

# rural roads

Fall 2012 National Rural Health Association



## Farm calls

Nurses deliver dose of care to farmers

*New foundation supports rural leaders*

Clinton calls on NRHA for community health worker training

*Morris explains path from small-town sportswriter to ORHP head*

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## Incredible story

Thank you! I can't tell you how excited we are. The cover story, "The friendliest skies: Aviator angels transport rural patients," is incredible.

Lindsey Corey did a great job writing about the availability and importance of charitable flying, particularly in rural communities.

As was mentioned in the article, Angel Flight Northeast in Massachusetts and Life Line Pilots in Illinois are two of the more than 60 of these kinds of volunteer pilot organizations throughout the country. Thank you for including the Air Care Alliance website, [www.aircareall.org](http://www.aircareall.org), to help folks find the organizations nearest to them.

We hope National Rural Health Association members and advocates will remember these services when facing difficult medical travel challenges with rural patients. In addition, some of the groups fly children on introductory flights, transport animals to new locations, perform search and rescue, and support many other missions of community service.

Finally, congratulations on an excellent story.

Sincerely yours,

Rol Murrow, Air Care Alliance chairman, and  
Lindy Kirkland, president



## Pilot praise

I enjoyed your article, "The friendliest skies: Aviator angels transport rural patients." It was well-written and heartwarming.

Thanks for showing how the aircraft owner/pilot community contributes to rural health.

Paul D. Moore, DPh

2008 NRHA president and a pilot

## Indescribable value

I would like to take this moment to thank Lindsey Corey for writing and *Rural Roads* for publishing such a wonderful article about Angel Flight Northeast and the services we provide to those in need.

We were so excited and proud to see the piece in your 2012 summer edition with many of our patients featured, in particular Odin Robinson, who we hold near and dear to our hearts.

Your magazine is proudly displayed in our office, and everyone who stops to read it comments what a wonderful piece. The overwhelming comments are how the article really captured what Angel Flight Northeast's free air transportation services means to those who live remotely and are able to access life-saving medical care with our assistance.

Thank you again for spreading the word about our services and educating NRHA members about what we do and how we do it. If your piece allows us to help just one more patient and/or family member by providing free air transportation, then its value is more than words can ever describe.

Warmest regards,

Larry Camerlin

Angel Flight Northeast president

### Write us

*Rural Roads* is interested in the opinions of readers. Letters to the editor must be signed and may be edited for space and style.

Send your letter to [editor@NRHArural.org](mailto:editor@NRHArural.org) or *Rural Roads* editor, NRHA, 521 E. 63<sup>rd</sup> St., Kansas City, Mo., 64110.

## Honored to serve NRHA



As I type this last letter for *Rural Roads*, the one word that comes to mind is honor. I have been honored to serve as president in 2012, and I have been humbled as we have worked together to make rural America a better place to live.

You have taught me lessons I will take with me the rest of my life, and I have looked in your faces and seen the determination and dedication that have made this organization what it is, the premier voice for rural health in America.

We live in the greatest country in the world, and access to health care in rural areas is better because of our members. You have taken the time to meet, discuss, debate and fight for a worthy cause: access to quality health care for all people living in rural areas.

As this chapter ends for me, I want to thank you for reenergizing my hope that the future of rural health care is bright because of you.

Thank you for allowing me the honor to serve you and our great organization.

See you soon,

A handwritten signature in blue ink that reads "Lance".

Lance Keilers  
2012 NRHA president

## pit stop

# 5 things I picked up in this issue:

1. The head of the Office of Rural Health Policy started out as a small-town sports reporter. *page 37*
2. Community health workers often come by the gig by accident. *page 25*
3. You name it, there's a health-related app for that. *page 53*
4. NRHA's new Rural Health Foundation raised \$100,000 even before it officially launched. *page 22*
5. Your new NRHA president is a marathoner, hunter, fisher, grandma and more. *page 45*



*Dairy farmer Nathan Retzloff undergoes a free health assessment with Rhonda Strebel of the Wisconsin Rural Health Initiative. The initiative makes annual house – or barn – calls to farms.*

# Farm calls

## Nurses deliver free preventative care to farmers

By Lindsey V. Corey

Jim Fuhrman will concede he “might be stubborn.”

And that “might” keep this fourth-generation dairy farmer from going to the doctor’s office for a routine physical.

OK, it has: “Unless I’m bleeding profusely, I’m just not going to take the time to get cleaned up to get there and wait for 20 minutes, thinking ‘heck, I could’ve been doing something else.’”

Jim’s not alone.

“These farmers care more about animal health than their own,” says Rhonda Strebel, Wisconsin Rural Health Initiative (RHI) executive director.

So the RHI nurse goes to the Fuhrman farm – and more than 200 others in Shawano County – every year.

### Kitchen wellness

They call it kitchen wellness, although the health screenings, farm safety tips and referrals have been conducted in barns and even on a tractor.

