



WITNESS an online magazine

CROSSROADS

Rural Healthcare In America:
The Mississippi Delta

Photographs by
Richard Falco

Text by
James Castonguay, Ph.D.
Richard Falco

RURAL HEALTHCARE IN AMERICA

The Mississippi Delta

by Richard Falco

Healthcare is one of the paramount concerns of our times. Twenty-first century medicine, technology and knowledge have extended and substantially improved the quality of life. At its best, modern healthcare gives us hope and joy, rehabilitation and healing, where there was none before. However, there are critical issues that need to be addressed, including a fundamental question: Who has access to quality care and who doesn't? This issue stretches the length and width of the globe.

In the United States, the divide is not just between rich and poor or the insured and uninsured. It is also about where you live — in an urban or rural area. Can rural environments attract the doctors, nurses, and other staff they need? Can communities build adequate facilities in sparsely populated areas? Who lives in these communities and which combination of partnerships and choices can lead to success or failure?

A healthcare system must be viewed as a multilayered network that functions best when different elements are linked together. It should not be seen as a group of separate entities working independently of one another. The South has its own unique set of problems related to healthcare. For many years, the population of the Southern states has ranked among the least healthy in the country. Rural communities have always had a difficult time obtaining the necessary resources to build adequate healthcare systems.

In 1998, the Southern Rural Access Program (SRAP) was formed to fund initiatives that recruit health care providers and help build healthcare networks in rural areas. Programs initiated by SRAP have enabled places like Helena, Arkansas and the surrounding counties along the Mississippi River to develop a system that connects medical, educational, and social services programs. All are linked together in tandem with state, local, private and federal initiatives. The result is an approach to community care that can provide a model for other parts of country.



The history of the Delta is inseparable from the land. Agriculture has always been an important component of life along the Mississippi where cotton is still king. The economy is farm based and a large source of jobs and employment. In addition to cotton, beans and rice are the other main crops. However, the times are changing. Technology and better machinery are transforming the landscape and work can now be done with less people.



Though the land produces a great abundance, poverty is the other critical component of life here. In the Arkansas Delta area, 21.9 percent of the population lives below the poverty line. Some counties, including the neighboring counties in Mississippi and Louisiana, have rates as high as 38 percent. Poverty, unemployment and low education levels contribute to a disproportionately high number of individuals without health insurance.



Community Connectors



Community Connectors

by Richard Falco

A small plume of dust followed Rosalind Stone's car as it moved along the red gravel road. A blanket of white cotton spread across the fields as far as the eye could see. It was mid October in the Mississippi Delta and Rosalind knew the harvest would be soon.

When she came to a quiet intersection, she looked down the empty roads and turned her vehicle south. She was heading toward a group of small houses and mobile trailers she had passed many times before. She sipped her coffee as she drove.

Rosalind Stone is a vibrant and energetic African-American woman who works as a Community Connector in the northern counties of Arkansas that border the Mississippi River.

The concept of Community Connectors was established out of a need for better long-term healthcare in the Delta area. The program was developed by the Tri-County Rural Health Network. Working together with the University of Arkansas's Medical Center in Little Rock, the Arkansas Department of Human Services, Americares and other community based groups, the goal of the program is to identify individuals in need of long-term healthcare and refer them to services and providers.

The Community Connectors are recruited from the communities in which they serve. Because they have previously established ties with the local residents and understand the culture and environment, they can more easily develop the rapport and trust necessary to help them identify the needs of a given individual or family. The Connectors contact residents through a variety of settings, including community events, public forums, going door to door, canvassing people on the streets, and referrals followed up by telephone and in-person visits. Their knowledge of the local area has helped to create grassroots solutions to problems that have long been neglected.

The Connectors provide community members with valuable information about existing healthcare programs. They can help to determine an individual's eligibility for medical, social or financial services, and link people to the necessary healthcare providers or home care services. Depending on the need, these referrals can be directed to public, private or government agencies.

Rosalind logs 500-600 miles every week traveling throughout the vast area of her domain that is spread across three counties. She knocks on doors of homes she has never visited before, stops her car to speak with individuals at almost every junction, and seeks to help people that others might be reluctant or even afraid to approach. Her personal commitment to the community enables her to connect people to a network of care that would be non-existent to them without her.



