

# The Southern Rural Access Program

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## *Editors' Introduction*

The most consistent priority of the Robert Wood Johnson Foundation, dating back to its earliest days, has been to expand access to medical care for underserved individuals, a disproportionate number of whom live in rural areas. Although 20 percent of the U.S. population lives in rural areas, only 9 percent of America's physicians work there. Because the 60 million people living in rural areas tend to earn less than people living in or near cities, health problems associated with poverty, such as infant mortality and many chronic diseases, are often more serious in rural areas.

The federal government is the key player in attempting to improve health care services in rural areas. Its efforts include the Health Resources and Services Administration's rural health and community health centers; the Indian Health Service's programs, which are largely, but not only, rural; and the National Health Service Corps, which forgives loans made to physicians and other health professionals practicing in underserved areas. State governments, too, have developed programs to attract health care professionals to rural areas.

The Robert Wood Johnson Foundation has employed a number of approaches to improve health services for people living in rural areas. The Practice Sights program, for example, supported states' efforts to attract health care professionals to rural areas.<sup>1</sup> The Reach Out program encouraged physicians to volunteer their services to people living in underserved areas, many of which were rural.<sup>2</sup> A variety of efforts provided training of and encouragement to nurses, nurse practitioners, and physician assistants practicing in rural areas.<sup>3</sup> The Foundation has provided scholarships to medical students from rural areas (on the assumption that they were likely to return to practice there), promoted rural hospitals, and developed rural perinatal care networks and rural physician group practices.

In this chapter, the award-winning author and frequent *Anthology* contributor Digby Diehl looks at a program designed to improve access to medical care for people living in some of the nation's most underserved areas—the rural South of the United States. The *Southern Rural Access Program* addressed some of the most important barriers that keep physicians from locating in rural areas of Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, East Texas, and West Virginia. In this chapter, Diehl chronicles the ways in which the grantees went about attracting health care professionals to rural practice and the many challenges they faced, including the devastation wrought by Hurricanes Katrina and Rita. Even after the program ended in 2006, the infrastructure that it had established in Louisiana and Mississippi provided a foundation for some of the post-hurricane reconstruction efforts.

1. Wielawski IM. "Practice Sights: State Primary Care and Development Strategies." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. VI*. San Francisco: Jossey-Bass, 2003.
2. Wielawski IM. "Reach Out: Physicians' Initiative to Expand Care to Underserved Americans." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care 1997*. San Francisco: Jossey-Bass, 1997.
3. Keenan T. "Support of Nurse Practitioners and Physician Assistants." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care 1998–1999*. San Francisco: Jossey-Bass, 1998.

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All grantmaking entails a leap of faith, but launching the Southern Rural Access Program required more leaps—and more faith—than most. The project began with the faith to allow a Robert Wood Johnson Foundation program officer, Michael Beachler, to pursue his strong belief that the Foundation should undertake a rigorous effort to improve health care in the dramatically underserved areas of the rural United States. The Foundation board made another leap of faith when it deviated from long-standing policy and identified the specific eight medically needy states the program would fund without knowing which agencies would lead their states' efforts.

In a considerable departure from standard procedure, the Robert Wood Johnson Foundation convened workshops in each recipient state so that key stakeholders could confer and agree on a lead nonprofit agency for the Southern Rural Access Program. After that lead agency had been identified, the Foundation provided financial and technical assistance to help the lead agency write grant applications to the Foundation. Finally, after the grants had been awarded, the leaders in each state made decisions about investments and techniques of intervention for particular regions within broad strategic components monitored by the Access Program's national program office. The grants were of varying size and duration. Once the program was launched, each state progressed at its own pace and followed its own agenda. All recipients were faced with significant challenges, the most tragic of which were the double devastations of Hurricanes Katrina and Rita, which ripped through many of the participating Southern Rural Access Program states.

Because the Southern Rural Access Program has only recently concluded (in March 2006) at a total cost of \$36 million, including a revolving loan fund and 21st Century Challenge Fund grants, not enough time has passed to be able to gauge its long-term impact. It is not yet possible to determine how successful the Southern Rural Access Program will be in sustaining the grant-funded programs, though the early evidence is promising in most of the eight states. From the outset, some states were better organized than others, and therefore made more significant progress. Even those states that struggled initially, however, have implemented most aspects of the program's agenda. It is also too soon to know whether successful Southern Rural Access Program interventions and techniques will eventually be replicable in other rural areas. Nonetheless, even given this limited perspective, the Southern Rural Access Program has clearly produced some major beneficial effects. Steps have been taken to create and strengthen regional health infrastructure; revolving loan projects and philanthropic partnerships are continuing in most of the states; and the problems of rural health access have a higher profile with both federal and state agencies throughout the Southern Rural Access Program areas.

## How the Program Was Formulated

“I recall seeing Michael Beachler in the workout room of the Foundation,” says Steven Schroeder, former president of the Robert Wood Johnson Foundation. “He would be sweating copiously, pounding on those machines with a ferocity that was unmatched by anyone else. You could hear the machines groaning. That is the same level of energy and dedication that Beachler brought to developing a program for rural health care.” Beachler had been recruited to work for the Foundation in 1987 and immediately plunged into Healthy Futures: A Program to Improve Maternal and Infant Care in the South. In 1991, he turned his attentions to Practice Sights: State Primary Care Development Strategies, which attempted to bring a variety of primary medical services to underserved areas of the United States.<sup>1</sup>

“At the end of most Robert Wood Johnson programs, the program officers are asked to present ‘lessons learned’ at a staff meeting, and I talked about some of the positive aspects of the Practice Sights Program and some of the things that didn’t work quite as well,” Beachler recalls. “This sparked a discussion within the staff about how the Foundation had not been entirely successful in coping with the areas of poorest health care, primarily in rural areas. After consultation with Dr. Schroeder, I was tasked to design a program based on several of the Foundation’s rural investments, but one that would be more comprehensive in its approach to the problems of the underserved communities. I tried to incorporate ideas from my experiences with Healthy Futures and Practice Sights, as well as other Foundation work, such as the Hospital-Based Rural Health Care Program.”