“Aside from the convenience, it’s far more relaxing to be able to sit at your kitchen table to have your blood pressure taken and go through health questions,” Jim’s wife Diane says. “They’re easy to talk to. They grew up on farms and know what it’s like out here and that getting



*Top: Diane and Jim Fuhrman get a dose of “kitchen wellness” and nutrition guidance from Rhonda Strelbel of the Wisconsin Rural Health Initiative (RHI). Above: RHI has a booth at the Shawano Farmers’ Market to raise awareness for its free services. Volunteer Sam Crawford, executive director Rhonda Strelbel, Wendy Crawford and daughter Morgan help spread the word to other farm families.*

these guys to go into a doctor is next to impossible.”

In addition to that so-called stubbornness, farmers work long hours with unpredictable animals, large equipment and dangerous chemicals. They tend to be prideful and self-reliant, Strelbel explains.

Those conditions, plus the stresses of unpredictable weather, little control over pricing their products and geographic isolation, compelled a group of concerned citizens and providers to create RHI nine years ago, she says.

Eighteen percent of farm families have no insurance, and four out of five don’t have insurance that covers checkups and preventive care, according to RHI.

“We knew we couldn’t fix insurance, but we asked what can we do?” Strelbel recalls. “Hypertension, cholesterol and diabetes were three big concerns we could help with. But the farm women said screenings would be great, but the men aren’t going to go. We had to remove the barriers of time, distance and money so

the wife doesn’t have to fight to get them to a clinic.”

### Between-chore checkups

Farmers are used to what they need – from livestock feed to tractor tires – coming to them.

“So when I first started, I rode along with the vets and the milk man and supply trucks to get introduced,” Strelbel says. “They were already trusted people, and I would introduce myself and leave my contact information. Little by little, people started calling, and pretty soon there I was at their kitchen table checking their blood pressure between chores.”

For the first few years, that was Strelbel’s job. But word of mouth spread and the program grew, so Dawn Dingeldein, a registered nurse and self-proclaimed “early bird farm girl at heart,” was hired to handle farm visits so Strelbel could focus on fundraising and coordination.

Adults in the home and on the farm undergo blood pressure, glucose and cholesterol testing and get results – that can easily be shared with nearby physicians – within 10 minutes.

“But I’m there as long as we need to be, no waiting because I get there on their schedule, and the only time they feel rushed is if they have chores that are calling them,” Dingeldein says. “I can sit at their table and have a teachable moment about their lifestyle and start reading labels on packages of things already right there in their home, where they’re most comfortable.”

Diane has lost more than 50 pounds, thanks to advice on diet and exercise from Strelbel, she says.

“A lot of farmers out here have grown up with a lot of cooking with butter and cheese, big portions or meat and potatoes,” she says. “But the whole family has learned to cut down the size, to steam vegetables instead of covering them with butter and make better choices food-wise than I think we would have had we not been involved in the program.”

**“Aside from the convenience, it’s far more relaxing to be able to sit at your kitchen table to have your blood pressure taken and go through health questions.”**  
Diane Fuhrman, Rural Health Initiative participant

At his annual kitchen table screening, Jim learned his cholesterol was a little high.

“She advised us on how to change our eating habits and what to stay away from,” he says. “I’ll admit I don’t follow that like I should; I’d miss the heavy gravy, but I did see a doctor and go on medicine to help keep my cholesterol in check.”

### Open to all

About 325 families – or 40 percent of the farm families in the county – participate in the program in some way each year, and there are 200 farm



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*Rhonda Strebel checks Alvin Bartz' glucose levels during an annual preventative health visit to his rural Wisconsin farm.*

visits with 400 to 500 individual screenings annually. Of those, Strebel says about half receive a referral, and 97 percent of those follow up on the referral with a physician like Jim did. Some call Dingeldein's house at night, but she doesn't mind.

"They see us as a very trusted source because of the relationships we've built," Strebel says. "We're finding at least 15 cases a year of something very serious that they had no idea was happening and another 45 cases of things that need some type of referral that they had no idea of. It's hard to measure what you prevented from happening, but we know we're saving people emergency room visits and possibly lives."

A local domestic violence shelter called Strebel when a woman decided to return to her farm.

"They knew once she went back, they couldn't have contact with her, so her and I set up a plan that if she called and said 'I need my blood pressure checked,' it meant that she needed help," Strebel says.

The woman eventually left her husband and now goes to Strebel's office for health checks.

Any adult connected to agriculture can receive RHI screenings and social services referrals at no charge. It took more than a year, but Strebel personally introduced Dingeldein to all of the people she'd visited.

"We see Amish, family farms, large dairies with Hispanic workers and their families, retired farmers, a grandma who lives in a house on the land. At one farm, we see four generations while there," she says. "It's for any farmer, not poor farms, so it doesn't feel like a charity or anyone is singled out."

Some of the farmers financially support the nonprofit initiative. Some give Dingeldein pickled asparagus, she says with a chuckle. Local health care systems, the public health department and agribusinesses provide the majority of necessary funds. And an annual fundraiser brings in about \$15,000.

In February, two neighboring counties – Outagamie and Waupaca – in Northeast Wisconsin and a part-time nurse for each were added to the program. Waupaca farm families hosted a barn dance that raised \$7,500 and helped spread the news.