Rosalind stops to speak with a group of men sitting in front of their mobile home. She continually reaches out to find people who have healthcare needs but are not accessing the system.

Cautious at first, the men are reluctant to disclose any information about themselves. This is typical of the culture in the Delta. It is also why having Connectors who understand that culture is so important. Once Rosalind has established a comfort level, the men opened up and she discovers that there are needs she can help to address.



Rosalind has an easy-going manner with everyone she meets. Her roots are deeply grounded in the community.



As Rosalind approaches a familiar home, she recognizes a short, white-haired woman and her husband in the front yard. She slowly turns her car into the driveway and rolls down the window.

“Mornin,” Rosalind says with the twang of a southern accent that echoes in the air.

“Rosalind,” the woman responds. They exchange pleasantries.

“How’s Terry?”

“Come on in and see for yourself,” the woman replies.



A smile stretches across Terry’s face as Rosalind enters the room. Rosalind has known Terry for decades. They went to school together.

Terry is forty-six years old and has spent most of his life in bed. Terry has suffered a number of terrible medical problems that have left him bedridden and continually connected to a breathing machine. Half of his skull has been removed due to a series of operations, yet his spirit is warm and friendly. He was taken care of mostly by his mother. Thanks to Rosalind, his family now has a home care nurse to assist them.

Terry is just one of the many people the Community Connectors have linked to services that have greatly improved the quality of their life.



Although Terry's situation is difficult, Rosalind's intervention has greatly improved the quality of care in the home.

Helena, Arkansas



Helena is the original home of the King Biscuit Blues Festival. Today, the only time the city vibrates with excitement is during the annual Blues Festival still held every October.



At one time, Helena was a thriving center of commerce. However, most of the manufacturing jobs are long gone and unemployment is high. The population in the area continues to decrease as people leave in search of jobs. Located on the Mississippi River, Helena is the medical hub for the surrounding counties in both Arkansas and Mississippi. It has a small local hospital, a group of dedicated family practitioners and a number of social service organizations that are vital to the community.

Unfortunately, the hospital has very few specialists. For any serious medical emergency, complex diagnosis or long term care and treatment, patients must travel to either Memphis or Little Rock. Depending on where they live, those trips can be one hour to three hours each way.

Dr. Thomas Bailey Family Practitioner





Born and raised in the area just outside Helena, Dr. Thomas Bailey was determined to return home when he graduated from medical school at the University of Arkansas. He has since settled in Helena and opened a family practice in 1999 with his sister, Helen Hull, who is a nurse.

Having grown up in poverty, Dr. Bailey feels a special connection with his patients. "I can identify with the problems of the community. I was one of these people," he says. "I don't want to lose sight of that."

The biggest problem rural communities face is attracting and maintaining qualified doctors, nurses and other healthcare workers. For many reasons, medical professionals choose to work in urban areas or where they can earn a higher salary. The saying goes, "If you aren't born here you don't stay." For this reason, many states are developing programs that encourage and help students (through financial support and incentives) to complete their education and return to the community.





Helen Hull, Dr. Bailey's nurse and sister, attends to a patient in his office. There is a close family tie between brother and sister.



Many of Dr. Bailey's patients would not have access to quality care had he not returned home. A large number of rural patients are on Medicare or Medicaid. Fifteen to twenty percent of Dr. Bailey's patients do not have any health insurance. "I feel obligated to help these people, otherwise they would get lost in the shuffle," says Dr. Bailey. Those without insurance are referred to as "self-pays," which often results in a doctor having to choose between giving free care or turning a patient away.



The Rural South: Getting To A Healthcare Provider



Like many other residents in the rural South, for Charles Rowe, getting to the doctor is sometimes as difficult as finding a one. As a Vietnam veteran, his health care is covered by the Veterans Administration, but Charles has no family doctor in the Helena area. Consequently, he must travel to the VA Hospital in Memphis to receive care. Suffering from a number of ailments, Charles has already lost his legs because of diabetes and his kidneys are now failing him for the same reasons. Charles must undergo dialysis treatment three times a week, but he lives far out in the country with limited transportation.



To serve his needs and those of many others, the residents of Phillips, Monroe, Lee and Prairie counties rely on the Mid Delta Community Services for help. This service provides transportation to people in need for free or at an extremely affordable rate depending on family income. Mid-Delta makes approximately 450 trips to medical care facilities a week.