Eventually, many of these previously tested interventions were combined with new ideas to make up the four primary components of the Southern Rural Access Program:

- *Recruitment and retention* of medical personnel in rural areas.
- *Revolving loan funds* to finance primary health care and other health care facilities in rural areas.
- *Rural health networks* to provide a multicounty or multiparish infrastructure for mutual support and economy of scale.
- The creation and support of *rural health leaders* who come from involved communities.

An additional component emerged from discussions with other philanthropies:

- *The 21st Century Challenge Fund*, a matching grants program much like the Local Initiative Funding Partners previously established at the Foundation.

Beachler’s initial proposal, created over the subsequent six months, embraced what he called the Rural Axis—a large geographic area comprising up to 16 states that included not just the South but the Dakotas, Wyoming, and Montana as well. An effort of this size was deemed unrealistic by other staff members, so Beachler and others began the process of narrowing the geographic scope of the program. Nancy Kaufman, then a Robert Wood Johnson Foundation vice president, recalls, “We created national maps with various overlays for poverty, infant mortality, access to health care, and other indices. The rural South consistently had the worst problems in the country, so we felt that we had to focus on that area.” More than 40 percent of all Americans in persistent poverty live in the South.<sup>2</sup>

One statistic generated by Foundation staff research was particularly persuasive in the decision to concentrate on the South. An internal review of Foundation investments between 1992 and 1996 compared spending in Minnesota with spending in five of the most underserved Southern states: Mississippi, Louisiana, South Carolina, Alabama, and West Virginia. According to an article in the *Journal of Rural Health*, “The ‘Needy Five’ have roughly three times as many residents, seven times as many uninsured and poor people, and 17 times as many residents living in shortage areas [as compared to] Minnesota.” However those five states combined received only 76 percent of the funding awards made by the Foundation to Minnesota in that same period.<sup>3</sup>

As contiguous states with similar health problems, Arkansas and Georgia were subsequently added to the Needy Five. Using the same reasoning, Kaufman argued forcefully for the inclusion of Texas in the program. “The reason I felt so strongly was that I could see border issues, immigration problems, and other new health problems arising in that state,” she recalls. “There was also very strong health leadership in Texas at that time. I felt that we could get ahead of the curve.” Although Schroeder objected that adding such a large state was too ambitious for a pilot program, a review of the statistics pointed the way to a middle ground. When Kaufman, Beachler, and other staff members looked at demographics and key health issues, they discovered that East Texas statistically resembled the rest of the South far more than it did the rest of Texas itself. As a result, just East Texas was added to the program as the last of the Southern Rural Access Program states.

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### The Beginnings of the Southern Rural Access Program

“One key moment was a meeting that the Foundation convened in February of 1997,” Beachler recalls. “It was held in New Orleans, just before Mardi Gras, and we brought representatives from 14 Southern and Great Plains states to discuss the general idea of the Southern Rural Access Program project. We batted around the concepts that were starting to jell within the Foundation, and asked for opinions. The Southern Rural Access Program was unanimously well received by the constituents from those states.”

In July of that year, the Foundation’s board authorized \$14.5 million for a broad range of initial grants, technical assistance, and planning to implement the Southern Rural Access Program in eight states over three years. Included was \$800,000 to establish a national program office at the Penn State College of Medicine in Hershey, Pennsylvania, with Beachler as director and Isaiah Lineberry as deputy director. Floyd Morris, who was then a program officer at the Foundation, worked closely with Beachler and Kaufman in conceptualizing the Southern Rural Access Program, and made the presentation of the project to the board. “When I presented the proposal to the board, I explained how we needed to be flexible and develop a program that would respond to the long-term needs of these rural underserved Southern states,” Morris says. “I also emphasized the fact that if we were going to make lasting changes to the rural health care infrastructure in the South, we needed to stick with it for a long time.”

The Robert Wood Johnson Foundation board was very supportive. “I think they were very much aware that this part of the country was underrepresented,” Schroeder recalls. “As a whole, they felt that the management strategies we had devised were reasonable, granted that there were risks.”

At the inception of the program, one question arose consistently: Why is a program for eight Southern states headquartered in Hershey, Pennsylvania? As Beachler points out, there are actually three answers to that question. First, when the location for the national office was selected, it was envisioned that the program would cover a large portion of the United States; under that assumption, Hershey seemed as reasonable as anywhere else. Second, Beachler had strong relationships with many colleagues at the Penn State College of Medicine who had experience in rural health care. Third, and perhaps most important, the Foundation initially planned to work with a large integrated rural health delivery system that was being formed in 1997 through the merger of the Geisinger Health System, the Penn State College of Medicine, and the Milton S. Hershey Medical Center (the merger was dissolved two years later).

