
- ID# 039542, $847,196 (August 2000–June 2002)
- ID# 045363, $972,089 (April 2002–September 2004)
- ID# 050637, $850,301 (April 2004–June 2006)

- ***Revolving Loan Fund Grants***

— **Southeastern Louisiana Area Health Education Center Foundation** (Covington, La.)

- ID# 049638, $500,000 (October 2003–December 2005)

Mississippi

- ***Lead Agency***

— **Mississippi Primary Health Care Association:** A nonprofit membership organization in Jackson that represents community health centers and other community-based providers in the state.

- ***Core Grants***
  - **Mississippi Primary Health Care Association** (Jackson, Miss.)
    - ID# 036031, $398,156 (February 1999–September 2000)
    - ID# 039541, $983,606 (October 2000–June 2002)
    - ID# 045361, $1,036,769 (April 2002–September 2004)
    - ID# 050639, $767,486 (April 2004–June 2006)
- ***Revolving Loan Fund Grants***
  - **Enterprise Corporation of the Delta** (Jackson, Miss.)
    - ID# 041014, $610,850 (February 2001–August 2005)
    - ID# 051740, $500,000 (November 2004–October 2006)

South Carolina

- ***Lead Agency***
  - **South Carolina Office of Rural Health:** An organization established in the 1990s to improve the health status of rural and underserved people throughout the state. Initially housed in the state Department of Health and Environmental Control, it is now a nonprofit with its own headquarters in a suburb of Columbia.
- ***Core Grants***
  - **South Carolina Office of Rural Health** (Lexington, S.C.)
    - ID# 035446, $458,482 (December 1998–October 2000)
    - ID# 038986, $981,930 (May 2000–July 2002)
    - ID# 045362, $986,480 (April 2002–September 2004)
    - ID# 050636, $819,552 (April 2004–June 2006)
- ***Revolving Loan Fund Grants***
  - **South Carolina Healthcare Recruitment and Retention Center** (Columbia, S.C.)

    Revolving Loan Fund
    - ID# 043154, $481,000 (October 2001–October 2004)
  - **South Carolina Office of Rural Health** (Lexington, S.C.)
    - ID# 051739, $500,000 (October 2004–March 2007)

Texas

- ***Lead Agency***
  - **East Texas Area Health Education Center:** An organization based at the University of Texas Medical Branch at Galveston that seeks to improve the health care workforce in East Texas. (It is part of the national Area Health Education Center (AHEC) network initiated by Congress in the early 1970s to recruit, train and retain health professionals in medically underserved areas.)
- ***Core Grants***
  - **University of Texas Medical Branch at Galveston** (Galveston, Texas)
    - ID# 036073, $294,613 (February 1999–June 2000)
    - ID# 039339, $875,454 (July 2000–June 2002)
    - ID# 045360, $942,186 (April 2002–September 2004)
    - ID# 050633, $749,715 (April 2004–March 2006)
- ***Revolving Loan Fund Grants***
  - **North East Texas Economic Development District** (Texarkana, Texas)
    - ID# 047451, $500,000 (January 2003–July 2006)

West Virginia

- ***Lead Agency***
  - **Center for Rural Health Development:** A private, nonprofit organization in Hurricane, W.Va. (in Dunbar, W.Va., at the time of the program), created in 1994 to provide technical assistance and resources to improve health care access in rural, underserved areas of West Virginia.
- ***Core Grants***
  - **Center for Rural Health Development** (Hurricane, W.Va.)
    - ID# 037776, $1,233,297 (December 1999–June 2002)
    - ID# 045365, $1,265,075 (April 2002–September 2004)
    - ID# 050638, $459,985 (April 2004–June 2006)
- ***Revolving Loan Fund Grants***
  - In part because the Claude Worthington Benedum Foundation co-funded the West Virginia project, RWJF built the seed capital for the fund into West Virginia's

core grants ($500,000 each). Another factor was that the lead agency administered the loan fund directly instead of handing it off to a partner organization.

APPENDIX 4

21st Century Challenge Fund Grants, Listed by State

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The fund supported the following projects, according to the program publication *21st Century Challenge Fund: An Innovative Matching Grant Initiative of the Southern Rural Access Program*:

Alabama

Project: Black-Belt Rural Congregation Health Project

Sponsor: National Black Church Family Council

Grant: $80,000

Project: Smile Alabama

Sponsor: Alabama Medicaid, Dental Outreach Initiative and Alabama Medical Agency

Grant: $250,000

Project: Southwest Alabama Children Youth Sickle Cell Network

Sponsor: University of South Alabama

Grant: $150,000

Arkansas

The national program office did not award any 21st Century Challenge grants to the Arkansas project. RWJF made a direct grant to Arkansas for a community health worker sustainability demonstration program; see Appendix 3.