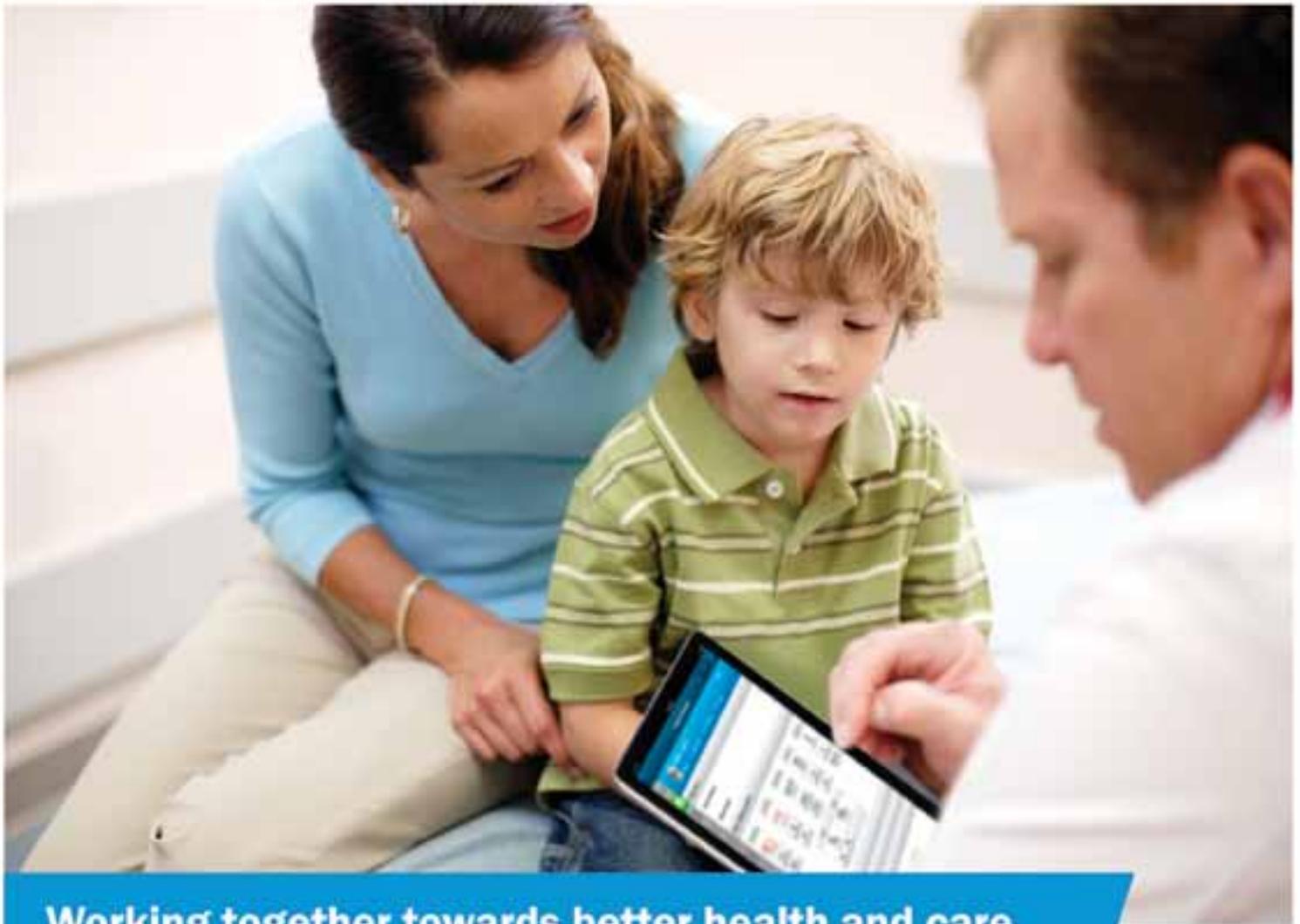
"It was a dream come true to reach a point of success where other communities want to replicate what we do," Strebel says. "Agriculture is an important industry in Wisconsin. We need to give back to keep them healthy and safe." 

## Nurses' chore list

Wisconsin Rural Health Initiative nurses visit farms to:

- Help farm families understand their health risks
- Provide farm and home safety assessments and information from sun protection suggestions and smoking cessation tools to CPR training and child development guidance
- Conduct cholesterol, diabetes and blood pressure screenings
- Provide information and referrals for:
  - health services in the community
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# Across cultures

## IHS practitioners' diverse heritages enhance patient interaction

By Jacquie Goetz Bluethmann



*Adams Solola, a pharmacist from Nigeria, greets a patient at Sells Indian Health Services Hospital in rural Arizona.*

Growing up in the Nigerian countryside, Lt. Cmdr. Adams Solola is no stranger to living in remote areas far from the hustle and bustle of city life.

This is perhaps why his move in 2009 from urban Delaware to rural Tuba City, Ariz., to practice with the Indian Health Service (IHS), wasn't a culture shock.

### A warm welcome

Solola, PharmD, a pharmacist and member of the U.S. Public Health Service Commissioned Corps, welcomed the change of pace and the opportunity to interact with a patient population whose culture shares characteristics with his own.