The national program office officially opened on October 1, 1997, with two major tasks: to staff and start up the office and to inform the individual states about the program. Achieving the latter task involved a considerable divergence from standard Foundation policy. Traditionally, a single applicant workshop was held in a central location. For the Southern Rural Access Program, however, the board approved allocations to hold eight separate applicant workshops, one in each state. The intention was to permit each state to identify its own lead agency and to allow Foundation staff members to advise that agency on grant-writing procedures. Other state stakeholders, including local philanthropies, banks, hospitals, health care providers, economic development agencies, and local United States Department of Agriculture staff, were invited as a way of making the entire regional community aware of the Southern Rural Access Program. Beachler recalls that six of the states quickly identified a lead agency, often through the state Office of Rural Health. Alabama and Mississippi deliberated for two or three months before focusing on an agency.

In yet another departure from Foundation policy, each state was given \$15,000 to fund planning meetings for the preparation of grant proposals. In traditional grant-making procedure, grant applications are received within six to eight weeks after the workshop. The Southern Rural Access Program allowed much greater flexibility, so that the startup time for each grantee was longer. The first Southern Rural Access Program grant was awarded to the South Carolina Office of Rural Health in December of 1998.

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### **The Program in Three States**

#### **South Carolina**

“When the Southern Rural Access Program came along, I had been on staff in the South Carolina Office of Rural Health for a while, and I felt as though our state was already doing pretty well with some of the things the Foundation was suggesting,” recalls Graham Adams, executive director of the Office of Rural Health. “We were better organized than many states to take advantage of the program, and there is no doubt that the Southern Rural Access Program enhanced and strengthened the programs we had already begun. However, we were a little slow to see the big picture of networking and infrastructure that Beachler kept hammering at us. The greatest gift that the Southern Rural Access Program gave us was the ability to understand how to make all of the necessary elements work together to create a synergy.”

The South Carolina Office of Rural Health was established as an independent 501(c)(3) nonprofit organization in 1991, so it was almost immediately recognized as the natural lead agency in that state. At the time the Southern Rural Access Program was initiated, the Office of Rural Health was already overseeing several successful programs. Its Rural Health Revolving Loan Program was set up in 1997 with a \$900,000 Rural Business Enterprise grant from the United States Department of Agriculture. A program to provide vacation relief for rural doctors, which had emerged from the University of South Carolina in 1994, became a key element of the Southern Rural Access Program medical recruitment and retention efforts. The Southern Rural Access Program also facilitated the expansion of an existing South Carolina Rural Interdisciplinary Program of Training. A new Community Incentive for Diversity program was designed to encourage minority nurse practitioners, physician assistants, and certified nurse midwives to go into underserved rural areas.

The first grant was for a 15-month planning and pilot implementation period. The Robert Wood Johnson Foundation allocated \$458,000 to establish elements of the Southern Rural Access Program in a 17-county region in the eastern part of the state, which encompassed nearly 664,000 people. “To begin, there was a lot of complaining and criticism about the four core elements of the Southern Rural Access Program,” says Amy Brock Martin, who began as a coordinator and quickly became director of the Southern Rural Access Program in South Carolina. “The public health mantra is that the community should identify the problem and drive the solution. For that reason, many people resisted a foundation that pushed us to focus on these four elements. I think, in retrospect, I can safely say that they were wrong. I credit Michael Beachler, this courageous Yankee who came down here and helped us use our own creativity to meet this model, but insisted that we include these four principles. I don’t think we all understood how interconnected these principles were until we began to implement them. Frankly, it was really brilliant.”

Mitch Wilkins, the revolving loan specialist for the South Carolina Rural Health Access Program, recalls that the existing revolving loan program really took off with an infusion of both capital and prestige from the Robert Wood Johnson Foundation. “We marketed the program with a series of conferences throughout the state, and it just mushroomed through word of mouth,” he says. “Wachovia Corporation has become our largest partner, although we work also with community banks. Probably 75 percent of our loans go through commercial banks. This is a perfect project for banks to meet the requirements of the Community Reinvestment Act, and our work ranges from doing the underwriting and legwork for the loan right up to being a 50/50 partner in some of the medical startups. One of the most impressive facts about our program, from the viewpoint of the financial community, is that we have never had a single default since we began.” Since the inception of the program, the South Carolina revolving loan program has facilitated 111 loans totaling more than \$43 million.

“We use a lot of different resources to attract physicians into our rural communities,” notes Mark Griffin, the director of recruitment for the Office of Rural Health. “This is a small state with a good highway system, and we are pocketed with hospitals in both urban and rural areas—we have half a dozen large ones. The vast majority of the recruitment I do is through the hospitals, because they can guarantee doctors a salary until they are ready to step out into their own practices. Then Mitch

can help them with the financial issues and Marsha Marze, our rural health clinic coordinator, provides technical support for their practice management. Our state is also a great retirement area, so we have an impressive supply of older experienced doctors who are wonderful part-time primary care physicians or *locum tenens* substitutes.”

*Locum tenens* is a Latin term that describes a physician who temporarily takes over the practice of another doctor. South Carolina’s *locum tenens* program now covers the entire state, and is divided into three regions, each of which has a set of doctors ready to step in to provide relief to colleagues seeking a vacation, further medical education, or just a little time off from stressful work. Griffin’s office coordinated roughly 320 weeks of *locum* relief in the first year.

The *locum tenens* program is particularly important in areas where there may be only one family practitioner or obstetrician in the community. In the town of Bamberg (population 3,700), for example, the Michael Watson Rural Health Clinic serves a patient base that includes impoverished African Americans, a nearby Mennonite community, and a seasonally shifting group of Hispanic migrant farm workers. “The South Carolina Department of Health mandates that the obstetrician on call may never be more than 30 minutes away from his hospital to be available for emergency caesarean sections,” says Laura Hoffman, Watson Clinic office manager. This is a reasonable requirement, except that William Glenn, director of the Watson Clinic, is the only obstetrician in Bamberg County. Not surprisingly, after several years of being continuously on call, he began to feel burned out. “The poor man was tethered to Bamberg for years without a break,” Hoffman continues. “When he did take a vacation, we had to hire both an OB and a family practice physician to substitute for him, and the expense was impossible. Now, with the *locum tenens* program, he can have a life and our clinic has good quality substitutes at a reasonable cost.”

