rural roads

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Lisa Kilawee

Capitol Hill or bust

It's been an honor serving as the National Rural Health Association president. Whenever I'm travelling or working in a different state, I always think of the great NRHA members there, and I'm heartened that our association is filled with such amazing talent to address challenges.

Over the past year, we've worked hard to preserve access to health care services despite the loss of many of our rural hospitals.

With a new president and administration, our 2017 Rural Health Policy Institute will be extra important. It will be a great opportunity to help educate our congressional representatives and federal partners about challenges we face in maintaining access to care in rural communities, embarking or continuing on the value-based reimbursement journey, or other issues our rural patients and providers face.

The 28th annual event's new location, the Omni Shoreham Hotel, is close to Capitol Hill and in keeping with the financial stewardship focus of many of our members. Let's ensure there's record attendance Feb. 7-9. I look forward to seeing you there.

Lisa Kilawee
2016 NRHA president

5 things I picked up in this issue:

1. One state is building a food security network that involves, and often begins with, health care providers asking patients if they have enough to eat. *page 11*
2. Rural patients are more likely than urban to have adverse childhood experiences, and adults who have had four or more are 60 percent more likely to develop diabetes. *page 20*
3. Rural physician burnout is common, but there are signs to look for and steps to build resiliency. *page 6*
4. COPD is the third most common killer of Americans, after heart disease and cancer. *page 12*
5. One in five Americans faces mental health challenges. *page 16*

Counteracting the darkness of physician burnout

By Jenn Lukens

Jill Kruse with her husband, Major Anderson, and children, Allison and Tyler. Kruse says burnout recovery methods helped her to be a better mother and rural physician.

It was 2008 when Jill Kruse, MD, fresh out of residency, took a job at St. Michael's Hospital Avera in Tyndall, S.D.

As a young primary care doctor, she was eager to put her years of school to use and took on anything that was asked of her.

Within a few years, she became the medical director for the nursing home, the overseer of the town's emergency medical service, the high school football team's sideline doctor, the clinic's medical director, and the hospital's trauma director and chief of staff. Kruse also shared rotations and call with only one other physician and two physician assistants to serve a town of 1,200 people.

Four years later, the demands of rural practice, coupled with trying to raise a young family, had started to take its toll. Her husband was the first to notice that she was experiencing burnout.

"He urged me to get a different job, saying 'you are killing yourself slowly in front of my eyes, and I'm not going to watch it happen,'" recalls Kruse.

She admits trying to hide the burnout behind a brave face while working even harder, but that strategy only made it worse. Kruse was at her limit and didn't know where to turn.

Then, her second child was born. During maternity leave, Kruse began questioning if she was even going to return to work. She remembers thinking, "If I am going back, something has to change. I can't go back to the same way, or I won't survive."

Glass houses

Randall Longenecker, MD, serves as assistant dean for rural and underserved programs at the Ohio University Heritage College of Osteopathic Medicine. He is an advocate of teaching medical students and residents skills to build their resilience and help them deal with the stresses of rural practice.

Longenecker points out that the recent spotlight on physician burnout doesn't mean it is a new issue.

> "If I am going back, something has to change. I can't go back to the same way, or I won't survive."
>
> Jill Kruse, rural physician

"There is clearly more publicity, but physician burnout has been an ongoing problem in medicine, both rural and urban," he says.

In Longenecker's experience, rural settings can actually encourage providers to admit they have a problem.

"One of the advantages of living in a 'glass house' where everyone knows each other's business is that [burnout] quickly becomes apparent to others," he says.

As in Kruse's case, it is often a third party who initially notices the burnout and encourages change.

Providers who build strong relationships within their community also

have an advantage when dealing with burnout.

"Resilience, or the ability to persist and thrive through hardship, is a competency for a rural practice," Longenecker says. "Hardship itself is not the most important contributing factor to physician burnout; the lack of healthy relationships is."

The downward spiral

While in Tyndall, Kruse sought help from Dike Drummond, MD, CEO of The Happy MD, physician coach and speaker, who specializes in physician burnout. Through regular coaching sessions, Drummond walked her through burnout coping strategies that started a path toward healing.

Drummond teaches that the difference between stress and burnout is the ability to recover in your time off. Physician burnout accelerates when there is no time set aside to recharge. This results in a downward spiral characterized by physical and emotional exhaustion, depersonalization with patients, and a reduced sense of personal accomplishment.

Kruse can attest to the necessity of recharging. She says her lack of it made her feel like she was constantly withdrawing money from an overdrawn checking account.

"You keep writing checks, but they continue to bounce, and there is no way to get back in the black," she explains.

Making a change

Slowly, Kruse started to see improvement, but not without a struggle. After exhausting all of Drummond's coping methods, she realized that the pressure of two children, multiple responsibilities at work, and a strict call schedule was simply unsustainable.

"It became very evident that this was not the right clinical fit for me in this stage of my life," Kruse recalls.

In 2013, Kruse and her family moved to Brookings, S.D., a town of 22,000, where she started working at Avera Medical Group Brookings. She says the change was exactly what she needed. The increase in time allowed her more energy to put toward being a better mom and doctor, engaging with her patients the way she used to.

"When you are not burned out, you can go the extra mile to talk with patients and meet their entire need," Kruse says. "Now, I can enjoy the relationships that come with practicing medicine. I feel like I'm a healer, not just a physician."

She wanted to share the burnout recovery methods she learned with her medical community. Kruse was hired as medical director of Avera LIGHT, a physician burnout prevention and coping program launched by Avera Health with a dedicated budget. The program was specifically designed for physicians, physician assistants and nurse practitioners within Avera's health care system. A steering committee of physicians, advanced practice providers and administrative leaders provides oversight and strategic direction. Mary Wolf, Avera's employee assistance program director, also serves as the LIGHT program director.

Hope and healing

The name comes from the image that Kruse explained, "As opposed to a candle burning at both ends, we want our providers to be a light that counteracts the darkness of burnout."

LIGHT is also an acronym for the program's goals: live, improve, grow, heal, and treat.

> "Even though burnout is very common, we rarely talk about it. We want our medical professionals to know that their work doesn't have to feel like this. We can make things better."
>
> Jill Kruse, rural physician

Through executive coaching, accountability and practical steps to improve work-life balance, Avera LIGHT helps prevent burnout and heal participating providers.

Because of the perceived stigma that often accompanies seeking mental or emotional help, many services like Avera LIGHT have difficulty getting people in the door. Kruse says the first step is for a provider's attitude to change from feeling ashamed to admitting that they need help.

"Even though burnout is very common, we rarely talk about it," Kruse says. "We want our medical professionals to know that their work doesn't have to feel like this. We can make things better."

Avera LIGHT attendees and conversations are confidential, which has helped providers sign up.

Since its launch in 2014, Avera LIGHT's services have had positive effects on staff. After going through the courses, those who have been on the brink of quitting their jobs have chosen to stay, Kruse says.

More providers are accessing employee assistance programs that were previously left untouched, and those who have benefitted from the program are becoming peer coaches to help fellow physicians. Kruse recalls one physician who approached her after a seminar.

"He said he was so burned out that he saw suicide as the only option. After receiving the help he needed,

continues on page 9

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Randall Longenecker

this physician is already interested in helping others," she says.