Georgia

Project: Philanthropic Collaborative for a Healthy Georgia: Rural Health Access Initiative

Sponsor: Georgia Health Policy Center and Georgia State University

Grant: $500,000

Louisiana

Project: Mobile Dentistry Delivery System

Sponsor: Catahoula Parish Hospital District No. 2

Grant: $201,545

Project: Operation Heartbeat Emergency Medical Services Project
Sponsor: American Heart Association, Southeast Affiliate
Grant: $163,762

Project: Pharmaceutical Access Program
Sponsor: ASSIST Agency
Grant: $50,000

Project: Transportation Rural Area Network System
Sponsor: Health Enrichment Network
Grant: $113,336

Mississippi

Project: Analysis of Physician Fee Schedule Changes in Mississippi
Sponsor: Mississippi State University
Grant: $53,502

Project: CATCH Kids
Sponsor: CATCH Kids Inc.
Grant: $49,281

Project: Medical Billing Curriculum Development Project
Sponsor: Mississippi Board for Community and Junior Colleges
Grant: $60,141

South Carolina

Project: Emergency Medical Services Initiative
Sponsor: Low Country Health Care Network
Grant: $114,680

Project: Health and Faith Communities Collaborative
Sponsor: Beaufort Jasper Hampton Comprehensive Health Services
Grant: $131,180

Project: Heart and Soul Project
Sponsor: Palmetto Project
Grant: $116,252

Project: School Nurse Chronic Disease Management Project
Sponsor: Marion Regional Healthcare System
Grant: $148,000

Texas

Project: Telecare Plus Spanish Language Expansion
Sponsor: Trinity Mother Frances Health System Foundation
Grant: $50,000

West Virginia

Project: Evaluation of the West Virginia Transportation for Health Project
Sponsor: West Virginia Center for Healthcare and Policy Research
Grant: $69,522

Project: Pediatric Preventive Oral Health Project
Sponsor: West Virginia Center for Healthcare Policy and Research
Grant: $23,741

Project: School-Based Health Center Practice Improvement Project
Sponsor: West Virginia Primary Care Association
Grant: $24,730

Project: SEARCH Project
Sponsor: Center for Aging and Healthcare in West Virginia
Grant: $51,550

Project: Transportation for Health
Sponsor: Center for Rural Health Development
Grant: $234,844

APPENDIX 5

Communications Activities of the National Program Office

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The *Southern Rural Access Program* national staff took numerous steps to disseminate information about the program, including the activities of the individual states and funding opportunities of the 21st Century Challenge Fund. The staff:

- Arranged for the *Journal of Rural Health*—a quarterly publication of the National Rural Health Association—to produce a special summer 2003 supplement issue devoted to the program, including the challenges faced by the national and state staffs and lessons learned. The 424-page issue, which was paid for with RWJF funds, featured 15 articles authored by members of the national staff, state teams and evaluation team.
- Published a newsletter—*Rural Health Connections*—three to four times a year with information about the states' activities. The distribution list of 2,000 included government agencies, philanthropies and health care organizations in the eight states.
- Published two booklets with in-depth information on aspects of the program:
  - *A Clean, Well-Lighted Place* focused on the states' revolving loan funds, with case studies of five of the funds.
  - *21st Century Challenge Fund: An Innovative Matching Grant Initiative of the Southern Rural Access Program* provided detailed reports on five projects supported by this special fund.
- Developed a website that included summaries of the state projects, news releases on program activities, the newsletter and other program information.
  - Initially the site (*www.hmc.psu.edu/rhpc*) was part of the Penn State Web operation. In 2003, with assistance from a consultant and RWJF personnel, the staff redesigned the website and, in 2007, it moved under RWJF's auspices.
- Made numerous presentations to professional, business, philanthropic and government organizations, many in the target region, including the Southeast Council of Foundations and the Southern Rural Development Center.
  - Staff also participated in events outside the region, including meetings of the National Rural Health Association and a Washington meeting on oral health convened by the federal Office of Rural Health Policy.

- Issued news releases about program activities and helped the state staffs develop their own communications efforts. The communications director advised the state teams on working with local media and creating press releases.

For details of many of these publication and activities, see National Program Office Bibliography.

APPENDIX 6

Support for Three Public Radio Stations

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

In July 2004, RWJF awarded a $125,000 grant (ID# 051405) to the Benton Foundation to provide minigrants to local public broadcasters and their community partners in the eight-state *Southern Rural Access Program* region.