Just across the street from the Watson Clinic, near the Bamberg County Hospital complex, are the modest offices of the Low Country Health Care Network. Cathy Schwarting, executive director of the network, points out, “Before the Southern Rural Access Program, we never entertained the idea of networking, sharing ideas, health problems, and sometimes solutions. The four county hospitals in the four counties that I represent—Bamberg, Allendale, Barnwell, and Hampton—certainly did not cooperate before we started meeting with them. They saw each other as competitors. Now they share a radiology group that services all four hospitals. Through the revolving loan program, the network purchased a mobile MRI unit that travels to each hospital on different days of the week on a regular schedule. They are all linked by PACS, a computer accounting system that allows them to communicate about patients. We are now looking into converting all of our hospitals into one hospital information system that will make available medical records of all patients in the area. The Southern Rural Access Program allowed us to have the time and the manpower to brainstorm and discover common ground. The state offices are now setting up two other networks—one in the Fairfield area and one in Newbury. Health networking is a concept that is here to stay in South Carolina.”

Schwarting is a graduate of the South Carolina Rural Interdisciplinary Program of Training, or SCRIPT, which is a five-week rural immersion program for health profession college students. The program, directed by Diane Kennedy, provides an opportunity for students to actually work in rural

areas and experience rural life. “Many of the students have come from rural areas and are already inclined to return,” Kennedy says. “Others see the advantages of small town life, particularly when raising a family. And then there are always a few who can’t stand the quiet or the lack of movie theaters. That’s okay too, because there is no point in trying to recruit people who are already disinclined.” Initially funded by the Southern Rural Access Program, the SCRIPT program is continuing with grants from local, state, and federal resources. By the end of 2005, it had graduated a total of 609 students from six participating universities.

Similarly, the Community Incentive for Diversity project provides scholarship, leadership, and mentoring opportunities for South Carolina minority students in the 17 Southern Rural Access Program counties. “I never would have been able to complete the nurse practitioner program at the University of South Carolina without the Community Incentive for Diversity project,” Wilicia Gaymon says. “Now I am working in a community health center in Eastover, the town where I grew up. I am happy to be near my family and proud to be serving my community.”

Two practice management technical assistance programs fostered by the Southern Rural Access Program will also continue in South Carolina. The South Carolina Medical Association operates Project Stay Put, a service that helps private physicians stay financially viable, and the Office of Rural Health has a service that helps facilities that are designated as rural health clinics. Because areas of poverty and poor health care were targeted, 59 of the 105 rural health clinics in South Carolina are in the original 17-county Southern Rural Access Program focus area. “We support the existing rural health clinics with billing, coding, and handling the mazes of Medicare and Medicaid, which is how a majority of their patients can afford medical help,” says Marsha Marze, coordinator of the clinic program. “We also teach them how to meet the state Department of Health requirements and to be sure that they are compliant with HIPAA [the Health Insurance Portability and Accountability Act of 1996] and OSHA [the Occupational Safety & Health Administration] regulations. We also encourage new clinics. Right now I have 11 providers who are applying for rural health clinic status. Adding them will greatly enhance health care in our poorest areas.”

Of the four 21st Century Challenge Fund grants in South Carolina, perhaps the most innovative is the Health and Faith Communities Collaborative Project. Designed to educate people in rural communities about health issues, the program reached deep into the African-American communities through their churches. “The initiative took the information to the faith community—the most primary institution in the African-American community,” says Mary I. Mack, former director of the project. “Through our faith-based initiatives, we were able to reach most of the people in these communities.”

### **Arkansas**

The Robert Wood Johnson Foundation board approved the first Southern Rural Access Program for Arkansas on February 1, 1999. The lead agency, a newly formed organization called the Arkansas Center for Health Improvement, received a total of \$537,000. Dr. Kate Stewart heads the agency, and at her offices in the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Science, she looked out over a vista of downtown Little Rock and recalled the beginnings of the Arkansas Rural Access Program. “One of the things we struggled with up front was the Foundation’s

insistence on a prescribed program with four components,” she says. “There was already a lot going on in the health area in Arkansas, and we didn’t want to duplicate those efforts. As a result, our strategy was to build capacity and to strengthen existing programs, which ultimately has been great for our ability to sustain those programs as the Southern Rural Access Program winds down.”

One element already in place was a revolving loan program through the Southern Financial Partners, a nonprofit affiliate of Southern Bancorp, the largest rural development holding company in the United States. “Although we had been in operation since 1986 to help the poverty situation in Arkansas, we had never made any loans in the health care area,” says Paul Shuffield, community development officer for Southern Financial Partners. “We were the first revolving loan organization to be granted \$500,000 in seed capital by Robert Wood Johnson in October of 1999. We received another \$500,000 grant in 2002, and have had generous grants and loans from several other state, federal, and philanthropic sources—most notably the Walton Family Foundation.”

By the end of 2005, Southern Financial Partners had leveraged that seed capital into approximately \$16 million in health care loans. “We’ve done everything from cash flow loans for individual providers to financing the construction of hospitals,” Shuffield says. “Our first loan was \$25,000 to a nurse-midwife to help her get her clinic started. We’ve made equipment loans to general practitioners and clinics, and built or renovated hospital facilities. You should see the new \$4 million 25,000-square-foot health and wellness center that the loan fund financed to house the Delta Area Health Education Center in Helena.”

