

# Grassroots Advocacy For the Rural Poor

---

By NANCY ANNESS, RN, MSN, APN, BC

**W**hen I was 6 years old in small-town Kentucky, I was standing in line at the local thrift store, buying a doll. In front of me was a child who asked her mother for something — I don't remember what — but her mother apologetically told her there was no money for it. I remember wanting desperately to give the child my doll.

Turns out, it was a calling, not a child's whim. As time moved forward and I grew older, I realized how deeply I wanted to help, serve and heal those less fortunate, those who were poor and those who were vulnerable.

I went to school and eventually became a nurse practitioner. For nearly 30 years, I have served the poor and vulnerable in Tennessee. I have set up rural and urban community clinics. I have cared for patients with acute and chronic illnesses, treating uninsured and underinsured people in desperate condition. Over the years, thousands of patients have come to me with diabetes totally out of control, skyrocketing blood pressure, significant heart disease, end-stage renal disease, infections beyond the reach of antibiotics and "a cough that will not go away" that turns out to be lung cancer.

These all are illnesses that possibly could have been prevented, or at least detected earlier, with a visit to

the clinic or a health care professional. When detected early, the five-year survival rate for breast cancer is 99 percent. When detected after the cancer has spread, that survival rate drops to 24 percent, according to the American Cancer Society. Therefore early detection and preventive health care are very important. But these are people who have no access to health care, no access to preventive care, because of where they live, their socioeconomic status — or they simply can't afford health care or insurance. These all are people for whom I am an advocate.

Advocacy is a calling — a vocation. Advocacy is being a voice for the voiceless. Advocacy is telling the story of those who cannot tell their own story. Advocacy is seeing a need, seeing a gap, seeing the marginalized, seeing those who fall through the cracks, seeing and hearing the vulnerable, the poor — and being compelled and called to do something about it. Advocacy is to speak out,

to plead a cause, to support and defend. Advocacy is being in solidarity with the poor. In this cause, advocacy is to speak up against injustice and inequality of health care access and for health care coverage for the poor and vulnerable.

I suppose my advocacy for the poor began back in the days when I was seeing patients in rural Middle Tennessee. In at least three cases, farmers had cut their fingers on rusty wire but waited too long to come in — and they each lost part of a hand as a result. None of them had insurance, and all were hoping the cut finger would heal on its own.

I heard that Sen. Al Gore was coming to the Carthage, Tenn., courthouse for a town hall meeting. Between patients, I left the clinic, drove directly to the courthouse, listened to Gore speak and popped up to be the first in the audience to ask a question.

"What are we going to do about the people in rural Tennessee who work so hard, and have limited access to care, and no health insurance?" I asked.

The question took Gore off guard. The audience was full of county officials, and they were very quiet. I was the only "outsider" in the room. The senator was very gracious and agreed "we need to do something." I gave him examples of farmers, people who were chronically ill, unvaccinated children, and diabetics who were going blind. I shared with him the plight of those who

**Advocacy is a calling — a vocation. Advocacy is being a voice for the voiceless. Advocacy is telling the story of those who cannot tell their own story.**



had been laid off, lost their insurance or who never had insurance in the first place. I told him the largest factory in town had recently closed, meaning workers lost their jobs and their insurance, and so many of them were in need of health care.

I described how the rural health clinic where I practiced, with its two exam rooms and three staff members, overflowed with patients every day because we were the only practice in town that saw patients with no health insurance.

**I described how the rural health clinic, with its two exam rooms and three staff members, overflowed with patients every day because we were the only practice in town that saw patients with no health insurance.**

Gore listened. I think he heard the “cries of the poor” in my voice, in my stories — their stories. Gore said he would go back to Washington and try to do something about it.

Five years later, Al Gore became the 45th vice president of the United States. He worked diligently on health care issues while in office, and during his presidential campaign in 2000, Vice President Gore proposed a plan for providing access to coverage for the country’s 11 million uninsured children.

I’d like to think my stories of the patients I had seen at the rural health clinic in Trousdale County, Tenn., caught his ear and remained on his mind. In any event, the day I spoke up at the town hall meeting was the beginning of my role in advocacy — and I knew I had to do more. Meanwhile, I continued to see patients and joined as many community coalitions as I could to ensure access to care for those who needed it most.

I started clinics in Middle Tennessee serving the uninsured and underinsured. Before each clinic opened, we completed a community needs assessment to ensure we offered the services the community needed. I met every community leader, every community councilman and every community agency where the clinics were to be

located and spoke to them on behalf of the needs of their neighbors. I met and developed long-lasting relationships with many local government leaders, mayors and other formal and informal leaders.