"In Nigeria, we are very welcoming of visitors," Solola explains. "We're open to new people and are open-minded in general."

Solola says he was greeted with similar hospitality by the Hopi and Navajo patients he met on his first assignment in Tuba City, population 8,611, from 2010 to 2011. Now, as director of pharmacy at the Sells IHS Hospital in Sells, Ariz., population 2,495, Solola experiences that same welcome from Tohono O'odham Tribe patients.

"I am African-American. I have an accent, but I have been nothing but welcomed," he says.

And though he is a visitor, Solola has become an accepted member of the Native American communities in which he serves. He says he found himself greeting patients on a first-name basis not long after his arrival.

"My background and theirs are very similar," says Solola, who joined the Commissioned Corps to achieve one of his personal goals of becoming an officer while furthering his pharmacy career.

## Improve access and outcomes

Learn more about Native American health care, health education on reservations and initiatives to improve access and outcomes for all underserved rural residents during the National Rural Health Association's 18th annual Rural Multiracial and Multicultural Health Conference Dec. 4-6 in Asheville, N.C.

The nation's only educational event aimed at eliminating health disparities for rural multiracial and multicultural populations will begin with members of the local Lumbee Tribe blessing the NRHA conference.

Visit [RuralHealthWeb.org/mm](http://RuralHealthWeb.org/mm) for the conference agenda and to register.

## Similar traditions, different cultures

Lt. Inna Voinich, PharmD, who hails from what is now known as the Russian Federation, was also warmly welcomed into an American Indian community. And like Solola, Voinich says her heritage helps her relate more closely to patients from the Jicarilla Apache Tribe with whom she interacts daily at the Jicarilla Apache Health Care Facility in Dulce, N.M., population 2,263.

As within the Russian culture, family is very important to Native Americans, Voinich quickly noticed.

**“People see that you’re staying, and they become open to sharing their lives. In turn, they want to know about yours. Over and over, we find we have mutual interests.”**

*Inna Voinich, Jicarilla Apache Health Care Facility pharmacist from the Russian Federation*

“Many times patients will have multiple family members with them for even routine doctor appointments,” she says.

Voinich has also been struck by the deep respect for elders within the Native American community.

“Children and grandchildren bring elderly family members into their homes,” she explains. “This is much like it is in Russian culture. In Russia, there are no nursing homes. At the end of a family member’s life, that person comes into your home.”

Voinich’s motivation for pursuing a pharmacy degree and working in the tribal health system was to serve a patient population in need of medical services.

“Native Americans are among the people who need my help the most – especially those in remote areas,” she says.

While completing a required internship for her doctorate program at the Massachusetts College of Pharmacy, Voinich saw an Indian Health Service ad in *Pharmacy Today* magazine. She says she became fascinated by the culture and was eager to learn more about their health care options. After doing some

additional research, she made the decision to join IHS as a Commissioned Corps officer – a move she says she’s never regretted.

“Native Americans are open to sharing their culture with anyone who is interested,” she says.

Likewise, Voinich is able to share her heritage with an eager audience.

“My patients are often surprised when they meet me and hear my accent,” she says. “They have never seen a Russian person

and often ask why I came here. I tell them stories. I talk about the Itelmen and Eskimo tribes present in the northern part of Russia, many of whom have similar facial features as Native Americans. They’re always surprised to hear that.”

This mutual sharing forges a connection, she says.

“Over and over, we find we have mutual interests,” Voinich explains. “People see that you’re staying, and they become open to sharing their lives. In turn, they want to know about yours.”

After work, Voinich volunteers with the Jicarilla Student Residence, a home for children unable to live with their parents. In addition to discussing health care topics, she shares with them stories of her Russian culture.

Voinich says she’s been pleasantly surprised by how warm and welcoming the Jicarilla people have been and how quickly she has adapted to the “slow pace” of Dulce.

“I lived simply in Russia. Most people there do,” she says. “Native Americans also live simply, and I can appreciate that.”

*Jacque Goetz Bluethmann is a writer for Horne Creative Group, hired by Indian Health Service, a division of the U.S. Department of Health and Human Services.*



*Inna Voinich, a pharmacist from the Russian Federation, works with patients and physicians at the Jicarilla Apache Health Care Facility in New Mexico.*



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*Gage Dover, 6, and his brother Wyatt, 3, were ready to roll at the grand opening of the Poplar Bluff Skate Plaza in southeast Missouri.*

# Ready to roll

Rural community comes together to create skate park

By Julia M. Johnson

As high obesity rates continue to threaten the nation's health, it's clear kids need guidance on nutrition and exercise from an early age.

While there's plenty to be said for traditional classroom instruction on healthy living, one southeast Missouri town of 17,000 residents found a way to make it fun for young people to head outside and burn calories.

Theirs is not the most traditional solution to sedentary lifestyle trends, but that's a big part of its appeal.

In July, about 350 skaters and community members attended the Poplar Bluff Skate Plaza grand opening celebration.

The 19,000-square-foot plaza is pedestrian-friendly and smoke-free; it's located in the heart of downtown and includes green space and room for spectators.