Helena, Arkansas is a sad portrait in poverty. “You are in the highest concentration of rural poverty in America right here,” says Mary Olson of the Tri County Rural Health Network Board. A raft of poverty surveys confirm that she is correct—the Arkansas Delta has the lowest income levels and the highest unemployment of all of the rural United States. Olson’s office is a storefront on one of the main streets in Helena, a dismal, trash-strewn, empty avenue. There are only two restaurants and a couple of dingy bars. Naomi Cottoms, director of the Southern Rural Access Program’s Community Connecting Program, corroborates Olson’s bleak overview of Helena: “Our unemployment rate is double that of the state as a whole. Our per-capita income is less than half the national average. Our population is two-thirds African American. But you don’t need statistics. Just look around. There are no jobs.”

The Community Connecting Program is a grassroots organization funded by the Southern Rural Access Program through the Tri County Rural Health Network. Cottoms and her five community connectors go door-to-door in the three counties—Lee, Monroe, and Phillips—to link up citizens with health care services. They serve a population of approximately 45,000, spread out over a wide geographic area.

“In this community, health care does not have a high priority, because people are so concerned about food, clothing, and shelter,” Cottoms points out. “Many of the people we contact have never had health services in their lives. We connect about 2,000 people each year to a doctor, a dentist, a clinic, or a hospital, most of them for the first time.” They also help sick and elderly people to find a way to navigate the tangle of government health bureaucracies that will pay for their care and treatment.

In the Helena Regional Medical Complex, situated away from the bleak downtown area, a more hopeful picture emerges. The Pillow Clinic is run by Dr. John Pillow—and his extended family. His brothers and their wives will eventually all be working here. “Helena is our hometown, and before we went to medical school we knew that we wanted to come back here to raise our families, so we all took advantage of the Community Match Program,” says Pillow, speaking in the tiny area that serves both as a lunchroom and a nurse’s office.

The Community Match Program pays 50 percent of a medical student’s tuition in return for a commitment to work in a designated rural community. “There are nine doctors in the area, so we’re able to rotate,” Pillow says. “Each of us takes the responsibility of a week on call for the regional hospital every ninth week. Here in the clinic, my brother Gil and I are very busy. We see 35 to 45 patients per day, and our nurse practitioner probably sees 20 to 30 patients. But I love it. I love the town and the people. As a physician, I also like the diversity of pathology that I deal with in a family practice—I see a much more challenging array of problems than I would ever see as a specialist. I’d just like to have a little more time with my family and...” he adds, looking around the crowded little lunchroom “...more space.”

Joyce Shepherd, who worked with the Southern Rural Access Program recruiting health care providers into the Delta for five years, understands how rare the dedication of someone such as John Pillow can be. “I was born in Wynne, here in the Delta, and after I went to Tulane to work on my master’s degree in public health, I swore I would never come back,” she says. “But here I am, and I would rather be here than any place else on earth. My recruiting experience is that the financial incentive programs work fine to bring physicians into rural communities, but they really have to be happy in order to stay. More often than not, this means someone who was born in a rural community.”

Larry Braden, a physician who came from Hawaii to work in the rural Arkansas community of Camden, agrees. Braden now mentors medical students interested in practicing in rural areas. “I tell my students about the satisfaction I get from primary care medicine in a rural community,” he says. “Some of them get it, and some of them are simply headed for brain surgery. More than anything, I think we have to persuade students to ignore the stigma that some medical school professors place on family practice.”

Perhaps the most impressive aspect of Arkansas’s Southern Rural Access Program experience is the creation of three health care networks—the Arkansas River Valley Rural Health Cooperative, the Delta Hills Community Access Program, and the Crittenden Community Health Council. This trio of agencies began forging links among health care providers so they could pool their resources in practice management, finances, and transportation.

M. Robert Redford, the executive director of the Arkansas River Valley Rural Health Cooperative, created a highly effective two-year demonstration program. His community-based managed health care plan cost less than half the Medicaid average, and provided health care services to a large number of low-income families. “We started in a three-county area with 51,000 people. Now we’re going into a new phase with 245,000 people,” Redford says. “What excites me is that this model works for the

doctors; it works for the hospitals; it works for the patients; and most of all, it works for the state of Arkansas. It is a win-win formula for patching the hole in Arkansas' health care safety net."

### **Louisiana**

Even before the hurricanes, Louisiana was plagued by institutional and political infighting. The beginning of Louisiana's Southern Rural Access Program was delayed by a power struggle between the Louisiana Department of Health and Hospitals and the Louisiana State University Health Sciences Center over which entity would be the designated Southern Rural Access Program lead agency. Dr. Mervin Trail, the dynamic chancellor of the LSU Health Sciences Center, finally won the turf tussle, but the battle made Louisiana the next-to-last state to receive an initial Southern Rural Access Program implementation grant. It also left a key partner, the Department of Health and Hospitals, with ruffled feathers. After Louisiana received a grant of \$513,678 on March 1, 1999, the project director, Marcia Broussard, brought the program up to speed. Together with Ruth Landis, her program coordinator, the two also began to heal the rift between the two agencies.

"The decision to focus the Southern Rural Access Program on the pilot area of southwest Louisiana was not mine, but it was a good one," Broussard recalls. "This is not only an area of tremendous health care need but also of cultural integrity. Historically, it is Cajun country, where the French Canadians settled. We needed a strategy to work on the development of health capacity in communities—and that cultural unity helped us." Broussard identified the closest element to network infrastructure that Louisiana had working for it: the Area Health Education Centers, which began in the 1970s as a national network of community agencies.