Building resiliency

The efforts Avera LIGHT is making to minimize physician burnout are part of a national trend among health care and educational facilities. Medical schools, including the University of South Dakota's Sanford School of Medicine, are starting to adopt wellness programs and integrate physician burnout prevention into their curriculum. As a board member of the South Dakota State Physician Burnout Committee, Kruse has helped with this process.

Longenecker says the number of physicians who quit due to burnout is hard to measure, since it often goes unrecognized or is attributed to other factors. He has seen many doctors leave their practice due to burnout, only to go on to other places ill-equipped to handle the conditions they will inevitably face again.

> "Be the mentor that helps them flourish as opposed to throwing them in the deep end and hoping they can swim."
> Jill Kruse, rural physician

To prevent this, Longenecker says that resiliency needs to be a key competency for rural medical providers. This is not to be taken as an encouragement to endure harmful situations, but to understand personal and professional limits, he explains.

"Those like Dr. Kruse, who acknowledge burnout and do something about it, become resilient," Longenecker says. "Living with scarcity and limits has been identified as a competency for rural practice. It refers not just to limited resources, but to maintaining healthy boundaries and guarding margin for self and family. Those who are most susceptible to burnout in rural practice are those who fail to recognize and embrace their limits and work within them."

In his article in the National Rural Health Association's *Journal of Rural Health*, "Teaching and Learning Resilience: Building Adaptive Capacity for Rural Practice," Longenecker and his co-authors outline these key steps for building resiliency:

- Embrace hardship as an opportunity for growth
- View resilience as both an individual and community property
- Pursue adaptability more than hardiness
- Set a lifelong pattern of learning this competency in practice

Provider pointers

As an experienced rural doctor, Kruse has a wealth of advice for rural medical administrators, starting with budgeting.

"Make room to pay locum doctors to take weekend calls. You are going to lose your doctors if they are constantly working and never getting a chance to recharge," suggests Kruse.

She also recommends actively looking for burnout signs among providers and offering them support.

"It can be very isolating in a rural community. Find ways that your doctors, especially new graduates, can connect with someone that understands," she advises. "Be the mentor that helps them flourish as opposed to throwing them in the deep end and hoping they can swim."

Longenecker encourages administrators to look beyond productivity levels and the financial bottom line.

"I believe it is as important to reward creativity, agency, community engagement and relationships as it is to act with integrity and fiscal responsibility," he says.

This article originally appeared in the Rural Health Information Hub's The Rural Monitor *in March.*

Signs of burnout

Jill Kruse, MD, says providers and their employers and colleagues should be aware of these signs of burnout:

- Exhaustion
- Cynicism
- Lack of efficacy
- Desperation
- Internalization
- Overworking
- Disruptive behaviors

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Finding food for impoverished patients

Hunger leads to generation of 'overweight but malnourished'

By Nok-Noi Ricker

Doug Michael

Doctors can write a prescription for a headache, but what do they prescribe for hunger?

Finding an answer to that question in Maine – where large numbers of children and seniors live in poverty – is why Eastern Maine Healthcare Systems (EMHS) applied for a Partnerships to Improve Community Health grant through the U.S. Centers for Disease Control and Prevention. EMHS was awarded the $4.05 million CDC grant and has used the funds to create partnerships in Maine's seven most northern counties to increase access to food resources.

"We've started to ask patients: 'Do you have enough food?' And if they don't, we connect them with the resources to help feed their family," says Doug Michael, chief community health and grants officer for EMHS. "Providers need to know where to send their patients to [for food] that is a respected and reliable and trusted source."

Michelle Hood, EMHS president, says the goal is to increase the number of health care providers screening patients to keep Mainers as healthy as possible and to prevent chronic illnesses.

The CDC grant also has been used to help create new partnerships with Good Shepherd Food Bank of Maine and Maine farmers to increase the availability of nutritious, locally grown foods and access to programs that help people learn to better themselves.

"Hunger is a significant issue for people in Maine," says Kristen Miale, Good Shepherd president. "Over 200,000 people, or 16 percent of Maine, has food insecurity. The impact is one in four are children. We're 12th in the nation for poverty, up from 22nd. We are going in the wrong direction.

"What is most alarming is that Maine ranks third in the country in very low food security," she adds. "These are more than sad figures – they are shameful."

Nearly 500 people, from health care providers, schools and food pantries from around the state, as well as lawmakers, members of Healthy Maine Partnerships, business owners and others, gathered for the Food is Medicine Conference in Bangor, Maine, in June.

The goal is to "build the network of food security" in six mostly rural counties, according to Lee McWilliams, a grant consultant for EMHS.

Children and seniors make up two-thirds of the people who get food through Good Shepherd, and another 16 percent are disabled, according to Miale.

"Hunger impacts our most vulnerable," she says. "People [go to Good Shepherd] because they do not earn enough to feed their families. Ninety-seven percent are working. We have a high rate of what we call under-employed. They're incredibly hard-working Mainers but still don't make enough money to survive."

She says when people are worried about money, they tend to skip meals or purchase high calorie foods that are low in nutrition, which can lead to poor health and chronic health problems such as diabetes and hypertension.

"We are left with the paradox of a whole generation of people who are overweight but malnourished," Miale says. "The rich get organic, and the poor get diabetes."

Good Shepherd increased the amount of fresh produce given out by 34 percent in the last year through partnerships with 43 farmers, she says.

The CDC grant also increased access to technology at rural locations and helped Good Shepherd to locate and secure a warehouse in Hampden, population 7,200, so the region can benefit from the farm-to-table program, Michael says.

"We have enough food to feed everybody," Miale says. "We can end hunger."

This article originally appeared in The Bangor Daily News *on June 7.*

COPD patient founds rural clinics

Chris Janson leads the Harmonicas for Health program at St. Thomas Rutherford Hospital in Murfreesboro, Tenn. The program was the first harmonica class for COPD patients sponsored and facilitated by the COPD Foundation.

Grace Anne Dorney-Koppel knows firsthand the impact of chronic obstructive pulmonary disease (COPD). Diagnosed in 2001, she served as a patient advocate for the National Institutes of Health's "Learn More Breathe Better Campaign" for the last decade.

In 2009, she founded the Dorney-Koppel Family Charitable Foundation, which has helped fund several rural pulmonary rehabilitation clinics.

She became president of the COPD Foundation in May. She has appeared in national broadcasts to raise awareness of COPD, which affects 30 million Americans.

Rural Roads asked Dorney-Koppel about her work.

Rural Roads: What brought you to this work?

Dorney-Koppel: I did not find this work, it found me. In 2001, I couldn't do things I had easily done before. I thought it was just t hat I was out of shape and getting older. Wrong! I had all the classic symptoms of COPD but didn't know it, and what's worse, my family doctor missed the diagnosis even though it was staring him right in the face.

I was an ex-smoker. I suddenly found I could not take a deep breath, could not walk half a block without stopping to catch my breath, had trouble walking up a

Left: Grace Anne Dorney-Koppel. Above: Patients and staff at St. Mary's Hospital in rural Leonardtown, Md., gather for an anniversary celebration of the Grace Anne Dorney Pulmonary & Cardiac Rehab Clinic.

flight of stairs and had wheezing sounds coming from my lungs and throat. There is a simple breathing test that my doctor could have given me, or he could have referred me to a lung specialist. He did neither.