The purpose was to help stations and local organizations work together to engage the community in health care access issues.

The Benton Foundation, located in Washington, administers *Sound Partners for Community Health*, an RWJF-funded program that supports programming and community engagement techniques to increase public awareness of health issues.

The grant enabled *Sound Partners* to include up to four public radio stations located in the eight southern states. The funding came out the *Southern Rural Access Program* authorization.

Although there were some 35 eligible stations within the eight states, many were too small to have a news department with the capacity to participate, according to the *Sound Partners* staff.

The *Sound Partners* advisory committee received and reviewed three proposals, and approved the three for funding. Each of the three stations received $15,000, and the local organizations with which the stations collaborated got an additional $7,500. The funds supported program production and outreach activities. (Of the $125,000 grant total, the Benton Foundation used $99,785.)

The three projects were:

- Georgia Public Broadcasting partnered with the Morehouse School of Medicine to focus attention on rural health care in three of the state's poorest counties: Stewart, Quitman and Randolph.

  A series of aired reports addressed teen pregnancy, sexually transmitted diseases and other health problems, culminating in a town hall meeting involving policy-makers,

health care professionals and community members. More information is available online.

- KASU-FM at Arkansas State University in Jonesboro, Ark., collaborated with the state's *Southern Rural Access Program* staff to provide high school students with information about health care careers.

  The station aired a series of five 30-minute educational programs about different health care careers and the staff encouraged high school science teachers to incorporate the programs into their curricula. Additional details are online.

- WYRC-FM—a low-power station in Spencer, W.Va., operated by the Roane County school system—promoted health careers students through programming and outreach activities, including a health fair at the high school. A more detailed description of the project is available online.

APPENDIX 7

Evaluation Methodologies

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The program evaluation by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina-Chapel Hill consisted of two research activities. The following provides details of each:

1. Monitoring Changes in the Supply of Primary Care Professionals

RWJF staff and the evaluation team viewed the ratio of primary care physicians to population as one useful measure of health care access, while acknowledging that other factors, such as health insurance coverage, also affect access.

The evaluation team used the American Medical Association's *Physician Masterfile* and census data to calculate physician-to-population ratios. The *Physician Masterfile* provides location information on all U.S. allopathic physicians, including nonmembers of the association, and the majority of osteopathic physicians.

To assess the program's impact on physician supply, the team made two comparisons:

- The team compared the growth in physician numbers in the 150 counties targeted in Phase II with physician growth in the 457 rural counties that were not targeted.
- The team also compared physician growth between high-poverty target and high-poverty non-target counties. High-poverty counties were those with 18 percent or more of the population living below the federal poverty line.

Because the non-target counties as a whole were economically better off than the target counties, a comparison between the two potentially masked the program's impact, according to the evaluators.

To equalize the economics of the two groups and avoid that bias, the team created and compared the high-poverty subgroups. Among the 150 target counties, 124 were in the high-poverty category. Among the 457 non-target counties, 202 were high-poverty.

The team stipulated that a comparison between these two high-poverty subgroups provided the best, most pertinent assessment of the program's impact on practitioner availability.

The assessment covered December 31, 2001. through October 31, 2005 essentially the second four years of the program. The team had planned to cover all of 2005, but in August and September that year two hurricanes (Katrina and Rita) disrupted the Gulf coast, including physician locations.

In addition to the four-year assessment period, the team calculated annual changes in practitioner densities from 1996 to 2001 in order to establish a pre-program baseline. Analysis showed that during this baseline period, physician growth was greater in the non-target counties than in the target counties.

Initially, the team sought also to assess changes in the numbers of nurse practitioners and nurse midwives based on data from state licensure records. However, these data were available for only four of the eight states (Mississippi, South Carolina, Texas and West Virginia) and even when available had weaknesses, according to the evaluation team.

As a result, the team excluded nurse data from its final report in 2006. (An interim report—covering the years 2002–2003 and issued March 31, 2005—said the available data indicated no significant program effect on the primary care advanced practice nursing workforce.)

The assessment of physician growth focused on primary care physicians since primary care was the focus of the program. However, the team did analyze changes in specialist physicians:

- To determine if other kinds of physicians might also have been affected by the program.
- To provide a control group against which to compare changes in primary care physicians.

2. Tracking Changes in How Target Area Residents Assessed Their Access to Health Care

The team collected and analyzed survey data on how rural residents assessed their access to health care—whether, for example, they had difficulty seeing a clinician or used an emergency room for primary care.