Charles is picked up at about 9:00 am. The bus will pick up four to six other people and bring them to the dialysis center in Helena. They arrive at approximately 12:15 pm. A three hour ride. Three hours in dialysis. Three hours back home. Three days a week.



The ride across the Delta is long. The land is flat and fertile. After the crops are harvested the fields are empty and desolate.





For Charles, the day is tedious. The arrival at the dialysis center only begins another period of waiting and filling up the time. He will often seek solace by reading the Bible and reflecting about his life. He will tell you he is an optimist and feels lucky to have a wife he loves dearly.



Prescription Drugs

Accessible & Affordable

One of the most effective ways to lower long term healthcare costs is to provide accessible and affordable prescription drug programs. Should it be acceptable in a civilized society that some people cannot get access to medications that can save lives or improve the quality of life?

Too many prescription programs do not cover all of a patient's needs. Others are so complex that they discourage enrollment or confuse a patient about which program they should choose. Some programs, such as Medicare, put monetary limits on drug coverage, which often leads to the patient falling into what medical providers call "the donut hole." This refers to the coverage gap in which patients are required to pay thousands of dollars out of their own pocket in order to continue receiving their medications. The results are predictably bad. A patient must now choose between food or medicine. Some patients will take smaller doses to stretch out their supply. Others will simply go without until their benefits are renewed. For any of these scenarios the consequences are the same. A patient who could have remained stable and healthy ends up in poor condition or back in the hospital. All of a doctor's work to stabilize the patient must begin again with greater complications and at a far greater cost to the healthcare system.

Prescription Drugs

by James Catonguay, Ph.D.

As drug prices and insurance premiums continue to escalate each year, the prescription drug crisis continues to worsen. Reports and studies from the Robert Wood Johnson Foundation document a trend since 2000 of increases in the uninsured. By 2008, more than 8 out of 10 uninsured people were from working families with 6 out of 10 having at least one person working full-time for the entire year. For those who have insurance prescription coverage, the premiums and cost sharing obligations often limit or prohibit patients from obtaining the care and treatment they need. According to a 2008 Kaiser Family Report on prescription drug trends, 45 percent of people without prescription drug coverage do not fill the prescriptions they need.

Since 2006, Medicare beneficiaries can enroll in a Private Drug Plan (PDP) under Medicare Part D, a subsidized program created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Health care professionals use the term “donut hole” to refer to the temporary limit or “coverage gap” periods under current Medicare prescription drug plans. In 2008, after the \$275 deductible, patients paid 25 percent of the drug costs until reaching an initial coverage limit of \$2,510. From that point there is a \$3,216 donut hole or coverage gap until reaching the “catastrophic coverage” threshold of \$5,726 when 95 percent of the medication is covered. In 2009, the total out-of-pocket expenses will total \$4,350 before almost all of the drug costs are covered. According to Kaiser, roughly 25 percent of those with prescription plans under Medicare hit the donut hole each year and less than 5 percent cross the gap to the catastrophic coverage. Many on fixed incomes try to improvise their way through the coverage gap by taking partial doses, finding cheaper alternative medication, or skipping doses altogether. This means that a significant percentage of older Americans go without their medications.

According to Cal Woodridge, the prescription assistance coordinator at the Delta Area Health Education Center (AHEC) in Helena, Arkansas, there are many programs sponsored by the major pharmaceutical companies that help qualified patients get their medications. “The Prescription Assistance Program is for some the difference between life and death,” Woodridge says. “It means the difference between managing a disease and living life somewhat normally, and the unnecessary hospital stays that are expensive to the community as a whole.”

As Woodridge also points out, however, Medicare Plan D can be confusing to navigate, which often leads to seniors being enrolled in “plans that don’t do them any good.” And although many of the pharmaceutical companies have programs for getting patients through the “donut hole,” the paperwork to enroll in these programs can be very difficult to complete, especially if someone lacks the necessary literacy skills. As with many other aspects of the healthcare system, a lack of awareness of safety net options that can provide a bridge across the coverage gap, especially among the poorest populations, combined with a lack of an adequate support network -- either from extended family or the community healthcare system -- contribute to the prescription drug crisis.