My husband and I were desperate, and we went to a major health clinic, where a simple breathing test showed that I had already lost 75 percent of my lung function. The outlook was not good. I was told that I should begin making end-of-life preparations and perhaps I had three to five years left to live. The news was a shock, but I was lucky. I took my inhaled medicines exactly as prescribed and most importantly, I got a prescription for pulmonary rehabilitation.

Fifteen years later, I am still going strong, and I am convinced pulmonary rehab saved both my life and the quality of that life.

Rural Roads: How has COPD affected rural communities?

Dorney-Koppel: COPD is a particular problem in rural America. The states with the highest rates are located along the Ohio and lower Mississippi rivers. West Virginia has the highest rate of COPD at 12.3 percent of the population with Kentucky and Tennessee close behind.

In rural areas, the rate of women's deaths from COPD has increased alarmingly from 1994 to 2014 compared to urban and suburban women. Men's death rates are also higher in rural than urban and suburban areas.

Access to diagnosis and treatment, particularly pulmonary rehabilitation, is very limited for rural patients. This needs to change.

COPD is a disease of inequities. Women, veterans, Native Americans, those who are poor and with less education suffer the most.

Rural Roads: What are some of the barriers confronting COPD patients and the providers who treat them?

Dorney-Koppel: COPD is the third most common killer of Americans, right after heart disease and cancer. It kills 145,000 Americans every year and is the second leading cause of disability in the country.

You may know it as emphysema (the small air sacs in the lung are destroyed) or chronic bronchitis (a cough with mucous that does not go away). Fifteen million Americans have been diagnosed with COPD; it's estimated another 12 to 15 million Americans have the disease but are not yet diagnosed and are not being treated.

It's a chronic disease that gets worse over time. There is no cure for COPD – that's the bad news – but the good news is that it can be treated. We could be improving millions of lives if we just did a better job of early diagnosis. We need primary care doctors to be alert for the symptoms, and patients who suspect they have breathing problems need to tell their doctors if they

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"We are pleased to have been a charter Member of RWHC for over 35 years. We have appreciated and benefited from Coop staff expertise and leadership with rural health and critical access hospital advocacy, credentialing and quality assurance initiatives. I have really enjoyed the personal interactions and open-sharing culture that has been fostered throughout our tenure."

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- Laurie Whitfield-Trautlein, RN MSL ARM cpHRM
Compliance Officer/Medical Staff Liaison
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have shortness of breath and trouble doing things they easily did before.

Where available, doctors should refer their COPD patients to pulmonary rehabilitation. That's been a real life-saver and life-changer for me.

Rural Roads: What is pulmonary rehabilitation, and why is it so important for COPD patients?

Dorney-Koppel: Pulmonary rehabilitation is a program of wellness for life. Patients learn about the disease, exercise while being supervised, learn how to take their medicines, learn how to breathe to reduce symptoms, learn about nutrition, and learn how to recognize signs of changes in their condition that could lead to hospitalizations or ER visits.

The Dorney-Koppel Foundation has helped fund six pulmonary rehabilitation programs in rural Maryland and West Virginia and one in New Orleans. In each case, the location has a high rate of COPD but no pulmonary rehab facilities. Another clinic is opening in rural North Carolina later this year.

We partner with local and state foundations to start programs where there is a high prevalence of COPD but no rehab facilities.

I know from personal experience that gaining strength and confidence in a pulmonary rehab program helps people get their lives back, and my husband and I want others to have the same chance that I had 15 years ago. Each of us should have the same chance.

Rural Roads: How can COPD patients and other stakeholders at the community, state and federal level help make a difference?

Dorney-Koppel: All of us need to speak up and comment on the national action plan for COPD. In February, patients, doctors, researchers, payers, health systems and state and federal agencies came together for two days to draft a plan.

The only way to move forward and find the millions who have COPD and are not diagnosed yet, the only way we can hope to find better treatments for the 15 million who are diagnosed and ultimately cure the disease, is for all of us to work together.

The truth about COPD

COPD Foundation president Grace Anne Dorney-Koppel debunked common misconceptions about COPD:

Myth 1: Only smokers get COPD.

Smoking is the primary risk for COPD, and if you smoke, you should quit. That said, 20 to 25 percent of COPD patients have never smoked. Occupation (anything where fumes, dust, fibers, chemical vapors are in the air) can be risky. Environment (geography where we live and how polluted the air is) can be a risk for COPD. Outdoor and indoor air quality can be factors in getting COPD later in life.

Myth 2: If you stopped smoking 10 years ago, you must be safe.

COPD develops for decades silently in the lungs before the symptoms appear. Definitely stop smoking and don't let anyone smoke in your home or workplace. That prevents further damage, but it won't undo the harm already done.

Myth 3: COPD is an old man's disease.

Since 2000, more women than men have been diagnosed with COPD, more women die of COPD, and women have more shortness of breath, more primary care visits, more ER visits and more hospitalizations.

Seventy percent of people diagnosed with COPD are still working, and two-thirds are 65 or younger.

Resources

The COPD Foundation is dedicated to finding better treatments, improving the lives of those with COPD, and ultimately finding a cure.

Visit copdfoundation.org for research and programs for patients, providers and caregivers.

Call the hotline at 866-316-COPD (2673) for resources in your community.

Rural veterans get help combatting mental health issues

By Chelsea Radler

Many veterans live in rural communities far from mental health specialists.

When Jesse* moved back to North Carolina after serving in the Vietnam War, he grew out his hair and pretended to be a war protester.

"I didn't want to say I was a Marine," he says.

He struggled with depression and feelings of shame. Later, nightmares worsened and other signs of post-traumatic stress disorder affected his marriage.

> "Long travel times, harsh weather, stigma associated with seeking services and provider shortages all make it more difficult for rural veterans to get mental health support."
> Gina Capra, VA Office of Rural Health director

One in five Americans faces mental health challenges, according to the National Alliance on Mental Illness. Because of stigma, many people – especially veterans – who need mental health support remain hesitant to talk openly about it. Only about half of those who are affected receive treatment.

"I felt like an outsider," Jesse says. "People couldn't understand me, and I couldn't open up to them. I kept everybody at arm's length."

Only years later did Jesse seek help for the mental health issues that resulted from his military service.

Although the majority of America's 22 million veterans do not have a mental health issue, the number of veterans receiving mental health treatment from the U.S. Department of Veterans Affairs (VA) was 1.6 million in 2015. Many of those veterans live in small, rural communities, far from mental health specialists.

To serve the growing need, VA is working to expand access to mental health services, especially in rural areas where fewer clinicians practice. VA increased resources and staffing, allocating more than $24 million from VA's Office of Rural Health toward innovative mental health programs for rural areas in 2016. VA leaders say these programs will increase access to care for veterans like Jesse.

"Long travel times, harsh weather, stigma associated with seeking services and provider shortages all make it more difficult for rural veterans to get mental health support," says Gina Capra, VA Office of Rural Health director. "VA is coming at these barriers from all sides

to support rural veterans in accessing the services they earned and deserve."

The targeted funding will grow telehealth programs that bring mental health care closer to home for rural veterans. Telehealth uses secure phone and video technology to link a provider with a veteran, who might be hundreds of miles away at a small local clinic or even in their own home. It allows for the same quality of care, without the burden sometimes associated with travel.