"The centers were originally designed to connect the residents in large urban medical schools with rural areas and to provide local health education," explains Jeanne Solis, the executive director of the Southwest Louisiana Area Health Education Center. "We're kind of matchmakers between the urban folks and the rural folks. We're very systems-oriented. There are five divisions in my center: the largest is wellness education; second is recruitment and medical staffing; the third is community health network development; fourth is career education for medical students; and fifth is clinical support services. As you can see, this is very similar to the four core elements of the Southern Rural Access Program, so we were a good match."

The Southwest Louisiana center was contracted to establish pilot programs in networking and recruitment and retention for the Southern Rural Access Program. The development director, Kristy Nichols, was the first employee hired. "We started by doing a survey in the parishes to identify local needs," Nichols recalls. "It was called Health Access Barriers in the South—HABITS—and truthfully it did not discover any problems of health access that were not well known to us anecdotally. It did, however, provide hard evidence of community needs in areas such as medication access, transportation, and financing the uninsured—we were able to quantify the problems. The survey also allowed us to point out that there were 82 people in one particular small town who said they needed another doctor in the community. This put a human face on the problem and gave us the voice of the constituents, so that legislators and others in power had to listen."

Nichols began in St. Mary Parish, one of the poorest areas of Southwest Louisiana, and worked with a fledging project called ByNet (the Bayou Teche Community Health Network) to meet the needs identified in the HABITS survey. ByNet implemented a patient assistance program to help individuals get prescription drugs at little or no cost. It solicited donations of medical equipment—hospital beds, canes, crutches, etc.—to be given to needy patients. ByNet also established a medical transportation network through local churches to help patients get to appointments with their physicians. According to the newly appointed ByNet executive director Craig Mathews, the organization is now in the process of establishing relationships with providers within its three-parish area—St. Mary, Iberia and Terrebonne—to access mental health services.

The second major component of the Louisiana Rural Health Access Program is its revolving loan fund program, headed by Brian Jakes, who is also the chief executive officer of Southeast Louisiana Area Health Education Center. “We were slow coming out of the chute,” Jakes recalls. “As a guy who has spent 28 years in the business of banking, it didn’t take me long to size up the problem: Louisiana is not a state with a lot of resources for capital formation. We started with two large banks with a strong regional presence and were not successful in working with the home offices. They were cut and dried, not real compassionate. We found it much easier to go into rural communities and establish a relationship with the local bank.”

Jakes, a sophisticated banker and stylishly elegant dresser, clearly has a bit of riverboat gambler in his soul. “I made a conscious decision *not* to ask the Robert Wood Johnson Foundation for the initial seed capital,” he says. “It was important to prove that Louisiana could get this started on its own.” Jakes approached Jim Parks, president and chief executive officer of the Louisiana Public Facilities Authority, which is described as a quasi-governmental public/private funding enterprise, and came away with a \$500,000 no-interest loan as seed capital. “At this point, Robert Wood Johnson said that it would match that sum if we could come up with another \$300,000,” Jakes recalls with a smile. “Well, we went back to Jim at Public Facilities. While we were waiting our turn, their board approved a \$60 million bond transaction in about 12 minutes. I said to myself, ‘\$300,000 is going to be a piece of cake!’”

Not exactly—an hour and a half’s worth of sweating and grilling later, Jakes came away with the rest of his seed money. He hasn’t looked back since. The project has secured additional seed capital from the United States Department of Agriculture (\$99,900) and anticipates a \$1.2 million award from the Department of the Treasury’s Community Development Financial Institutions Fund by early 2007. The Louisiana Rural Health Loan Program has already closed 35 loans worth more than \$52 million, and expects to have completed \$6 million more in loans by the end of 2006.

Almost all of these loans have been made in partnership with small local banks. “There is gratification in working with community bankers,” notes Richard Blouin, Jakes’ senior loan coordinator. “They know what having a health care provider in a small rural community really means.”

The Louisiana Rural Health Access Program was looking strong and sustainable until August 29, 2005. On that day, one of the largest and deadliest hurricanes ever to hit the United States swept in, leaving more than 1,800 people dead. Hurricane Katrina devastated large sections of the Gulf Coast,

including areas of Louisiana, Mississippi, Alabama, and 80 percent of the city of New Orleans. Damage is estimated at more than \$100 billion. Less than a month later, Hurricane Rita hit Mississippi, Louisiana, Texas, and Arkansas, and added to the misery and devastation that many of these areas had already suffered.

One of the inadequately reported stories of these hurricane tragedies is the great response of outlying areas, especially in southern Louisiana, that were overwhelmed by hundreds of thousands of evacuees from New Orleans and other coastal cities. “All across the state, evacuees were walking into hospitals and clinics with no medical records, no medications, and in need of help,” Marcia Broussard recalls. “Our rural coalitions were amazing in their response to health problems, in setting up shelters, in locating food, and many other things. We had a fledging pharmacy access program and some other elements, but what made everything work was network connections. Our offices in New Orleans were gone, but we were able to communicate with our networks of rural providers by cell phone.” Michael Beachler adds, “The ability of Louisiana’s Rural Health Access Program to respond to the Katrina tragedy was an important demonstration of its value.”

