

Nov-23-00 04:50A

P.01

ATTACHMENT "A" - 1

Post-it® Fax Note	7671	Date	11/4/99	Page	7
To	Lynn Sampson		From	Clyde Bargar	
Co/D Dept.			Cn.		
Phone #			Phone #	(334) 206-5396	
Fax #	(205) 933-5292		Fax #		

Introduction

The Southern Rural Access Program is designed to help improve access to basic health care in eight of the most rural, medically underserved states in the country. The Robert Wood Johnson Foundation has made available \$13.8 million over three years for the first phase of an effort to improve access to care in Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, East Texas, and West Virginia. The program will support work to increase the supply of primary care providers in underserved areas, strengthen the health care infrastructure, and build capacity at the state and community level to address health care problems.

The Foundation intends to make grants in each of the eight states and it will use a flexible grant-making approach to meet the individual needs in each state. This approach includes holding an application workshop/key stakeholders meeting in each of the states; providing financial resources to help applicants assemble applications; a rolling admissions period during which applications can be submitted; grants of varying size and duration; and providing intensive technical assistance.

Background

Providing rural Americans with access to health care services has been a challenge to policymakers, researchers, providers, and rural health advocates for decades. Despite a number of federal and state-level efforts, many rural areas continue to have fragmented health delivery systems, a shortage of health professionals, inadequate access to capital for health care infrastructure, and high proportions of working poor people without health insurance.

However, recent policy changes provide some opportunities to improve access to basic health care in rural areas. Significant among these are changes in federal Medicare policy that provide payment incentives to develop managed care options in rural areas, and that provide an opportunity for provider-sponsored organizations to participate in the Medicare+ Choice Program.

Also, it may now be easier for underserved rural areas to make progress on persistent primary care workforce shortages. Emerging market forces combined with medical education reforms have stimulated significant growth in the number of students who choose careers in primary care, such as generalist physicians, nurse practitioners, physician assistants, and certified nurse midwives. Additionally, support mechanisms are being developed to enhance the capacity of underserved rural areas to recruit and retain more primary care practitioners.

The Foundation has supported a number of efforts to improve access to care in rural regions of the country. Key lessons from these experiences indicate that: 1) the most severe rural health care access problems are disproportionately concentrated in certain

Nov-23-00 04:50A

P.02

ATTACHMENT "A" - 2

regions of the country -- particularly the South; 2) some states have had limited resources to plan or initiate efforts to markedly improve rural access; 3) regional clusters of states are more likely to learn from each other; and, 4) no single intervention, by itself, is likely to improve access to care significantly.

Based on these lessons, the Foundation believes that combining promising interventions and working over a sustained period with a regional group of states will provide the best opportunity to improve access to care.

Program

The Program is intended to build the institutional and leadership capacity necessary to improve access to basic care in underserved rural communities. Grants will support efforts in the eight target states to develop and start to implement long-term strategic plans to increase the supply of primary care providers in underserved areas; design service delivery and reimbursement systems to provide basic health services to residents in underserved areas; and, build capacity at the state and community level to address the health care conditions that disproportionately affect the residents of rural, underserved areas. It will also strive to integrate its efforts with those funded by other public and private grantmakers at the local, state, and national level.

A broad consortium of stakeholders (described in the **ELIGIBILITY** section) in each state must designate and support a single organization to lead activities under this program. About \$11 million (between \$800,000 and \$2.2 million per project) will be available for states to plan and begin to implement strategic components that:

- develop a cadre of health professions students committed to becoming leaders in primary care in rural underserved areas;
- recruit and retain primary care providers;
- develop rural health networks; and,
- use a Revolving Loan Fund in support of a strategic plan.

States' strategic plans would include the above and other important components necessary to achieving lasting improvements in access to basic health care for people living in rural underserved communities.

During the first three-year phase of the Program, planning and implementation grants of varying duration will be made (e.g., a site could receive a two-year planning grant, followed by a one-year implementation grant). **THE EXAMPLE OF PLANNING AND IMPLEMENTATION PERIODS PROVIDED HERE IS ONLY A GUIDE; A**

Nov-23-00 04:51A

P.03

ATTACHMENT "A" - 3

...GREAT DEAL OF FLEXIBILITY WILL BE GIVEN TO THE STATES, DEPENDING ON THEIR READINESS TO MOVE FORWARD TO IMPROVE ACCESS TO HEALTH CARE.