The National Telemental Health Center and VA's Telemental Health Hubs make therapy more accessible using telehealth to connect with medical specialists who are trained and experienced in supporting veterans with their unique mental health needs. VA also supports rural community programs that raise awareness of veterans' mental health needs and help refer veterans and their families to VA for services and support.

> "I felt like an outsider. People couldn't understand me, and I couldn't open up to them."
> Vietnam War veteran

Chaplain Keith Ethridge leads the VA Rural Clergy Training Program, which educates local religious leaders in rural communities on how to recognize signs and symptoms of mental health issues among veteran parishioners and their families.

"The clergy is a trusted source for counsel and often the first-line contact in small, rural communities. The confidentiality it provides is important to veterans, especially when discussing mental health issues," Ethridge says.

Veterans can also engage directly with resources online. Funded by VA's Office of Rural Health, veterans can log on to VetsPrevail.org for customized digital training, peer-to-peer chats and expert mental health coaching to work toward personalized solutions. Additionally, Make the Connection, the VA's national mental health awareness campaign, features personal stories of recovery from veterans.

"The maketheconnection.net website features hundreds of inspiring stories of veteran and family member resilience in dealing with and overcoming mental health and other life challenges," says Wendy Tenhula, MD, VA's deputy chief consultant for specialty mental health.

**Last name withheld for privacy.*

Chelsea Radler is a communications specialist with the U.S. Department of Veterans Affairs' Office of Rural Health.

Caring for rural veterans

One in every five veterans returns from combat with at least one serious mental health issue.

And veterans living in rural areas are more likely to have current or lifetime depression and are at a significantly higher risk of suicide than their urban peers.

These problems are compounded by limited access to care:

- There are only 16 psychologists for every 100,000 rural residents, about half the amount in urban and suburban areas.
- More than 85 percent of rural Americans live in a mental health professional shortage area.
- Rural community providers report feeling less knowledgeable than urban providers about post-traumatic stress disorder, substance abuse, depression and suicide treatments.

The VA Office of Rural Health's mental health initiatives include telehealth and community outreach programs, interactive online and phone-based resources, and workforce support. These initiatives help increase access to care for rural veterans and support the providers and loved ones who care for them.

For more information, visit ruralhealth.va.gov.

Rural telemental health hubs

In 2016, VA established rural telemental health hubs to connect mental health specialists with rural-serving sites where veterans require same-day or urgent access to mental health services, where access is limited due to provider shortages or other barriers.

Each "hub" contains specialty providers who see patients, and its "spokes" are locations where patients receive treatment: either at the veterans' home or at a telehealth-ready VA community-based outpatient clinic or VA medical center.

Mercy Hospital, Moose Lake, MN

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Preventing trauma that leads to health issues

Rural patients more likely to have adverse childhood experiences

By Tom Bell and Herb Kuhn

Tom Bell

Herb Kuhn

The adult in your waiting room — the one with chronic health problems, or illness or injury resulting from harmful behaviors — may have had adverse childhood experiences.

Childhood abuse and neglect, troubled homes and toxic stress aren't things that happen elsewhere; they happen everywhere. And rural providers are more likely to treat patients suffering from adverse childhood experiences (ACEs) than urban providers. In fact, research from the U.S. Health Resources and Services Administration found that among children in all age groups, urban children were significantly less likely than those in rural areas to have had at least one adverse experience in their lifetimes. And 22.6 percent of urban children were exposed to two or more ACEs, while children from large rural areas suffer a rate of 28.4 percent and small rural areas 28.9 percent.

The long-term and often invisible damage caused by ACEs can influence an individual's physical and behavioral health throughout life – and even result in early mortality. Research initiated by the Kaiser Permanente Foundation and the CDC suggests that this damage is compounded by multiple ACEs. This is particularly bad news, as rural children are more likely to have multiple ACEs than their urban counterparts.

Health care providers regularly experience the downstream impacts of ACEs. However, prevention and early intervention are essential to improving population health. Looking to the upstream causes of downstream health problems requires a different approach. Hospitals and providers must look past the walls of the health care facility and into the communities they serve.

"This is the long journey of addressing risk factors today to prevent diseases of tomorrow, and it requires commitment to long-term population health improvement."

Hospitals' community health needs assessment process provides a good starting point for addressing populations at risk for ACEs. Looking through an upstreamist's prism, hospitals can identify why cases of diabetes, heart disease and other chronic conditions that have proven widespread in rural areas flow through the hospital.

For example, pre-diabetes and diabetes plague many rural communities with high obesity rates. These same rural communities may lack access to healthy food. For hospitals and health care stakeholders, the challenge is determining whether to expend limited resources on prevention through better nutrition, expanded access to healthier food and community-based exercise, or on disease management.

Looking further upstream, a hospital might choose to intervene in diabetes by reducing toxic stress for its children. Adults who have experienced four or more ACEs are 60 percent more likely to develop diabetes and more than twice as likely to develop the typical culmination of diabetes: heart disease.

This is the long journey of addressing risk factors today to prevent diseases of tomorrow and requires commitment to long-term population health improvement.

Focusing upstream is hard. So is identifying and rooting out ACEs. Although there are some very promising efforts to address the individual and community costs of ACEs – including building community resiliency – too often these programs are challenged by the burden of repressed physical and emotional wounds for the individual. Addressing this at the population level requires deliberate planning informed by research.

The Kansas Hospital Association and Missouri Hospital Association asked the Hospital Industry Data Institute (HIDI) to research whether it could develop a community-level score to help stakeholders identify the home- and community-based risks for ACEs. With community risk data at the ZIP-code level, stakeholders could then steer assets toward high-risk communities to more effectively prevent ACEs. This approach ensures resources are directed where they are needed.

HIDI researchers delivered a community ACE risk score for ZIP codes in both states. The risk analysis aggregated three years of hospital inpatient, outpatient and emergency department data at the ZIP-code level and evaluated diagnosis codes for 25 measures attributed to abuse, neglect, household challenges and toxic stress factors.

The data is alarming.

A growing body of research suggests individuals from communities with sociodemographic challenges often have poorer health outcomes. HIDI researchers found a large cluster of contiguous high-risk ZIP codes from Missouri's boot heel across the southern part of the state. A similar pattern exists in southeast and western Kansas. In addition to their high risk for ACEs, these areas include some of the state's poorest counties and lowest rankings for health factors and outcomes, suggesting a strong correlation between ACEs, social determinants of health and socioeconomic deprivation.

Rural communities and the health care systems that serve them often are resource-poor. They also may lack community-based framework to identify and address upstream social problems that lead to long-term health challenges. In urban and suburban communities, the cost of these efforts often are borne by hospitals, the business community, foundations and other community partnerships in concert.

To be effective at reducing ACEs, rural hospitals must identify partners and engage stakeholders throughout the community.

> "Hospitals and providers must look past the walls of the health care facility and into the communities they serve."

Although the risk-based modeling in the research is preliminary, a ZIP-code level tool holds promise for hospital-centered collaborative population health improvement efforts. When resources are limited, targeting is essential. A ZIP-code based approach can help hospitals look upstream and improve downstream return on investment.

No community is immune from the cost of ACEs. Every hospital has a stake in reducing the cost to children, presently and in the long term.

Adverse childhood experiences have high downstream costs: poorer health, lower quality of life and reduced longevity. Better health starts upstream from the health care system.

Tom Bell is president and CEO of the Kansas Hospital Association, and Herb Kuhn is president and CEO of the Missouri Hospital Association.