## Pulling it together

The plaza's design and construction were supported by a \$250,000 grant from the Missouri Foundation for Health (MFH), under the foundation's Healthy and Active Communities funding program. Poplar Bluffs Parks Department funding and private donations rounded out the project's total \$450,000 price tag.

*continues*



Residents look on as a skateboarder shows off his skills at the Poplar Bluff Skate Plaza.

Parks Department director Clark Allen describes it as “a skateable park setting with color and landscaping, and a sculptural, artsy look.” There are trees and flowering plants, and plenty of lawn area to go with the jumps, ramps, steps, railings and other skate-friendly features.

Allen expects the plaza will be used by kids on wheels 90 percent of the time, but it’s also an attractive spot where locals can take a break or eat lunch. And it’s a plus for downtown merchants looking to draw traffic.

**“It’s a positive thing for the community, and it’s good exercise.”**

**Justin Stevenson, 17**

According to Allen, the community’s youth were involved in

the project from the outset. They proposed the idea to the Parks Department, and were invited to planning meetings to sketch what they wanted to see in the plaza. All their ideas were taken into consideration.

Then, professional sport designers were chosen to bring the ideas to reality and ensure the park can host skate competitions and other events.

MFH program officer Amy Stringer Hessel spoke at the grand opening, and was struck by the level of excitement the park has generated.

“It’s so strongly embraced here because it’s not just for the skaters, it’s also for families,” she says. “People even drove in from outlying areas. They were able to see that a high quality skate park really can happen in smaller communities – and that they deserve it.”

### Taking the hurdles

The skate plaza’s planning process was a long one, and it proved frustrating at times, Allen says. But he and the park board were committed, and their persistence paid off.

“We’d had an interest in developing a skate plaza for about eight years,” he says. But an original site choice fell through, and Allen’s office applied for some grant and tax credit funding without success. And once construction began at the downtown site, there were problems with old tanks discovered underground.

“Things like that slowed our progress, but we kept at it. We got photos and ideas from all over the U.S. and Canada,” Allen says. “Our plan was to



Residents receive a tour of the new Poplar Bluff Skate Plaza from ASD/Stantec lead designer Kanten Russell (center, with microphone).



The new downtown skate park has become a popular hangout for boarders of all ages and skill levels.

accomplish more than a skate park.”

The project also is designed as a springboard for lifelong wellness. As skaters move around the park, take jumps and stay in motion, they’re building a culture of daily physical activity, which contributes to better health, Stringer Hessel says.

### Spreading the word

As other communities consider similar plans, Jan Neitzert, Missouri Park and Recreation Association executive director, hopes planners will remember that each project must involve its users from the start.

**“A high quality skate park really can happen in smaller communities – and they deserve it.”**

**Amy Stringer Hessel, Missouri Foundation for Health Healthy and Active Communities program officer**

“Two things stood out about this plan,” says Neitzert. “There were no ‘higher powers’ imposing their vision, so there’s real pride of ownership. And the plaza is in the middle of downtown, which is a tremendous reminder that this is a community project.

“People may have presuppositions of crime, smoking and graffiti with a project like Poplar Bluff’s,” Neitzert adds. “This was an opportunity to prove instead that skaters have a legitimate sport, a stringent skill set, and professional organizations behind them. Maybe not every young person will skate, but it’s also a great place for healthy social interaction.”

To ensure the plaza is welcoming to everyone, stereotypes must be left at the curb, Neitzert says. She admires the fact that it wasn’t built on the outskirts of town, which could have sent a negative message about skaters’ level of welcome.

“It’s a positive thing for the community, and it’s good exercise,” says Justin Stevenson, 17, a senior at Poplar Bluff High School. “I use it almost every day. And younger kids are getting into it and skating more. It’s great to have a place to skate without worrying about getting kicked out or getting in trouble.” 

*Julia M. Johnson is communications and media specialist for the St. Louis-based Missouri Foundation for Health.*

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# Caring for the future of rural America

New NRHA foundation raises \$100,000-plus

By Lindsey V. Corey



## Give back, move forward

Together, we can continue to protect and advance rural health through NRHA's new nonprofit foundation.

NRHA offers secure online giving at [RuralHealthWeb.org](http://RuralHealthWeb.org). Just click on the "donate" tab, where you can also learn more about the foundation in a short video featuring several founding donors.

Or send your tax-deductible donations to NRHA Rural Health Foundation, 521 E. 63rd St., Kansas City, Mo., 64110.

Please give whatever you can. All 2012 contributors will be recognized in the next issue of *Rural Roads* magazine.

The National Rural Health Association's first foundation had strong support even before its public launch.

"We're proud to report that NRHA leadership and staff have started the ball rolling with their donations and pledges, totaling more than \$100,000," Lance Keilers, NRHA's 2012 president, told 650 attendees of the association's Rural Health Clinic and Critical Access Hospital Conferences in September.

**"A key responsibility of those here now is to support the mentoring of tomorrow's leaders."**

*Tim Size, Rural Health Foundation co-chair*

Through the new Rural Health Foundation, NRHA is on its way to establishing a permanent endowment to educate and empower rural leaders for generations to come.