Given the complexity of problems each state will be addressing, it is expected that issues will emerge in each state which fall outside of their original strategic plan. Consequently, the National Program Office will make available about \$2.5 million in additional, more flexible funding to the sites beginning in the second or third year of the program, after receipt of planning grants. This additional funding, known as the 21st Century Challenge Fund, will be made to support pilot demonstrations of highly innovative methods or small analytic projects that address specific problems and serve to build capacity within each state. **A SEPARATE APPLICATION FORM FOR THIS COMPONENT OF THE PROGRAM WILL BE DEVELOPED AT A LATER DATE.**

Based upon the lessons learned from this first phase, the Foundation intends to support subsequent phases of the program.

Program Components

The program components listed below are critical elements for helping states achieve some of the objectives of their strategic rural health care access improvement plans.

1. **Rural Leaders Pipeline Effort:** This component will seek to establish a cadre of health professions students committed to becoming leaders in primary care in rural underserved areas. Specifically, this effort is intended to build or strengthen partnerships among rural communities, primary care health professional students from these communities, educational institutions, and state agencies. Support mechanisms for students may include mentoring, summer jobs, academic assistance, clinical rotations, loan forgiveness, long-distance learning support, leadership training, assistance in establishing a clinical practice, or other innovations created by the partners in each state.
2. **Recruitment and Retention of Primary Care Providers:** This component will work to develop an effective recruitment and retention strategy similar to that of the Foundation's Practice Sights Program, including the promotion of primary-care friendly policy changes. To enhance recruitment of practitioners, a site could develop an individualized recruitment process to match the needs of underserved communities with those of practitioners; foster community involvement and investment during the recruitment process; or, create new opportunities for organized practices such as hospital systems or rural health networks to participate in recruitment. To enhance retention of practitioners, sites could provide ongoing technical assistance to practitioners on practice, financial and facility management issues, and on developing regional *locum tenens* networks to ensure coverage for isolated health care providers. Sites could also promote primary care-friendly policy changes such as effective

Nov-23-00 04:51A

P.04

ATTACHMENT "A" - 4

targeting of reimbursement under Medicaid and other state funded insurance plans for practice in underserved areas or removal of policy barriers to allow nurse practitioners, physician assistants, and nurse midwives to provide services commensurate with their training.

3. **Building Rural Health Networks:** This program component will help states develop rural health network policies and foster planning and development of networks at the local level. Rural health networks are formal organizational arrangements among rural health providers (e.g., physicians, hospitals, community health agencies, local public health agencies, and possible consumers and social service providers) that use the resources of multiple organizations and specify how various collaborative functions will be achieved. Such networks can help rural providers improve their ability to enter into and administer risk contracts with payers, use population-based approaches to assess health care needs, involve local residents in decision-making processes, and seek to retain health care dollars in local communities.
4. **Revolving Loan Fund:** This component will enable sites to establish a Revolving Loan Fund to help rural communities improve their health infrastructure. Loans made from this fund must be consistent with the project's overall strategic plan. Examples of loans include those to enhance emergency medical services systems, to purchase management and clinical information systems for networks or provider-sponsored organizations; to develop regional transportation systems for health services, or as start-up capital for primary care practices. The loan fund will be highly leveraged, combining Foundation funds with other state, federal, and private capital vehicles to enhance the size of the loan pool. Projects will be given considerable flexibility concerning the size of the loans to individual providers. Foundation support for an individual state's loan fund will vary from \$700,000 to \$1,200,000. Foundation funds should leverage a minimum of an additional \$6 for every Foundation dollar committed to the Revolving Loan Fund.

GIVEN THE TECHNICAL NATURE OF THE REVOLVING LOAN FUND, A SEPARATE APPLICATION FORM HAS BEEN DEVELOPED (SEE APPENDIX K) FOR THOSE PROJECT SITES READY TO IMPLEMENT THIS PROGRAM COMPONENT.

5. **21st Century Challenge Fund:** This component will be made available during year two or three of the program. The application process for these resources will be developed at a later date. The purpose of this fund is to encourage creative risk-taking and solutions. The Fund will be used to support those highly innovative pilot demonstrations or small analytic projects that address specific health care problems and serve to build capacity within the state. Sites will be expected to seek co-funding from regional or local philanthropies and other sources. Examples could include an analysis of the impact of Medicaid managed care policies on rural providers, a demonstration that bolsters the consumer infrastructure for access improvement efforts, or a pilot of new methods of delivering health services to remote areas.

Nov-23-00 04:51A

P.05

ATTACHMENT "A" - 5

A SEPARATE APPLICATION FORM FOR THIS COMPONENT WILL BE DEVELOPED IN YEAR 2 OF THE PROGRAM.

Eligibility and Selection Criteria

Applications will only be accepted from the eight targeted states: Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, East Texas, and West Virginia. In Texas, the program will be a regional one, serving only East Texas. A consortium of key community and state-level stakeholders must designate and support a single lead private organization to apply under this program. Only one application per state may be submitted; the National Program Office will work closely with the key stakeholders in each state to help develop applications and ensure only one application is submitted.