Initially, the team planned to obtain this information from the *Behavioral Risk Factor Surveillance System*—an annual Centers for Disease Control and Prevention (CDC) survey that includes an access component. The evaluators hoped to expand sampling within the target counties, thus providing an ongoing system for tracking access indicators.

However, the team found the CDC survey data was inadequate and costly to use. One problem was that the data did not have enough indicators of access, according to Pathman, the evaluation director.

Also, while the data permitted a statewide assessment and, in some states, a rural-versus-urban comparison, it was not possible to break down the data to the target counties.

As a substitute data source, the team commissioned—with RWJF's approval—a random phone survey of adults living in the 150 rural counties targeted by the program's Phase II. The team hired Professional Research Consultants of Omaha, Neb., to conduct the calls from November 2002 to June 2003.

The questionnaire covered various aspects of access to outpatient services. Examples:

- How many minutes does it usually take to travel from home to get care?
- How easy or difficult is it to get a doctor's appointment for an illness or injury within one or two days?
- During the last 12 months, has a doctor or nurse asked you about or given you advice regarding diet and nutrition?

A total of 4,879 adults (600 or more per state) completed the 25-minute survey, a response rate of 51.7 percent.

The data provided a more detailed picture of access than would have been possible from the CDC survey, the evaluators said. However, there was no follow-up survey and, thus, no means to track changes in access indicators, as had been planned.

In awarding the last of the three evaluation grants, the RWJF program staff explained the decision not to fund a follow-up survey:

"We feel that the activities of SRAP are so long term and diffuse that the expense of a [second] survey is not warranted at this time; however, the Foundation may wish to support such a survey five years out to help inform the field."

As of early 2007, neither RWJF nor the Sheps Center had plans to initiate a follow-up survey.

APPENDIX 8

Additional Findings and Conclusions of the Evaluation Team

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Evaluators from the Cecil G. Sheps Center for Health Services Research at the University of North Carolina-Chapel Hill reported on these additional aspects of the *Southern Rural Access Program*:

Assessment of Health Care Access

The following were among findings and conclusions reported in journal articles based on data from evaluation team's 2002–2003 telephone survey:

Article: "How Adults' Access to Outpatient Physician Services Relates to the Local Supply of Primary Care Physicians in the Rural Southeast"—in *Health Services Research.*

- "Among adults as a whole, more individuals reported traveling over 30 minutes for outpatient care in PCSAs (Primary Care Service Area) with more than 3,500 people per physician than in PCSAs with fewer than 1,500 people per physician (39.1 versus 18.5 percent…) and more reported travel difficulties."
- "Otherwise, PCSA density of primary care physicians was unrelated to reported barriers to care, unrelated to people's satisfaction with care, and unrelated to indicators of people's use of services."
- "Among subjects covered under Medicaid or uninsured, lower local physician densities were associated with longer travel time, difficulties with travel and reaching one's physician by phone, and two areas of dissatisfaction with care." Dissatisfaction included the overall care subjects received and how welcome and comfortable they felt when they received care.

  Conclusion: "For adults as a whole in the rural South and for the elderly there, low local primary care physician densities are associated with travel inconvenience but not convincingly with other aspects of access to outpatient care. Access for those insured under Medicaid and the uninsured, however, is in more ways sensitive to local physician densities."

Article: "Differences in Access to Outpatient Medical Care for Black and White Adults in the Rural Southeast"—in *Medical Care.*

- "Compared with whites, blacks reported similar or higher use of outpatient services over the previous year, including the likelihood of having had an outpatient physician visit and regular checkup."
- "Nevertheless, blacks more often reported forgoing needed care, encountering various barriers and experiencing dissatisfaction with some aspects of care."

  Conclusion: "Blacks and whites in the rural South report similar use rates of outpatient medical care, but blacks more often report unmet needs, barriers to care and dissatisfaction with care. Beyond socioeconomic differences, black versus white differences in sites of care, the quality of care received, the quality of interactions with providers, and expectations for their care may explain group reported access differences."

Article: "Length of Patient-Physician Relationship and Patients' Satisfaction and Preventive Service Use in the Rural South: A Cross-Sectional Telephone Survey"—in *BMJ Family Practice.*

- "Of 3,176 eligible respondents, 10.8 percent saw the same physician for the past 12 months, 11.8 percent for the previous 13–24 months, 20.7 percent for the past 25–60 months and 56.7 percent for more than 60 months."
- "Compared to persons with one year or less continuity with the same physician, respondents with over five years continuity more often were white, insured, a high school graduate, and more often reported good to excellent health and an income above $25,000."
- "Compared to those with more than five years of continuity, participants with either less than one year or one to two years of continuity with the same physician were more often not satisfied with their overall health care…."
- "No significant associations were found between physician continuity and use rates of any of the queried preventive services."