In addition, according to Woodridge, “some people cannot afford to go to a doctor that can write the prescriptions for them,” and most communities do not have someone like Woodridge to assist patients. “We’re the richest country in the world and our people are suffering from things that they shouldn’t be suffering from,” Woodridge says. “Hopefully there’s going to be more people doing what I do and more funding for people who do what I do in order to help those people.”

Patients try to make drugs more affordable by purchasing generic brand medications and, although it is illegal, Kaiser estimates that over \$700 million dollars of prescription drugs are purchased from Canada, mostly online. In the absence of someone like Woodridge, the Internet is another good source of information about safety net programs. Many who would benefit from these programs do not have easy access to the Internet or may not have the literacy or computer skills necessary to find the information and complete the application process. Before AHEC and Helena Health Foundation assisted these patients, they were “forced to make choices that a person shouldn’t have to make,” Woodridge notes, by “cutting into their food budget, [or] going off their medication, [or] taking partial doses.” “When you have people making choices that could endanger their health and their life, and put them in a critical state [in which] they wind up going to the emergency room . . . and staying in the hospital.” Ultimately for Woodridge, “Preventative medicine is the key to making this nation stronger again,” and drugs are central to preventing and treating illness. “You have a majority of your population that is literally just scraping by. In the city, there’s more opportunities [and] clinics . . . Down here [rural areas] it’s not like that.”

Woodridge sees his role as one part of a broader AHEC strategy to increase the health literacy of Delta residents through outreach and education. “It goes without saying that it’s much cheaper all the way around for every last one of us . . . to promote some type of health plan that keeps people from having to get to that point.” Woodridge sees his program and partnerships as proof that the system can be improved despite the challenging realities as long as you “make [health] a priority and you get the resources that you do have and try to pool them together.” “The doctors, the nurses, the [AHEC workers], the politicians, are all trying to do something [together],” he says. “We’ve taken the resources that we have and tried to use them in order to better the health of this community.”

As we see throughout the region, the Delta at once epitomizes the healthcare challenges in the United States, while also serving as a model for the rest of the country to begin to address those challenges. While the many dedicated individuals have been able to make substantive improvements with the modest resources available to them, including funds from the tobacco settlement, they all wish they could increase the scale of what they do to serve more members of their communities.

Delta - AHEC



Education and prevention are the best methods for improving healthcare in the long term. Using millions of dollars from the Tobacco Settlement, an Area Health and Education Centers (AHEC) was set up in Helena in affiliation with the Helena Health Foundation. AHECs have been set up throughout the nation to address these issues, including eight in Arkansas. These Centers have become crucial components within the medical networks that serve to define the quality of a community's healthcare. To make substantive improvement to any healthcare system, doctors consistently emphasize the importance of education and prevention initiatives.

The AHEC has a Wellness Center that offers exercise and fitness programs. There are free education programs and public clinics covering a broad range of health issues. The Center seeks to address problems directly affecting the community, including diabetes, heart disease, smoking, drug and alcohol abuse, diet and nutrition. The staff includes doctors, educators, nurses, dietitians, fitness instructors, patient advocates and administrators. The center maintains a close relationship with the area's medical providers in order to reinforce the importance of network care to adapt to evolving concerns.

One of the Center's most beneficial programs is the Prescription Assistance Program. This program employs a patient advocate to help individuals and families select the best prescription plan available to them. In addition to the Prescription Assistance Program, the Center created an Emergency Medicine Program for the uninsured and those with inadequate drug coverage. The Delta-AHEC spends approximately \$60,000 a year helping individuals pay for prescription drugs.



A program for diabetics.

Exercising at the Wellness Center.



Nutrition and diet are often discussed at the center.



The Pillows





Jim, Gil and Ned Pillow all grew up in Helena. After the older brothers, Jim and Gil, entered medical school, Ned decided to follow suit. All three Pillows are graduates of the University of Arkansas' Community Match Student Loan and Scholarship program, which, along with the Community Match Rural Physician Recruitment Program, provides an added incentive for doctors like the four Pillows to set up their practices in rural areas around the state. By agreeing to practice for at least four years in underserved and impoverished regions, doctors receive assistance with their tuition or medical school loans. The University of Arkansas programs emphasize that serving rural communities epitomizes the values that underpin the medical vocation. Not surprisingly, this has been most successful with medical students like the Pillow brothers with roots in rural communities.