Rural risk

Rural residents are significantly more likely than urban to have had at least one adverse childhood experience (ACE) in their lifetimes.

Rural children are 5.5 percent more likely to have multiple ACEs than urban kids.

Adults who have experienced four or more ACEs are 60 percent more likely to develop diabetes and more than twice as likely to develop heart disease.

The research and outlines of efforts at two Midwest hospitals are available at http://bit.ly/2dZ6UBG.

Beginnings & Passages

Ada Pariser

"A summer in the city confirmed my desire to live and work in rural America."

Family inspires NRHA intern to pursue rural medicine

By Ada Pariser

My interest in health care began while witnessing my parents work many hours providing physical therapy for the underserved around the cities of New Orleans and Louisville.

I also watched my father serve in leadership roles for the Louisiana, Kentucky and American Physical Therapy Associations, striving to get patients access to the care they needed. When he passed away in 2013, I found the magnitude of the community he was able to serve and the drive of the professional organizations he worked with to be inspiring. I wanted to love and fight for people in such an impassioned and purposeful way.

After his death, when I visited family in rural Appalachia where I had visited countless times, I viewed their community with fresh eyes. I spoke with elderly members of the community who feared being too far from primary and emergency care, and farmers who feared injuries that could be career-ending simply because they did not have access to adequate follow-up care.

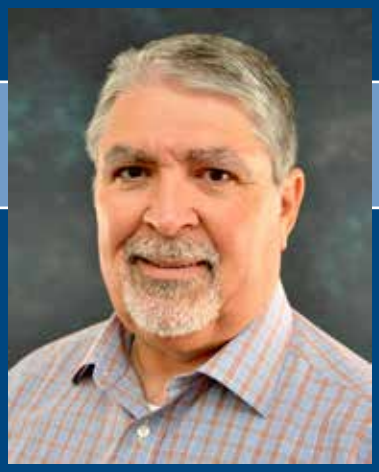
Yet, each member of the community seemed to be fighting for the betterment of those around them. Difficulties of rural living fueled their camaraderie, and I realized that there could be no better place to launch community health efforts than rural America. These are the people I want to fight for, because I know that they will be fighting right along with me, and any obstacles we face we will work through as a team.

Last summer, I was blessed to serve as an intern in the National Rural Health Association's D.C. office, where I was able to not only expand my knowledge of health care access in Appalachia, but also expose myself to the problems faced by frontier Americans.

I was moved by the compassion poured out by providers from across the country as we drafted policy papers and met to discuss an endless range of battles fought on behalf of rural Americans. At the end of the day, a summer in the city confirmed my desire to live and work in rural America.

A career in rural medicine will allow me to immerse myself in a uniquely beautiful culture, appreciate its strength, and forge ahead with a community as a team.

Ada Pariser is a is pre-medicine major at the University of Dayton and served as a National Rural Health Association intern in 2016.



Robert Guerrero

"My experiences … gave me a much wider view of rural and binational health care and public health issues and led me to the understanding that we did not live in two separate states but instead in one region."

A life-changing experience and a lifetime of dedication

By Robert Guerrero

I started my professional career in 1980 as a respiratory care practitioner (RCP) at Tucson Medical Center (TMC) in Tucson, Ariz. In 1992, TMC was actively working to establish relationships with physicians in Ciudad Obregon, Sonora, Mexico, and in the process of donating mechanical ventilators to one of the local hospitals. The TMC administration asked if there were any RCPs that would be willing to travel to Mexico to help train the physicians on how to use the donated equipment, and I immediately volunteered to do the training.

That was my first experience working with medical professionals from Mexico, and it was life changing. The physicians I met were appreciative not only for the donation, but because I had traveled to their city to help them understand how to use the equipment. I was treated with respect and gratitude.

Following that first international experience, I decided to return to school and in 1995 began working in corporate and affiliate services at TMC. Part of my charge was to work with the rural communities in Southern Arizona and oversee a customer service and referral office, working closely with Mexican colleagues throughout the states of Sonora and Sinaloa. In addition, I represented TMC at the Health Services Committee (HSC) of the Arizona-Mexico Commission (AMC), a public-private organization chaired by the Arizona governor.

It was through the AMC HSC that I met Andy Nichols, a public health pioneer in Arizona's rural and border communities. With Dr. Nichols' guidance, I became an active member of the AMC HSC, allowing me to work closely with public health authorities in the state of Sonora. Following Dr. Nichols' death in 2001, I was appointed by Arizona Gov. Jane Hull to serve as the private sector co-chair of the AMC HSC.

My experiences as private sector co-chair gave me a much wider view of rural and binational health care and public health issues and led me to the understanding that we did not live in two separate states but instead in one region. In my current position, I am still in contact with many of the physicians I met back in 1992.

Robert Guerrero is chief of the Arizona Department of Health Services Office of Border Health. He joined the National Rural Health Association in 2010.

Are you relatively new to rural health or looking back on years of serving rural America? Email editor@NRHArural.org if you'd like to share your story.

Get to know your new NRHA president

2017 NRHA president David Schmitz in rural Australia.

The National Rural Health Association's 2014 Volunteer of the Year, David Schmitz, MD, was elected its 2017 president.

After 20 years in rural practice and teaching with the Family Medicine Residency of Idaho, he recently became chair of the Department of Family and Community Medicine at the University of North Dakota School of Medicine and Health Sciences and says "teaching those who serve while serving those in need seems like more of a vocation than a 'job.'"

What led you to choose a career in rural health?

I can still remember as a child my mother reading me a book, "What Will I Do When I Grow Up?" My answer wasn't to be a doctor or even a teacher, which I am both now; it was to be a farmer. The problem was I never had the farmland or even a tractor, except the John Deere toys I got for Christmas. The first time I drove the John Deere mower in our back yard as a kid, I ran into the side of the pool and collapsed the whole thing, so maybe that was never to meant to be.

As I went on to find great teachers, mentors and people in my life, I found ways to stay connected to the land and its people in rural America, and that part has really worked out.

What's the best thing about your new job?

Working to bring health to people, inspiration to students and help to rural communities is the best thing about my role that allows me to be a physician, an educator and a scholar. When it can all work together, you know you have found the right place to be. I know that many of my friends and your readers have the fortune of a similar blessing in a sense of purpose in rural health.

Why do you choose to volunteer with NRHA?

NRHA allows me to work with my colleagues, friends and the new people I meet in a way that is truly unique. From widely respected and recognized national leaders to first-time attendees and students, we can meet together for the good of rural health.

From all walks of life, career paths and experiences, from remote islands to the central northern plains, I can share my own ideas and you make them better and I learn new perspectives I wouldn't have otherwise ever known. People I have met are also kind, thankful and try their best. They are volunteers too, and the mission binds our efforts.

What is your most memorable moment in rural health?

I was in a scary situation (at least for me) with a patient during my first year of rural practice. He told me that he was going to help me become a "real doctor." Our relationship changed that day as I cared for him (and did just fine). He was right about what I could do, and I remain thankful to him for his trust and confidence to this day. He met me "where I was" when I needed the confidence in our relationship. I had the opportunity a few years later to do the same for him and his family. That is an example of the power of rural and what family medicine has meant for me; it's about relationships.

What excites you most about serving as NRHA president?

Each of us as NRHA members have the opportunity to contribute in our own way. Our efforts together make up what we can do about our reality today and also scatter seed for tomorrow.