By 2008, I was still practicing as a nurse practitioner, as well as managing several clinics for the poor within Saint Thomas Health, an integrated health system based in Nashville and a ministry of Ascension Health. I was asked to consider taking a formal position in advocacy as Saint Thomas Health’s vice president of advocacy and access.

I really knew nothing of the formal role of advocacy or influencing health policy. After much prayer, reflection and many interviews, I accepted the position and immediately had an assignment in Washington D.C. I was to take a group of senior leaders from our local health ministry to Capitol Hill, where I was to make an appointment with each of our group’s U.S. senators and representatives and tell them about Ascension’s 100% Campaign at Saint Thomas Health. Our 100% Campaign meant we were advocating for 100 percent access and 100 percent coverage for all. Basically, our message and our challenge was to convince our members of Congress to vote for the Affordable Care Act.

Well, thinking of all the patients I had treated over the years in rural and urban areas, I jumped right in. I began calling and emailing our Tennessee legislators and requesting appointments. It was wonderful. All of the schedulers were so kind and gracious. They did not ask me for my credentials or background, they just provided the appointments at the times I needed, freely, generously and graciously.

When we met with them, each U.S. senator and representative listened closely to what we had to say. They listened to our senior leaders and heard our hopes for 100 percent access and 100 percent coverage; they listened to our recommendation regarding a robust health policy that was fair, just and equitable, much like their own health care plans that offered choices and access to a medical home and specialists. Most importantly, they listened to stories of the patients who were in desperate need of access to care and coverage.

**We have found that inviting legislators and staff to tour the hospitals and clinics and to meet ministry leaders in their district really helps them see each ministry in action.**

Who knows if we convinced anyone, persuaded anyone, changed any votes. The important thing is, we advocated and they listened, and, in 2010, the ACA was signed into law. Since then, the Saint Thomas team has worked on many advocacy efforts — federal, state, and local — striving to influence the discussion and decision-making around transforming the delivery of health care, payment reforms and population health.

Our latest advocacy efforts have been around furnishing health care coverage to more than 470,000 Tennesseans who are currently without insurance. These people fall in the coverage gap affecting people with household incomes less than 138 percent of poverty — that is, an individual whose income is \$16,000 or less, and a family of four with a household income of \$32,900 or less. More than half of those in the coverage gap are employed in service positions, transportation, construction, cleaning and maintenance. These Tennesseans are not eligible for Medicaid, and they are unable to afford health insurance on the federal marketplace, even with tax credits.

In addition, more than 24,000 veterans are without VA benefits in Tennessee, and they would be eligible for health care coverage under this proposed health policy. Not all honorably discharged veterans are eligible for long-term VA benefits, because they don't meet certain criteria, even though many served in combat in the Middle East. This was an epiphany for me, learning there are veterans who have served our country in times of war yet are unable to get insurance or to afford insurance for themselves or their families.

I have learned that the most effective advocacy efforts seem to be when coalitions form around a particular effort, legislation or health policy. Legislators seem to listen closely when individuals, associations, businesses and civic organizations come together for one purpose on an issue, policy, or proposal. One example is the Coalition for a Healthy Tennessee, an advocacy group of more than 100 members supporting health care coverage for Tennesseans who can't afford to buy it.

Building and developing relationships with each legislator is very important. So is communicating regularly with each legislator or his or her staff in person, by email or phone; offering assistance on a subject that the member is interested in, especially if he or she is introducing legislation.

We have found that inviting legislators and staff to tour the hospitals and clinics and to meet ministry leaders in their district really helps them see each ministry in action. Visiting legislators in their local office to discuss policy issues when they are in town is important, as well. Also, I invite them to our Saint Thomas Health Medical Missions at Home, where we treat hundreds of uninsured and underinsured patients. Some members tour the medical mission and listen, some walk around and meet patients and staff and some come ready to pitch in and work.

These are the kinds of efforts that will help legislators learn your ministry's expertise and lead them to reach out to you when they need your expertise on a specific health policy.

I have learned so much from my advocacy colleagues throughout our national health ministry — they have taught me everything I know. But in my heart of hearts, I know that my true passion for advocacy centers in the compassion I still feel, so many years later, for the child in line ahead of me who couldn't afford to buy anything at the thrift store.

Truly, that must have been my sign from God.

**NANCY ANNESS** is vice president of advocacy, access and community outreach, Saint Thomas Health, Nashville, Tenn., an Ascension ministry.



JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

[www.chausa.org](http://www.chausa.org)

# HEALTH PROGRESS®

---

Reprinted from *Health Progress*, March - April 2015  
Copyright © 2015 by The Catholic Health Association of the United States

---