When the Pillows decided to set up a clinic in their hometown along with Ned's wife, Jill, a pediatrician, they doubled the number of doctors serving the community. The family has become the area's next generation of healthcare. Their position as primary care physicians, enables them to understand the importance of working together with all the other components established to benefit the area's healthcare network. It is the integration of all these components that will determine if the system succeeds or fails.



Because the Pillows have roots in the community the clinic is deeply committed to making a difference. They, along with Dr. Bailey, have given the community a level of care that did not exist before.





As a clinic, the Pillows consider themselves a team. Working together enables them to discuss and treat the more difficult and complex medical issues that often confront them. This is critical because one of the biggest problems facing medical personnel in rural environments is the lack of access to other doctors and specialists, as well as the latest information about medical developments or the collective brainstorming that exists in larger medical institutions. Too often, they work alone.



The clinic will see ninety to one-hundred patients a day.





Even though the Pillows provide excellent primary care, almost all of the serious cases must be referred to Memphis or Little Rock in order to receive the more advanced or specialized care that the clinic can not offer. That journey can range from an hour and a half to three hours each way, depending on where the patient lives.

The Pillows also serve as residents at a small local hospital. The hospital is small and has few specialists. For almost all specialized surgery, acute trauma or any other complicated procedures, patients must go to Memphis or Little Rock.



The Uninsured



Artric Jackson is 62 years old. He has coronary heart disease. Although he worked many years with the Army Corps of Engineers, when he could no longer work he did not qualify for health insurance. The Pillow Clinic periodically gives him free examinations and medicine in order to help him get by.

A Snapshot of the Uninsured

by James Catonguay, Ph.D.

Over 46 million people or roughly one in six Americans have no health insurance, including over 9 million children. The uninsured are more likely to go without or delay necessary and routine care, which often leads to greater healthcare needs for the uninsured population. Roughly 20,000 Americans die each year as a result of being uninsured (one person every 24 minutes according to the Robert Wood Johnson Foundation) and are 37 percent more likely to die from traumatic injuries than the insured. Research also shows that the uninsured are less likely to be admitted to a hospital than the insured.

According to a 2008 Alliance for Health Reform report, “The uninsured don’t fit any stereotype. They come from every community, every walk of life, every race and ethnic group, and every income level.” The working population ineligible for public or private group insurance must seek individual coverage at a higher cost and with fewer benefits than group plans, and people with a pre-existing medical condition or considered a high insurance risk are often denied coverage altogether. In addition, many uninsured individuals and families are already struggling to pay for food, rent, heat and other living expenses, perhaps relying on high interest credit cards and loans to pay for medical bills. A 2005 Harvard study found that unexpected medical expenses were responsible for over half of all bankruptcies for both uninsured and insured Americans.

The South

More than 40 percent of the U.S. population living below the poverty line resides in the South, which also has the lowest education attainment levels in the country. According to the Robert Wood Johnson Foundation’s *Cover the Uninsured Project*, Southern states consistently have a higher percentage of uninsured than other regions, are less likely to be offered insurance by their employer, and have the most difficulty getting medical care when needed.

In addition to having a significant percentage of the uninsured living in the South, according to the Commonwealth Fund’s 2007 state scorecards for health system performance, Arkansas ranked 48th ahead of Texas (49th), and Mississippi and Oklahoma (tied for 50th). Other Southern states are also concentrated in the lowest rankings, with Alabama, Georgia, Florida, West Virginia, Kentucky, and Louisiana all in the bottom ten.

Despite this challenging context of high poverty and unemployment, low levels of education, and low scores for the overall quality of health and care in the South, we can still find examples where the system is not only improving but can even serve as a model for health care reform across the country.

The Arkansas Delta Region

Although the uninsured come from a wide range demographic groups in the U.S., ethnic minorities and the poor are less likely to be insured or to access healthcare services than other segments of the population. Arkansas is the third poorest state in the country (after Mississippi and West Virginia) with a median household income of \$36,599. Within this context, the Delta region is the most economically distressed area in the country, poorer than rest of the rural South with higher unemployment rates than Appalachia. In the Arkansas Delta’s Phillips County, where Helena is located, the median household income is below \$20,000 with 33 percent of the population below the poverty line, including 45 percent of children. According to the Delta Regional Authority, compared with the rest of the country, Delta residents have a 55 percent higher poverty rate, 25 percent higher disability rate and a 20 percent higher high school drop out rate. Deaths in the Delta from circulatory diseases and cancer are 21.2 and 12.7 percent higher, respectively, while the death rate from accidents is 42.7 higher and the infant mortality is 30 percent above the national average.