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### Highlights from Programs in Other States

In carrying out the required elements of the Southern Rural Access Program, the states adopted a variety of approaches. Some highlights:

#### Recruitment and Retention

Among the most creative programs to address problems of recruitment and retention is West Virginia’s Recruitable Community project, which reversed traditional recruitment techniques. Instead of seeking out physicians willing to practice in rural communities, this program, administered by the West Virginia University School of Medicine and the West Virginia Department of Health & Human Resources, works with rural communities to make their towns more appealing to health care professionals who might settle there. Initially, seven communities recruited a total of 27 providers by using this technique. A second, more traditional, program, Coordinated Placement, engaged placement counselors in all three of the state’s medical schools—the West Virginia University School of Medicine, the West Virginia School of Osteopathic Medicine, and the Marshall University’s Joan C. Edwards School of Medicine. By working together with traditional recruitment techniques, this program continues to place approximately 25 health professionals in rural areas every year.

Strengthening practice management formed a part of all states’ programs. For example, in East Texas, the Piney Woods Area Health Education Center coordinates the work of the Practice Management Technical Assistance program, which serves 42 clinics, physicians, and hospitals in the Southern Rural Access Program area, and provides clinics and workshops on billing and coding for family practice residents. At present, this assistance program serves 16 counties with almost 500,000 people.

### **Rural Health Networks**

Rural health networking figured prominently in the Texas program. The East Texas Health Access Network now serves a five-county area—Jasper, Newton, Sabine, San Augustine, and Tyler counties. It was awarded a federal three-year Health Resources and Services Administration grant for \$595,000. The Access Network has expanded its prescription assistance program to 315 medically indigent patients and provides over \$1 million in free medications per year.

The Philanthropic Collaborative for a Healthy Georgia funded nine multicultural health networks. A \$500,000 Robert Wood Johnson Foundation 21st Century Challenge Fund grant was matched with a \$500,000 grant from the Robert W. Woodruff Foundation. The Georgia Department of Community Health then added two grants totaling \$1.5 million. Working through the nine separate networks, the Southern Rural Access Program served thousands of impoverished residents in need of health care. The program provided individual case management, mobile screening units, free prescriptions, and programs targeting diabetes, obesity, and cancer. Six of the original nine networks continued at the conclusion of the Robert Wood Johnson funding.

Smile Alabama!, a dentistry program, was jump-started by a \$250,000 21st Century Challenge Fund grant. This sum was quadrupled by matching grants from nine other institutions, including the federal government (Medicaid), the Alabama Department of Public Health, and the Alabama Power Foundation. Smile Alabama! increased the number of dentists willing to accept Medicaid by 57 percent; increased the number of Medicaid-eligible children receiving dental treatment by nearly 9 percent; and decreased the number of Alabama counties with no Medicaid dental care from 19 to 10.

### **Rural Health Leadership**

The East Texas program excelled in the growth and development of new rural health professionals. Described by Michael Beachler as “one of our stronger leadership programs,” the Health Career Admission Planning Service, housed at the Piney Woods Area Health Education Center, is a three-tiered program for health care professional students from Texas colleges and universities. Beginning with larger programs and health career convocations, the program provides students who already have an interest in rural health with workshops, and eventually with one-on-one career mentoring.

In Alabama, the Southern Rural Access Program enhanced and connected two rural health leaders pipeline programs. In 1994, the Tuskegee Area Health Education Center had begun a program to make high school students aware of health issues in rural areas. The purpose was to prepare participants for college-level study in the health sciences and eventually for careers in rural health. Under the Southern Rural Access Program, this program was enlarged with specific emphasis on minority students and students from 18 counties in Alabama’s Black Belt.<sup>4</sup> Students received a \$1,200 stipend to attend the summer program. This program is now connected to the Rural Medical Scholars program, which originated in 1996 at the Department of Community and Rural Medicine at the University of Alabama Medical School in Tuscaloosa.

### Revolving Loan Funds

“Undoubtedly the most stunning achievement of the West Virginia Southern Rural Access Program is its revolving loan fund,” Michael Beachler notes. With an initial Robert Wood Johnson grant of \$500,000—later doubled—the West Virginia Rural Health Infrastructure Loan Fund raised a total of \$6.97 million in seed capital. This enabled the program to make thirty leveraged loans totaling \$15.3 million, funding a wide range of health care projects, including staff augmentation, the construction of new health care facilities, and substantially enhanced service to rural communities.

The Mississippi revolving loan fund is described by Beachler as “the sleeping giant of the Southern Rural Access Program loan funds.” Working with the Enterprise Corporation of the Delta, the original \$605,000 in Robert Wood Johnson seed capital was leveraged with \$3,645,000 to close seven loans totaling \$4.25 million by fall of 2005.

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### The Southern Regional Health Consortium

One of the most visible legacies of the Southern Rural Access Program is an interstate group called the Southern Regional Health Consortium, made up of representatives from the eight Southern Rural Access Program states that will continue to meet and exchange ideas. This 16-member board (two people from each state), chaired by Steven R. Shelton of East Texas, will continue to share information and discuss regional problems they have in common. “The consortium developed from discussions with Michael Beachler and Anne Weiss at the Foundation about what the legacy of the Southern Rural Access Program might be,” South Carolina’s Graham Adams recalls. “We seem to be learning a lot from one another, and we have explored different ways to employ the four components of the Southern Rural Access Program. As a result, we agreed to set up this virtual organization to continue networking.” The Robert Wood Johnson Foundation awarded a \$600,000 grant to support the concept. Curtis Holloman, former deputy director of the Southern Rural Access Program, has recently signed a contract to become the project director of the Health Consortium.