As NRHA president, I want to do what any of us can do and that which all of us must do: work together to lead, teach and serve from whatever capacity we find ourselves in today. As president, I will have the privilege of representing you, our members. I plan to champion our policies and communicate our message, and finally to help to set a shared vision for our NRHA going forward.

What are some of rural health's biggest strengths?

You. Rural health's biggest strength, hands down, is its people. I am always amazed what you learn about people by visiting their home or their workplace, by spending countless hours on the road together, or both. There is something unique about the togetherness of rural. It's a paradox of sorts, isn't it? So far to go while so close already. It's a strength to be called upon.

Tell us something most NRHA members don't know about you.

I love radio. While I never knew I would have the chance to do so, I have been involved in broadcasting with some of my dearest friends for a number of years now. Someday, even when I've retired from other things, I hope to stay active in broadcasting and programming. I particularly like the kind of talk radio programing you stumble upon in the wee hours of the night but somehow you stay to listen a little longer than you thought you would. As my best friend Bruce used to say, "I have the perfect face for radio."

I learned there's nothing like meeting at a local donut shop on a crisp winter morning before heading out to do a radio program.

What are your favorite ways to relax?

I study differential Christian theology, which means I have a lot of old books.

I love physics, so I spend time on the range and fly kites too. I've heard that North Dakota is a great place to fly kites; less power lines per square mile and more wind!

It's the belief and search for the truth that drives me; the grace when I fall short of it, however, is what saves me. Sometimes I miss the mark or fly the kite a little too high, but I still enjoy every moment.

I love my family, and I probably work "too much," mostly because it relaxes me.

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Register at **RuralHealthWeb.org/pi** today to save.

Clinics, CAHs collaborate in Kansas City

The National Rural Health Association's 15th annual Rural Health Clinic and Critical Access Hospital Conferences brought 525 clinic and hospital leaders to Kansas City in September.

NRHA's fastest-growing events featured sessions with rural-specific topics, including those on driving operational efficiencies, managing new frontiers in quality, financial tools, population health, and MACRA-based solutions.

"I really enjoy listening to best practices and speakers who gave workable solutions to problems," one attendee wrote. "The breaks were also great for networking."

The event also honored the nation's top critical access hospitals, and many sessions featured their leaders sharing strategies for success.

NRHA partnered with both CMS and 340B Health to host free meetings that bookended the event.

Plan now to join rural health pros from across the country for the 2017 clinic and hospital events Sept. 26-29 back in Kansas City. Presentation submissions will be accepted at RuralHealthWeb.org beginning in March.

More friendly faces

Continue your trip down Memory Lane or see what you missed with more photos from the Rural Health Clinic and Critical Access Hospitals Conferences and other NRHA events at facebook.com/ruralhealth.

Members on the move

NRHA award winner to head prominent research center


Mark Holmes

Mark Holmes, PhD, a longtime National Rural Health Association member, has been appointed director of the University of North Carolina Cecil G. Sheps Center for Health Services Research, one of the oldest and largest academic health services research centers in the United States.

Holmes is an associate professor and associate chair for research in the Department of Health Policy and Management in the university's Gillings School of Global Public Health. He has served with the Sheps Center since 1997, most recently as the director of the North Carolina Rural Health Research and Policy Analysis Center.

"I am honored to be entrusted with the legacy of one of the finest research institutions in the country," Holmes says. "Research conducted at the Sheps Center has been invaluable to improving the delivery of health care for North Carolina communities, and continuing this tradition is a top priority."

He joined NRHA in 2009 and received NRHA's Outstanding Researcher Award in 2015.

NRHA past-president accepts regional leadership role

2016 National Rural Health Association president Lisa Kilawee recently started working as regional vice president at Caravan Health. She focuses on developing and enhancing relationships with hospital CEOs, physicians and other potential rural health care partners as they develop value-based reimbursement strategies.

Kilawee previously served as a physician recruiter at Ministry Health and director of rural health services at Avera Health for 12 years.

"NRHA has always worked to advance innovative solutions that can help rural facilities maintain access to services at the community level," Kilawee says. "Caravan Health was started by NRHA member Lynn Barr as a way to help rural, independent and smaller facilities combat barriers to implementing value-based reimbursement strategies and address federal mandates. I'm truly excited to join Lynn and the staff at Caravan in our work to ensure all providers and facilities can implement the strategies they need to provide the best quality of care to patients and the lowest costs."


Lisa Kilawee

She joined NRHA in 2004.

NRHA member selected as top professional in rural health care


Gail Nickerson

Longtime National Rural Health Association member Gail Nickerson, Adventist Health director of rural health services, was selected as Top Professional of the Year in Rural Health Care by the International Association of Top Professionals. Honorees are distinguished based on their professional accomplishments, academic achievements, leadership abilities, longevity in the field, other affiliations and contributions to their communities.

Nickerson has more than 30 years of professional experience in the rural health care industry, demonstrating success as a health systems consultant and outpatient clinic administrator as well as working with a variety of nonprofit organizations.

"Being connected to NRHA has helped me connect

with people who support rural health across the whole country and brings me to D.C. once a year for the Policy Institute, where I get to visit all the senators and representatives who have rural health clinics in their districts and help them understand what is important for the people who live in those districts to stay as healthy as possible," Nickerson says.

She joined NRHA in 2004.

'Great American hospitals' list features NRHA members

Becker's Hospital Review selected eight National Rural Health Association members for its 2016 edition of "100 great hospitals in America."

Those on this list are recognized for their history of innovation, top-notch patient care, clinical advancement, forward-thinking research and importance within their community.

Hospitals were selected based on rankings and awards received and are considered health care leaders in their region, state or the nation.

The list included the following NRHA members:

Billings (Mont.) Clinic
Medical University of South Carolina-Charleston
Oregon Health and Science University Hospital-Portland
University of California Davis Medical Center-Sacramento
University of Michigan-Ann Arbor
University of North Carolina-Chapel Hill
University of Tennessee-Knoxville
University of Texas M.D. Anderson Cancer Center-Houston

NRHA members make list of great places to work

Becker's Hospital Review compiled a list of highly ranked health care provider organizations including hospitals, health systems, ambulatory surgical centers, home health agencies and other health care-specific companies.

The editors' list considered organizations that submitted nominations, as well as those that received national, state or local recognition for workplace excellence, benefits offerings, wellness initiatives, efforts to improve professional development, diversity and inclusion, work-life balance and a sense of community among employees.

The magazine's 2016 list included the following National Rural Health Association members:

Athenahealth, Watertown, Mass.
CHG Healthcare Services, Salt Lake City
Elizabeth (N.Y.) Community Hospital
University of Texas M.D. Anderson Cancer Center-Houston

57 members among 'most wired' hospitals

Hospitals & Heath Networks Magazine's 18th annual Most Wired Hospitals and Health Systems survey shows that U.S. hospitals are tackling cybercrime, telehealth and predictive analytics.