The lead organization/applicant should provide evidence that it can provide support, guidance, and leadership to the state-wide consortium and ensure that the interests of underserved rural communities are adequately represented. In Texas, the lead organization should display evidence that it can play that role in East Texas. Our preliminary definition of East Texas includes Public Health Regions 4 and 5 in Texas. Examples of potential lead organizations include: state rural health, primary care, hospital, medical, or nursing associations; consumer-oriented health agencies; state agencies; local, state or regional philanthropies; university-based health policy centers or health professional schools; area health education centers; and health provider organizations representing underserved rural communities. Applicants should also provide evidence of their qualifications to efficiently and flexibly administer the grant, including the ability to hire staff and subcontract with other organizations involved in the program.

Although both public and private organizations are eligible to apply under this program, preference will be given to applicants that are tax exempt under Section 501(c)(3) of the Internal Revenue Code or are public agencies.

Funding will be available for applications that show evidence of:

- Potential to make lasting improvements in access to basic health care in rural underserved communities;
- A strong state-wide consortium (region-wide for East Texas) ready to plan and eventually implement a broad-based access-improvement plan. (The consortium should be culturally diverse and should include support from key representatives from underserved rural communities, the governor, key legislators, provider and consumer

Nov-23-00 04:52A

P.06

ATTACHMENT "A" - 6

groups, health professions education institutions, county commissioners, other public officials, and local and regional philanthropies);

- Evidence of strong partnerships with the most underserved rural communities in the states;
- ✓ • Financial and resource commitment of relevant collaborators in the consortium. (Applicants should be prepared to describe the amount of in-kind or direct financial support, and provide evidence of their institutional capacity.);
- Effective and innovative targeting of The Robert Wood Johnson Foundation support to fund those program components that will make the greatest difference in improving access; and
- • Strong linkages with other access-improvement efforts funded by local, state, federal, and philanthropic sources;

In addition, proposals will be evaluated on the basis of the following characteristics:

- Evidence of the potential and capacity to institutionalize the work of the project in order that Foundation resources can be used for other priority access-improvement efforts in the second phase of this program;
- Evidence that the project is technically and politically feasible; and
- Evidence of creativity and innovation in the proposed interventions.

Use of Grant Funds

Approximately \$11 million in direct grants from RWJF will be available to support the activities of the lead agency and its subcontractors, and to seed the Revolving Loan Funds in each state.

Grant funds may be used to support personnel, office operations, travel, and subcontracts to help implement various program components. Subcontractors may include health professional schools, providers from underserved rural communities, area health education centers, state agencies, state provider associations, and development agencies and corporations.

Given the technical nature of the Revolving Loan Fund, the applicant must demonstrate the necessary financial expertise to administer this program component. The consortium of stakeholders may wish to identify a separate administrator for this program strategy, one having familiarity with capital financing vehicles. Examples of such agencies

Nov-23-00 04:52A

P.07

ATTACHMENT "A" - 7

include economic development corporations; state or local health care, education or housing financing authorities; or, hospital associations.

In general, more complex and ambitious projects will justify larger grant awards. During this first three-year phase, we expect to award grants for planning and implementation of between \$800,000 and \$2.2 million, depending on readiness. Money from other sources, including consortium members, should be provided to complete individual budgets.

Sites may be asked to target their implementation grant funding requests for one or two program components rather than the whole range of program components. Such a request will be made after consultation with the individual state, the National Program Office, and the Foundation.

Program Direction and Technical Assistance

Michael P. Beachler, director of the Rural Health Policy Center of the PennState Geisinger Health System, will provide direction for the program and lead the team that provides technical assistance. Isiah C. Lineberry will serve as deputy director of the program. James M. Herman, M.D., associate dean of Primary Care for the Penn State College of Medicine, will serve as senior medical consultant and focus on rural leaders pipeline issues. William A. McBain, senior vice president, PennState Geisinger Health Plan, will serve as a consultant on rural health plan and provider network issues. James D. Bernstein, president of the North Carolina Foundation for Advanced Health Programs, will serve as a consultant on state financing and policy issues. Foundation staff responsible for the program are Floyd K. Morris, program officer; Nancy J. Kaufman, vice president; Dale Alloway, program assistant; Paul Tarini, communications officer; and Spencer Lester, financial analyst. All applications will be reviewed by a committee appointed by the Foundation.

Evaluation and Monitoring

An evaluation of the national program may be funded by the Foundation. Such an evaluation would be conducted by an independent research group and would focus on key questions regarding the program's impact. As a condition of accepting grant funds, all grantees will be required to participate in such an evaluation. Grantees also will be required to submit periodic information needed for overall program monitoring, including annual narrative and financial reports.