  Conclusion: "Over half of this rural population has seen the same physician for more than five years. Longer continuity of care was associated with greater patient satisfaction and confidence in one's physicians, but not with a greater likelihood of receiving recommended preventive services."

  Limitation: Because no follow-up survey was conducted, the evaluation team was unable to track any changes in residents' assessment of health care access, as was initially planned.

Nevertheless, the one-time survey provided beneficial information on access and the perception of access in the rural South, said Nancy Wieler Fishman, the RWJF evaluation officer who oversaw the evaluation grants.

Implementation of Planned Interventions

In a May 12, 2005, report (*SRAP Grantees' Success in Reaching Outcome Objectives in the First Two Years of Their Phase II Initiatives*), members of the evaluation team reported:

- The state grantee organizations and their collaborators met the majority of the outcome objectives set for their initiatives in the first two years of Phase II.
  - Of 294 outcome objectives set for that two-year period, the states achieved 190 (65%).
  - Among the 190 objectives achieved, nearly half (46%) exceeded the targeted level of accomplishment, and almost all (93%) were completed on time.
  - Among unmet objectives for which partial completion percentages could be estimated, most (54%) reached more than 60 percent of their targets.

  Conclusion: "Given the great number, breadth and ambitiousness of grantees' programs and objectives, we consider that a 65 percent completion rate, multiple instances of surpassing targets, and the significant progress made even among unmet objectives indicate substantial program productivity and real accomplishment."

APPENDIX 9

Glossary

21st Century Challenge Fund: A special grant fund administered by the *Southern Rural Access Program* national staff in the program's first half to support health care improvements in the program's eight-state area.

Area Health Education Center (AHEC): An organization in a national network initiated by Congress in the early 1970s to recruit, train and retain health professionals in medically underserved areas. Federally funded AHECs operate in most of the 50 states.

Community health worker (CHW): A lay person trained to help his or her peers access community health and supportive resources.

Health Professional Shortage Area (HPSA): An urban or rural area that is determined by the U.S. Department of Health and Human Services to have a shortage of health professionals. Areas with fewer than one primary care physician per 3,500 people can receive a HPSA designation; areas with more physicians but a high level of poverty also are eligible for the designation.

Locum tenens: Temporary professional relief for physicians to allow them to go on vacation, take a continuing education course or otherwise absent themselves from their practice for a limited period of time.

Master charge review: The review and updating of a hospital's coding and pricing data that determine the charges for thousands of patient care activities.

Medically Underserved Area (MUA): The federal designation for an urban or rural area that does not have enough health care resources to meet the needs of its population. It is similar to a Health Professional Shortage Area but more liberal in its definition of shortages.

Practice management: The term for the administrative and financial practices of a physician office, clinic or hospital.

Primary Care Service Area (PCSA): A ZIP code-based geographic unit for measuring primary care resources.

Project logic model: A diagram that specifies the activities, objectives and timelines of a project and, thereby, provides benchmarks for gauging success.

Rural health network: A formal collaborative arrangement through which rural health providers pool their resources in order to improve and/or increase services to the community.

Rural Leaders Pipeline Effort: The component of the *Southern Rural Access Program* aimed at attracting undergraduate college students to the health professions and helping them gain admittance to education and training programs.

Synergy: The concept of two or more organizations working together in such a way "that their combined effect is greater than the sum of their individual effects." (The definition used by the Cecil G. Sheps Center for Health Services Research.)

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www.shepscenter.unc.edu/research_programs/srapevaluation.html and *www.shepscenter.unc.edu/srapeval* (no longer available), sections of the University of North Carolina website on which the evaluation team members posted some reports and presentation materials on the evaluation of the *Southern Rural Access Program*.

Presentations and Testimony

Angela Fowler-Brown, Evan A. Ashkin, Giselle M. Corbie-Smith, Samruddhi Thaker and Donald E. Pathman, "Perceptions of Racial Barriers to Health Care in Southern Rural Populations," at the Society of General Internal Medicine Annual Meeting, May 12–15, 2004, Chicago.

Sharon K. Hull, Timothy P. Daaleman, Samruddhi Thaker and Donald E. Pathman, "Access to Health Care and Use of Faith-Based Healers in the Rural South," at the American Public Health Association Annual Meeting, November 6–10, 2004, Washington.

Samruddhi Thaker and Donald E. Pathman, "Use of Chiropractic Services in the Rural South," at the American Public Health Association Annual Meeting, November 6–10, 2004, Washington.