Fifty-seven National Rural Health Association members were named on the 2016 list. The following NRHA members were included in each category:

Most Wired

Abraham Lincoln Memorial Hospital, Lincoln, Ill.
Adventist Health, Roseville, Calif.
Altru Health System, Grand Forks, N.D.
Avera Health, Sioux Falls, S.D.
Beaufort Memorial Hospital, Beaufort, S.C.
Bronson LakeView Hospital, Paw Paw, Mich.
Carilion Clinic, Roanoke, Va.
Carle Foundation Hospital, Urbana, Ill.
Central Maine Medical Center, Lewiston, Maine
Centura Health, Englewood, Colo.
Cibola General Hospital, Grants, N.M.
Citizens Memorial Hospital, Bolivar, Mo.
Community Hospital, McCook, Neb.
Coulee Medical Center, Grand Coulee, Wash.
Crawford Memorial Hospital, Robinson, Ill.
Fisher-Titus Medical Center, Norwalk, Ohio
Fort HealthCare, Fort Atkinson, Wis.
Fort Madison Community Hospital, Fort Madison, Iowa
Grundy County Memorial Hospital, Grundy Center, Iowa
Harrisburg Medical Center, Harrisburg, Ill.
Lakeland Health, St. Joseph, Mich.
Lake Regional Health System, Osage Beach, Mo.
Lincoln Hospital & North Basin Medical Clinics, Davenport, Wash.
Mason General Hospital, Shelton, Wash.

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Mercy, Chesterfield, Mo.
Mountain States Health Alliance, Johnson City, Tenn.
Nemaha County Hospital, Auburn, Neb.
Newport Hospital and Health Services, Newport, Wash.
Othello Community Hospital, Othello, Wash.
Otsego Memorial Hospital, Gaylord, Mich.
Pullman Regional Hospital, Pullman, Wash.
Saint Luke's Health System, Kansas City, Mo.
Sanford Health, Sioux Falls, S.D.
Sunnyside (Wash.) Community Hospital & Clinics
Susquehanna Health, Williamsport, Pa.
Tri-State Memorial Hospital, Clarkston, Wash.
University of Kansas Hospital, Kansas City, Kan.
Via Christi Health, Wichita, Kan.
Wake Forest Baptist Health, Winston-Salem, N.C.
Washington County Hospital & Nursing Home, Chatom, Ala.
Winner (S.D.) Regional Healthcare Center

Advanced

Altru Health System, Grand Forks, N.D.
Avera Health, Sioux Falls, S.D.
Mercy, Chesterfield, Mo.

Small and Rural

Columbia Memorial Hospital, Astoria, Ore.
Grande Ronde Hospital, La Grande, Ore.
Hammond-Henry Hospital, Geneseo, Ill.
Henry County Health Center, Mount Pleasant, Iowa
Indiana University Health Blackford Hospital, Hartford City, Ind.
Kalkaska (Mich.) Memorial Health Center
North Country Hospital and Health Center, Newport, Vt.
Tomah (Wis.) Memorial Hospital

Most Improved

Aroostook Medical Center, Presque Isle, Maine
Blue Hill (Maine) Memorial Hospital
Chadron (Neb.) Community Hospital and Health Services
Charles A. Dean Memorial Hospital, Greenville, Maine
Faith Regional Health Services, Norfolk, Neb.
New London (N.H.) Hospital
University of Texas MD Anderson Cancer Center, Houston
Winona (Minn.) Health

Send your career updates to editor@NRHArural.org.

NRHA news

NRHA announces new leadership

Leadership for the National Rural Health Association is secure for 2017 and beyond, thanks to recent elections for Board of Trustees and Rural Health Congress positions.

NRHA members chose Tommy Barnhart as president-elect. Barnhart, Ten Mile Enterprises president, will assume the duties of NRHA president in 2018.

"Although I've been involved in NRHA for many years, I don't recall a more exciting yet challenging time in rural health," he said. "The next couple years will be a pivotal time, and I look forward to the challenge – with our membership – to protect the health of rural Americans."

The following NRHA members were elected by their peers to serve in leadership roles:

Constituency Group chairs

Health Equity Council chair: Susan Kunz, Nogales, Ariz.
State Association Council chair: John Roberts, Lincoln, Neb.
State Office Council chair: Lynette Dickson, Grand Forks, N.D.
State Office Council vice chair: Margaret Brockman, Lincoln, Neb.

Rural Health Congress representatives

Hospitals and Community Health Systems:
Bill Auxier, Tampa, Fla.
Tommy Bartlett, Union, Miss.
Jennifer Dunn, Aurora, Colo.
Andy Fosmire, Oklahoma City, Okla.
Dale Gibbs, Kearny, Neb.
Jason Hawkins, McConnellsburg, Pa.
Jonathan Sprague, Bangor, Maine
Margaret Woeppel, Lincoln, Neb.
Brenda Wright, Kansas City, Mo.

Research and Education:
Mary Atkinson Smith, Starkville, Miss.

State Association Council:
Carol Galper, Hilo, Hawaii
Beionka Moore, Spokane, Wash.

Students:
Angela Bangs, Bozeman, Mt.
Cody Mullen, West Lafayette, Ind.
Jacob Thatcher, Yakima, Wash.

Elected in 2015, David Schmitz, MD, is serving as NRHA's 2017 president.

NRHA now accepting award nominations

The National Rural Health Association will accept nominations for its 2017 Rural Health Awards at RuralHealthWeb.org through Feb. 16.

Winners will be selected by a committee of NRHA members and honored during the 40th Annual Rural Health Conference May 9-12 in San Diego, Calif.

Each student award winner will also receive complimentary conference registration, a one-year NRHA membership and $1,000 from John Snow Inc.

Rural training track program concludes

The Rural Training Track Technical Assistance (RTT TA) Demonstration Program has concluded after six successful years of supporting the development and sustainability of rural training track programs.

The program, funded by the Federal Office of Rural Health Policy (FORHP) and administered by the National Rural Health Association, focused on supporting and developing "1-2" rural training track family medicine residency programs.

During the six years of the program, 13 new RTT programs were implemented and four more are set to open in July 2017. There was also a sustained rise in the number of positions available in these programs and an increased match rate for the positions, allowing for more family medicine residents to train in rural locations. In addition to direct technical assistance to programs and developing programs and student support for programs, the RTT TA also conducted research surrounding the impact of these residencies and their residents.

"NRHA is proud of its work with FORHP, the WWAMI Rural Health Research Center, the National Organization of State Offices of Rural Health, Ohio University, Family Medicine Residency of Idaho, Rural Health Information Hub, and the Robert Graham Center on this important project," says Laura Hudson, NRHA program services manager and RTT TA staff liaison. "This program supported not only the primary care residency programs and their staffs, faculty members, organizations and rural communities, but it also directly supported and encouraged medical students to train and remain in rural America. Although the program has concluded, NRHA remains committed to providing access to care for rural America."

To learn more about RTT programs, read student reflections about their rural rotations and apply for travel support, visit traindocsrural.org.

NRHA brings together rural primary care experts

The National Rural Health Association brought together 15 primary care experts including physicians, physician assistants, nurses, researchers and rural health clinic, community health center and state office of rural health leaders for the second Rural Primary Care Issue Group meeting in July in D.C.

Facilitated by David Schmitz, MD, the meeting was coordinated in conjunction with the Federal Office of Rural Health Policy (FORHP) as part of its cooperative agreement with NRHA and included agenda items such as the physician fee schedule, rural opioid abuse treatment, oral health, telehealth services, care coordination, and federal and private payer innovations.

These experts will serve as a rapid response group for NRHA and will

continues

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meet annually for the next three years to discuss rural primary care with NRHA and FORHP leadership.