Dr. Kate Stewart, head of the Arkansas Center for Health Improvement, was instrumental in the formation of the consortium, which is still in its infancy. She reports that in its earliest meetings the board had agreed to focus on three areas of discussion and cooperation:

- *Obesity and lack of physical activity*—a particularly acute issue in the region.
- *Racial and ethnic health disparities*—an exploration of why people of different backgrounds have different health outcomes from the same treatment.
- *Loan funding for health care.*

Graham Adams adds a provocative note: “I think the Foundation is taking a leap of faith here, as it did with the initial funding of the Southern Rural Access Program. Some of the discussions we have had about the root causes of health problems in our states go way beyond health care. We are talking about racism, education, lifestyle, socioeconomic status, politics, and other elements that affect health. I believe that the work we have begun with the consortium has the potential to be some of the most important work I’ve done in my career.”

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**Final Grantee Meeting:  
Lessons Learned**

There is Michael Beachler, out there on the dance floor at the Hilton Lafayette in Lafayette, Louisiana, sweating and stomping in “Don’t Mess with Texas” socks and T-shirt, dancing every dance, Mardi Gras beads around his neck, swinging to the infectious washboard beat of Jamie Bergeron and the Kickin’ Cajuns. This charming Irishman with his insistent, energetic style has been the driving force of the Southern Rural Access Program from the beginning. He is surrounded by 200 people, most of whom have shared the seven-year journey of the Southern Rural Access Program and have gathered here in February 2006, for one last time to review what they have learned or accomplished—and to celebrate the finale, Louisiana-style.

A broad extrapolation of thoughts expressed by numerous speakers and panelists at the conference (amplified by notes from a “Lessons Learned” presentation by Beachler on March 9, 2006) suggests the following precepts, organized according to the components of the Southern Rural Access Program:

*Revolving Loan Funds*—These were vital and successful elements of the Southern Rural Access Program for most of the states, having generated 100 loans totaling approximately \$131 million, which is more than an 18:1 ratio to the Robert Wood Johnson investment of \$7 million in grants. The key to success was finding a blend of state, federal, and philanthropic resources to provide seed capital. Because of leveraging, all of the loan funds proved to be a more efficient use of public dollars than state grants to individual providers.

*Regional Health Networks*—Virtually all conference participants agreed on the value of this program element. Economies of scale made providers more efficient, and shared practice management techniques improved revenues. Connecting consumers to multiple available services was more effective than leaving them to find their ways through the medical mazes. Synergies were created between regions, and sometimes between states, through networking. Several participants emphasized the need to generate network revenue through fees or to develop state support.

*Recruitment and Retention*—Don Pathman of the University of North Carolina at Chapel Hill, director of the evaluation team, noted that the Southern Rural Access Program had achieved the goal of increasing the number of primary care physicians in the target regions. He did, however, raise a troubling question: Did this actually improve health services to the consumer? Beachler pointed out that 114 new providers had been recruited in Mississippi. He also praised the innovative *locum tenens* project in South Carolina. Several participants noted that practice management technical assistance was one of the most effective tools for health provider retention.

*Health Leaders*—This was generally agreed to be the least effective element of the Southern Rural Access Program. The limited scale of most programs and the lack of support from some schools hindered development. Beachler praised the Community Incentive for Diversity and the Interdisciplinary Program of Training in South Carolina as innovations, and noted the reduced federal spending for a wide variety of health professional programs, which suggests the need for finding other support.

As the evening was winding down in Lafayette, the Robert Wood Johnson Foundation senior program officer Anne Weiss looked out over the festive scene and mused out loud, “I’ve been to a number of these final grantee meetings. They mark the end of our official involvement in a national program, so even though there is usually a lot to celebrate, there are goodbyes to say too and a certain poignancy to the occasion. You might expect it to feel a little bit more like a funeral, but the food and the music and the laughter at this one are amazing.”

Overhearing her remark, Brian Jakes commented, “Didn’t you know that all our funerals end like this in Louisiana?”

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## Notes

1. Wielawski IM. “Practice Sights: State Primary Care Development Strategies.” In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. VI*. San Francisco: Jossey-Bass, 2003.
2. MacGregor A and Warren D. *Philanthropy in the Rural South: A State Description and Analysis of Assets and Grants*. Raleigh, N.C.: Southern Rural Development Initiative, p. 463, 2003.
3. Beachler M, Holloman C and Herman J. “Southern Rural Access Program: An Overview.” *The Journal of Rural Health (The National Rural Health Association Supplement)*, 19: 303, 2003.
4. According to the Institute for Rural Health Research, the term “Black Belt” has long had a double connotation. The crescent-shaped region known as the Black Belt stretches from across South Texas to Virginia. As noted by Arthur Raper in his 1936 study *Preface to Peasantry*, this region historically has been home to “the richest soil and the poorest people” in the United States.  
  
Booker T. Washington described being asked to define the term “Black Belt.” “So far as I can learn,” he wrote in his autobiography, *Up from Slavery*, Black Belt “was first used to designate a part of the country which was distinguished by the color of the soil. The part of the country possessing this thick, dark, and naturally rich soil was, of course, the part of the South where the slaves were most profitable, and consequently they were taken there in the largest numbers. Later and especially since the war, the term seems to be used wholly in a political sense—that is, to designate the counties where the black people outnumber the white.”  
  
Dr. Washington’s analysis still holds true today. Within the roughly two hundred Southern counties that make up the Black Belt, over half the population is African American. In Alabama, it extends from the Mississippi across the heart of the state. Despite rich cultural traditions, the area faces significant socioeconomic problems, including economic stagnation, declining population, low educational attainment, and insufficient health care.