"A key responsibility of those here now is to support the mentoring of tomorrow's leaders," says Tim Size, foundation co-chair. "Rural leaders will arrive without the assistance of any of us, but leadership development will foster more effective and diverse leadership. NRHA's foundation will identify current and emerging leaders from and for rural communities and provide them with additional training and resources to help ensure access to quality health care in their states and communities."

Why now?

"We're at the point of 'what's the next big step we could take as NRHA to advance the goal of rural health?'" says Keith Mueller, foundation co-chair. "This is it: creating a foundation and building that foundation so it becomes a permanent source of financial support to sustain the high quality of life in rural places through the roles rural health leaders have on behalf of everyone who lives in rural communities."



NRHA 2012 president Lance Keilers and NRHA CEO Alan Morgan show conference attendees autographed sports memorabilia raffled off to raise money for the Rural Health Foundation.

Both Mueller and Size say they're pleased with the seed money contributed to the Rural Health Foundation and optimistic about its long-term potential.

"This is an effort that really has no limit," Mueller says. "The more we grow this foundation, the more effective it will be, and therefore, the better off our rural communities will be because we'll have leaders out there who will help transition rural communities through changes and sustain a rural health care delivery infrastructure that's vital for those communities and people living in them."

The Rural Health Foundation's co-chairs, also founding members of NRHA, see this as another opportunity to give back to the association.

"Next year is the 35th anniversary of our association, and this endeavor is an exciting way to celebrate this milestone anniversary," Size says.

"If you have not already supported NRHA in this way, we hope you'll consider becoming a part of this historic initiative by contributing now. Together, through this new foundation, we can help make a real difference in rural America." 

## Supporter spotlight



"I am honored and pleased to support the Rural Health Foundation to provide for the long-term viability for NRHA in its role as the leading voice of rural health in America. Please join us in ensuring that voice is always strong to protect equality, access and quality for rural Americans."

*George N. Miller Jr., Okmulgee Memorial Hospital CEO*



"I have not seen a more critical juncture in health care since joining the industry 25 years ago. Now more than ever, rural communities need strong leadership if we are to successfully navigate through this time of transformation.

NRHA's Rural Health Foundation is an investment in that future."

*Jodi Schmidt, Labette Health president and CEO*



"In a world with instant communication and rapid transitions, the need for wise leadership is more important than ever. Rural communities matter, and we need leaders to identify how to help communities to provide for the health and

health care matters of their citizens. I believe in the importance of this work and choose to invest in this effort through the foundation. Please consider your own investment in the future of rural people and places."

*Dennis Berens, Nebraska Times rural and rural health consultant*

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## Training the trainers

### NRHA exceeds Clinton Global Initiative goal educating community health workers

By Lindsey V. Corey



Attendees participate in group activities to learn about diabetic eye care during the NRHA Community Health Worker Training in June in El Paso, Texas.



Gerardo Torres

**A year ago, Gerardo Torres didn't know a thing about blood sugars and had never heard of a promotora. But after being diagnosed with type 2 diabetes, this handyman became one.**

The doctor's words terrified the otherwise healthy 40-year-old immigrant. So he sought out free classes to educate himself, classes he says could have prevented his diagnosis.

Today, Gerardo volunteers as a promotora – or community health worker – educating other Hispanic-Americans about disease prevention and management.

"It's a way for me to give back to my community," he says. "I think it's very important for our community to be aware this can be prevented. You don't have to deal with pills, injections and the aftermath of a diagnosis. You can prevent this."

Gerardo, who is successfully managing his diabetes

with diet and exercise, says sharing his story "makes a big difference" to people he meets at health fairs and classes, to his neighbors and for himself.

"People are surprised when I tell them I have diabetes," he says. "That and being a part of the community and understanding the culture really help them to relate, and it gives me more incentive to be healthier so I can show them they can be too. I want to be an inspiration for them."

#### Building a community of community health workers

Gerardo was one of 98 promotoras to participate in one of three trainings this year organized by the National Rural Health Association to help recruit and retain community health workers in rural and underserved areas along the U.S.-Mexico border.