Children in families earning below 200 percent of the federal poverty level (FPL) qualify for the ARKids First Medicaid program, but low income working-age adults do not qualify for Medicaid unless they are also disabled and have limited financial assets. As a result, almost half of Arkansans between 19 and 64 years of age with family incomes less than 100 percent of the FPL are uninsured. When residents do seek care, they often need to travel great distances to reach a provider. According to a study by the Arkansas House and Senate Interim Committee on Public Health, Welfare, and Labor, there is roughly one doctor for every 3,000 Arkansans compared with the national average of one per 390. This regional doctor-patient ratio is closer to those found in countries categorized as underdeveloped by the United Nations, including Haiti (1 in 4,000), Namibia (1 in 3,300), Yemen (1 in 3,000), Thailand (1 in 2,700), Nicaragua (1 in 2,700), Botswana (1 in 2,500), Iran (1 in 2,200), Vietnam (1 in 1,900), and Guatemala (1 in 1,100).

In addition to these economic and logistical barriers, Arkansas and the Delta region suffer from a general lack of what policy makers call “health literacy,” defined by the U.S. Department of Health as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” The lack of access to transportation and information technology that contributes to the health literacy problem in the region is exacerbated by a functional illiteracy rate of 56 percent statewide and the fact that close to 90 percent of the population in places like Phillips County read at or below literacy level two. According to federal literacy standards, this means that only 10 percent of adults have acquired the reading and problem-solving skills judged to be necessary for an adult to function in U.S. society.

Another problem lies in the fact that just having insurance does not necessarily guarantee quality care. “It’s one thing to have insurance,” notes one of the Pillow Clinic doctors. “It’s another to meet your deductible.” Insurance plans that require annual co-payments and cost sharing between \$2,000 and \$5,000 amount to a significant percentage of household incomes, forcing people to choose between medical care and other needs. It is also often the case that the underinsured do not qualify for many of “safety net” programs that prioritize the uninsured.

These grim statistics mean that the Delta region is the front line in the battle to provide healthcare to all Americans. If we are serious about addressing the problem of healthcare in the United States, we need look to the places where the greatest challenges exist. Although Arkansas is on the forefront of addressing the crisis in rural health care through inventive solutions, significant problems remain and the stability and reliability of the network is often tenuous.

Lavora Mills and her daughter, Candace, have no health insurance. Candace has Hodgkin’s disease. They are one of the many families that struggle to make things work under difficult conditions.



Home Healthcare





Home care is another important component of a healthcare network. It enables patients to stay in their home where they are most comfortable and can be supported by their family. It also enables a patient to receive monitored and continuous care that is far less expensive than a hospital stay. Melody Rogers is a registered nurse serving patients at their homes throughout the Tri-County Delta area. She works for the Arkansas Department of Health's Home Health Program. It is designed to allow patients recovering from serious illness or living with chronic diseases to receive skilled nursing and therapy. Melody sees three to six patients a day.



HOME HOSPICE CARE



The hospice care program is for patients and their families who are terminally ill and wish to remain at home. Hospice patients can receive nursing, social services, medication, and grief support. The goal is to allow patients to die with dignity in the comfort of their own home.

THE JAMARRION SANDERS FAMILY

Three Generations & An Inadequate Healthcare System





Jamarrion Sanders is three years old. Although he is just starting out in this world he already has a number of medical issues. After a very difficult birth, Jamarrion has a serious problem with his immune system, a loss of hearing that is hindering his development and a number of other undetermined ailments that the doctors are still trying to assess.

His father, Anton, has just lost his job and although his mother, Sarah, works, her salary does not allow the family to afford health insurance. Because he is a child, Jamarrion was able to get coverage through the ARKids

health insurance program set up by the State with Federal support. His parents have no coverage at all.

Jamarrion is a patient at the Pillow Clinic. He and his family have developed a special bond with Gil Pillow, the child's primary care physician.