"Primary care is the linchpin of the future health care structure," says Laura Hudson, NRHA program services manager. "Being able to bring together a group of primary care health professionals from across disciplines informs NRHA on true, real-time primary care successes and challenges in this new era of rural primary care. In turn, NRHA can continue to take that message back to our partners and Capitol Hill."

Submit poster proposals for NRHA events

The National Rural Health Association is accepting poster submissions though Jan. 26 for the 40th Annual Rural Health Conference and the Health Equity Conference.

Submit poster presentations for the 2017 Annual Conference at RuralHealthWeb.org/annual.

Poster proposals for the equity event can be submitted at RuralHealthWeb.org/equity through Jan. 26.

NRHA contributes to AHRQ report on telehealth outcomes

National Rural Health Association CEO Alan Morgan contributed key information and input to a recent Agency for Healthcare Research and Quality report: "Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews."

The brief was developed to provide an overview by creating an evidence map of systematic reviews published to date that assess the impact of telehealth on clinical outcomes.

In designing the study questions, the authors consulted several key informants, including Morgan, with diverse experiences and perspectives in implementing and evaluating telehealth.

accelerating advocacy

Washington is listening

The voice of rural America echoed loudly during the election.

Rural voters, like yourself, showed up in record numbers and shaped the outcome for both the White House and Congress. No matter your political persuasion, it's time for us to join our forces while the politically powerful are listening to rural America.

"This is an opportunity to help shape the agenda on health care in rural America," says Maggie Elehwany, National Rural Health Association government affairs vice president. "The new administration means there will be changes to rural health care, and it is important for rural to be at the table."

Now, more than ever, it is imperative to become engaged. Major health care policy is on a trajectory to change rapidly. The voice of rural health care must be loud to ensure access and affordability to all rural Americans.

And as our political leaders debate how to reinvigorate the economy and invest in infrastructure, we must remind them that rural health care is the critical component to a vibrant rural economy. Quality rural health care saves lives, provides skilled jobs, attracts businesses, and reinvests millions back into rural communities.

While our rural hospitals and health care providers continue to provide excellent health care with limited resources, we are in the midst of a crisis. Due to extensive federal cuts, 80 rural hospitals have closed since 2010. One in three rural hospitals is financially vulnerable, and at the current closure rate, more than 25 percent of rural hospitals will close in less than a decade. Closures of this magnitude will create a massive national crisis in access to emergency services and harm rural economies.

Join NRHA and advocates from across the country for the 28th Annual Rural Health Policy Institute Feb. 7-9 in Washington, D.C. It's the most important Policy Institute to date and your opportunity to deliver the powerful voice of rural to both the new administration and the new Congress.

Rural America, it's time to speak up. Washington is listening. Register today at RuralHealthWeb.org/pi.

Obama names NRHA to task force

The National Rural Health Association was proud to be named to President Barack Obama's Mental Health and Substance Use Disorder Parity Task Force.

As part of wider Administration efforts to expand access to treatment for people with mental health and substance use disorders, Obama signed a Presidential Memorandum in March.

The task force was created to focus key federal agencies on the work of ensuring that Americans receive the coverage and treatment that they need and issued a final report, available online, in October.

NRHA internships prove valuable to students

The National Rural Health Association has offered internships since 2005.

Because of NRHA's range of activities and programs, its internships have allowed students to pursue a project in an area of interest to them while participating in the overall NRHA experience.

Christopher Monse, a senior at the University of Missouri-Kansas City planning to become a physician assistant in rural practice, served as a fall intern.

He worked with NRHA's government affairs and program services teams and assisted with NRHA's Rural Health Clinic and Critical Access Hospital Conferences in September.

NRHA offers internships every semester in both our Midwest and D.C. offices and works with students to meet their internship requirements.

Learn more, apply and share this opportunity by visiting RuralHealthWeb.org/go/intern today.

Donor corner

Dennis Berens has given generously to the National Rural Health Association's Rural Health Foundation each year since it was established in 2012.

Berens, Nebraska Times founder and former, longtime Nebraska Office of Rural Health coordinator, served as NRHA president in 2010.

Rural Roads: Why is rural health important to you?

Berens: I have spent most of my life living and/or working in rural communities. Rural residents protect this piece of our nation and nurture it and each other. In rural, a sense of community often remains and is taught to the next generations.

I often call rural communities the "shelter belts of our nation." A place where we can recharge and really get to know and work with others on goals that enhance the broad definition of health. Health to me has always meant "when everything works." Rural areas know this because they see what happens when the connections of our neighborhoods, our jobs, our families and our bodies/minds become unhealthy. Rural is more than a place. It is a core piece of what our nation was, is and will be.

Rural Roads: Why do you support the Rural Health Foundation?

Berens: NRHA is one of those special communities that cares about what happens in rural areas and the people who live there. It takes volunteers, great staff and financial support to sustain this effort. My support comes because I believe in the mission and vision of NRHA and because of the great staff and members of NRHA.

Our challenge today is to communicate that rural matters by ensuring rural residents have their voices heard and their needs and visions acted upon. Education that creates knowledge and positive work is very important to me. I am so thankful that we have this foundation and the great leadership to guide it.

Rural Roads: Why would you encourage others to donate to this cause?

Berens: Donate because you know how important rural lives and communities are to your state and nation. Donate because you are part of this rural fellowship. Donate because you know NRHA will use your donations to help people and communities. Do it because you love rural.

NRHA thanks Dennis Berens for his ongoing contributions.

For more information and to help build a permanent endowment for rural leaders, visit RuralHealthWeb.org. Donations are tax-deductible.

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There's a new museum in town

After decades of dreaming and years of planning, President Obama led the dedication ceremony for the newest Smithsonian Institution, the long-awaited National Museum of African American History and Culture, in September.

The museum, located on the National Mall, has already collected more than 37,000 artifacts from 1750 to present day.

NRHA members in D.C. for the 28th Annual Rural Health Policy Institute (Feb. 7-9) have an opportunity to be a part of the opening year of the museum and experience some of its Black History Month programming.

Museum admission is free, but due to its popularity, same-day timed passes are available by visiting nmaahc.si.edu beginning at 6:30 a.m. daily. A limited number of walk-up passes will be available starting at 1 p.m. on weekdays.

National Museum of African American History and Culture

Off the beaten path

Petrified Wood Park

up to speed

NOvertime

Those who consistently put in more than a full work week (defined as 40 hours), are at a higher risk for a number of health concerns than those who don't, according to research shared by *Inc.* magazine.

Risks are wide-ranging and include a dependence on harmful substances, an increase in cardiovascular disease and a tendency toward weight gain in men and depression in women.

And if that's not enough to convince you to find a work-life balance, check out the research on productivity — or lack thereof — after 50 hours a week.

Over the (Cannonball) River and through the (petrified) woods

In Perkins County, S.D., roadtrippers can explore the "World's Largest Petrified Wood Park."

The park, including a wishing well and 300-ton castle, was conceptualized by Ole S. Quammen and constructed with more than 100 wooden pieces. This attraction takes up an entire city block in downtown Lemmon, population 1,127.

While the park's construction began in the early 1930s, the wood itself exhibits signs of dinosaurs and other fossilized life.

According to Roadside America, round rocks (also known as cannonballs) from North Dakota's Cannonball River were used to construct tree-shaped formations throughout the park.

National Rural Health Association

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