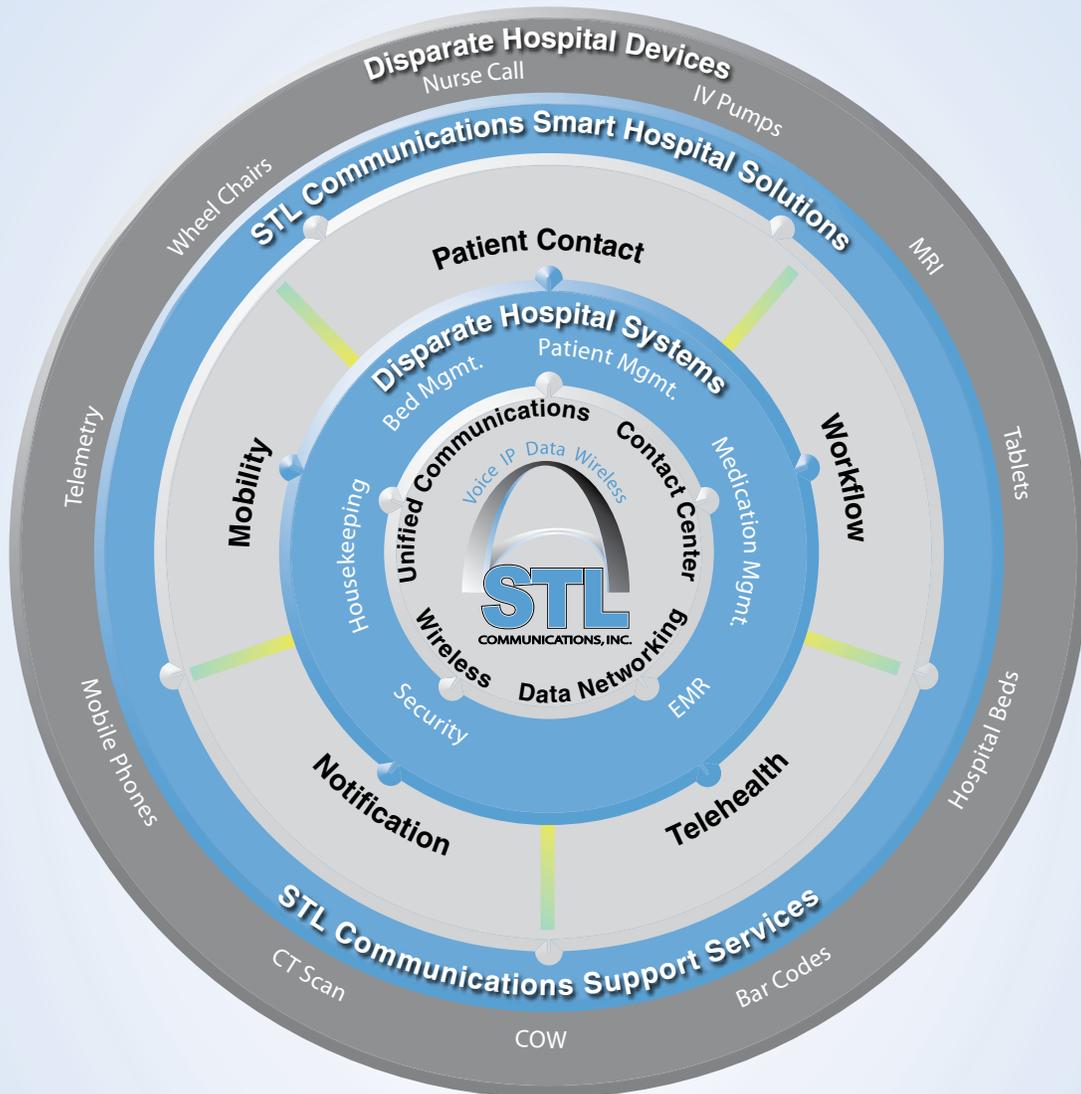
NRHA is working with the U.S.-Mexico Border Health Commission (BHC), the Office of Rural Health Policy as well as state partners to help enhance access to care, as part of a Commitment to Action that stemmed from NRHA's participation at the 2011 Clinton Global Initiative-America (CGI) meeting.

"Since April, NRHA has provided community health workers like Gerardo with training and follow up," says Amy Elizondo, NRHA's program services vice president who attended the CGI meeting. "The trainings have covered topics such as leadership, cancer prevention and diabetes care, and through

*continues on page 28*

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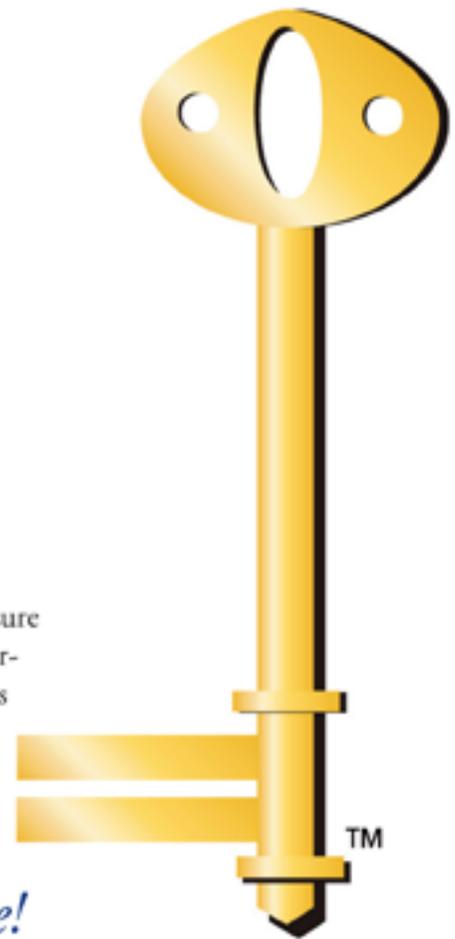
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You can also find the latest Joint Commission Top Performers on Key Quality Measures™ at [www.jointcommission.org/accreditation/top\\_performers.aspx](http://www.jointcommission.org/accreditation/top_performers.aspx).

continued from page 25

the community health workers, will support the growing needs within the rural and underserved areas of along the border.”