Jamarrion must now undergo some elaborate and specialized testing that can not be done in Helena where he lives. The family must travel two hours to a facility in Little Rock to receive a proper diagnosis..

This is one of the greatest obstacles faced by residents in rural America. There are not enough specialized health care workers and facilities to serve the population.





Jamarrion loves spending time with his grandmother, Yvonne. The two spend a good deal of time together. Recently, Yvonne was diagnosed with breast cancer. Because she had no health insurance, Yvonne was able to qualify for Medicaid. She had to travel to Little Rock for her surgery -- a two and a half hour ride each way for the family.



The extended family has a number of other health issues. Jamarrion's Grandfather, Cliff, has kidney failure and a severe disc problem in his back. He too must travel outside the community for care.

After Yvonne's surgery, the family discovered that there were no chemotherapy centers in Arkansas where they live. Every week she must travel to Mississippi for her chemo treatment. The traveling only serves to compound the emotional impact on the family.





Utilizing the transportation services provided by Mid-Delta Transit, Yvonne travels to Clarksdale, Mississippi for her weekly chemo treatments.



Healthcare is a critical issue in America, yet for many Americans it is out of reach or difficult to get quality care. However, it is an issue that is not going away and like any sick patient the longer we wait the worse the condition will become. The World Health Organization has ranked the United States thirty-seventh in healthcare. As a nation, we are at a crossroads.

A national debate will determine whether we have the resources and ability to make healthcare both affordable and accessible to all. As that debate unfolds, it is incumbent upon us to see healthcare as a multilayered network that functions best as a linked system and not a group of separate entities working independent of one another. Most important, we must remember that healthcare is about people and the quality of life. It is not pieces of paper that are moved from one side of a desk to the other. There are already people and networks in place that provide models for reform. Do we have the political will to get the job done without the polarization that often accompanies these debates?

Richard Falco

For the past thirty-five years, Richard Falco has worked as a photographer, documentary filmmaker, journalist, and educator. He has traveled extensively throughout the world, working on assignments in Asia, Africa, Europe, and the United States. His photographs have appeared in major publications. Clients include *Time Magazine*, *Newsweek*, *Business Week*, *New York Times*, *Life*, *National Geographic Society*, *People*, *Geo*, *New York Magazine*, *Stern*, and *U.S. News & World Report*, to name a few. There are six published books of his work: *To Bear Witness/September 11*, *Medics: A Documentation of Paramedics in the Harlem Community*; *Hunger and Rice in Asia*; *Witchcraft: Ancient Traditions Alive in Salem*; *Water, Wild & Light: The Dingle Peninsula, and Autumn Madrigals*. He has exhibited in the United States and abroad. Exhibitions include International Center of Photography, NY; Corcoran Gallery, Washington, DC; Nikon Galleries, Tokyo; New York Historical Society, NY and others. He is a winner of the *International Media Award*, a 15-time award winner for *Excellence in Journalism* from the Society of Professional Journalists, and an *Award for Excellence* from the Society of Publication Designers.

James Castonguay, Ph.D.

James Castonguay, Ph.D., is the Associate Dean, and Director of undergrad and graduate programs within the School of Communication, Media & the Arts at Sacred Heart University. Castonguay has been widely published in several academic journals, books and other publications, including, but not limited to, *American Quarterly*, *Cinema Journal*, *Discourse*, *The Hitchcock Annual*, *Rethinking Global Security*, *Hollywood and War*, the *Encyclopedia of Television* and the *Schirmer Encyclopedia of Film*. He has also written for the human rights magazine, *Witness*, and has collaborated on multimedia documentaries and exhibitions that focus on issues of social justice. He has received many accolades throughout his time at SHU including the "Final Four" Teaching Award and the Faculty Excellence Award. He has served as an administrative officer to the American Council of Learned Societies and received the service award from the Society for Cinema and Media Studies.

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The goal of Vision Project is to produce documentary material and educational programs that encourage understanding and awareness about a broad variety of social issues. This information and programming are made available to the general public with a particular focus on members of the younger generation.

Vision Project seeks to reinforce the social, cultural, and historical impact documentary work contributes to society. To reach these goals, we have assembled a group of talented professionals with extensive expertise in journalism, photography, video, design, web technology, and education.

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Vision Project Inc.

www.visionproject.org

info@visionproject.org

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