Trainings were led by Emma Torres, a longtime promotora and a BHC member, in English and Spanish. Native American tribal representatives also participated.

**“It’s unique to be a man in this job, but we are affected by these illnesses too. It’s not a women’s issue; it’s a public health issue.”**

**Gerardo Torres, volunteer community health worker**

“The work they do and how they mobilize their community is incredible, and I think I was able to validate that,” she says. “It was very powerful that they felt needed, recognized and gained an understanding that they are part of a bigger movement.”

NRHA secured funding travel expenses for community health

workers to attend each training, support for facilitators and support for completing evaluations of the trainings to assess outcomes. The association’s initial goal was to train 60 community health workers working along the border. Trainings took place in Denver in April, in El Paso, Texas, in June, and in San Diego in August.

NRHA plans to expand its efforts in 2013 to train promotoras in some of the poorest counties along the border to more directly track the impact of these workshops.

“The National Rural Health Association is both humbled and excited to be able to offer this opportunity to participants who may not otherwise have this experience,” says Alan Morgan, NRHA CEO.

Emma is grateful for the opportunity too.

“Having a national association and the Clinton Global

## The making of a promotora



Emma Torres immigrated to America from Mexico when she was 11 and quit school just a year later, barely able to speak English.

That didn’t matter much on the farm.

That’s where her family worked and where she would meet the man she married at 19.

Five years later he died of leukemia, and Emma was left with a 4-year-old little girl and a 3-week-old son.

“Among the dark times, the hospital social workers were my angels,” she recalls. “I was amazed at how they helped me. And I thought, if I got to live my life again and choose, I would be a social worker.”

Fearful but determined, Emma enrolled in night school.

“That’s when I realized I wasn’t that dumb,” she says. “When you have no formal education, you think you’re pretty dumb. But I had a lot of other education and motivation to learn about prevention and health promotion after my husband’s death.”

The single mom went on to earn her master’s degree in social work and founded Campesinos Sin Fronteras, a community-

based organization primarily helping with migrant workers in Somerton, Ariz. Along the way, she became a volunteer promotora, or community health worker, before there was a word for it.

Today, Emma seeks out others like her, those with a desire to help their neighbors lead healthier lives. She tells them her story, leads workshops and makes connections to education and health care that have the power to change lives.

“A lot are parents and naturally have an interest in improving children’s health or preventing obesity; there may be a cancer survivor who wants to educate their community or a person that wants to help because their parents died of diabetes,” she says. “A lot of them come to me and say, ‘I know how to do this; help me serve, and help me learn more’. I hope to help them understand how critical and important they are to their communities.”

She arms them with purpose, confidence and information.

“They’re smart and natural problem-solvers, and they can take the knowledge I share and share it further,” Emma says. “This is a model that works with our population. I know. I’ve seen it change my life.”

Once a promotora, always a promotora, Emma says of the path she paved 25 years ago.

“Promotora means health promoter,” she says. “It doesn’t matter what level you are. I am proud to be on the U.S.-Mexico Border Health Commission, and I continue to be a health promoter.”

— Lindsey V. Corey



Above: Community health workers from New Mexico and Texas receive training in leadership, diabetic eye care and HPV prevention in June in El Paso, Texas. Left: President Bill Clinton commences the second annual Clinton Global Initiative-America Meeting in June in Chicago.



Initiative behind this model is so powerful,” she says. “This is community empowerment about helping people help themselves. It’s the American way I learned when I came to this country: I will help you to help others. That’s what promotoras do. And it works.”

### Ancient concept gaining momentum

Emma, who has been a promotora for more than 25 years, says she’s thrilled the ancient concept is gaining momentum and support from the medical community, who now realize promotoras don’t give medical advice but rather promote healthy choices, connect neighbors to physicians and encourage treatment compliance.

“It’s a very grassroots model that initiated here in

Arizona about 25 years ago, but it’s a very old practice where people in villages help themselves, identify people with natural leadership who are already natural helpers, and they respond to help their community. Latinos and Native Americans have done this forever,” she says. “We have come a long way from being seen as ‘those tobacco women’ to getting national attention because research is starting to show our impact in reaching and helping minority people in economical and culturally competent ways.”

**“This is community empowerment about helping people help themselves. It’s the American way I learned when I came to this country: I will help you to help others. That’s what promotoras do. And it works.”**  
Emma Torres, community health worker training facilitator

Emma says Gerardo is one of those “natural helpers.”

“I don’t recruit promotoras through newspapers or anything,” says Emma, who founded Campesinos Sin Fronteras, a community-based organization in Somerton, Ariz., working primarily with migrant workers. “I still use the old-fashioned model that we began with in 1987. I speak directly to the population that we need to serve, people who have the respect of the community, who really know them and can reach them. They are already serving in a way, so I train them so they are better prepared to serve their communities.”

Gerardo says being a promotora is the most rewarding thing he’s ever done, and he wishes more men stepped up to the task.

“It’s unique to be a man in this job, but we are affected by these illnesses too. It’s not a women’s issue; it’s a public health issue,” he says. “My favorite part is when I see the people later and the little changes they have made in their lives that are making a difference.” 



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## CHANGES will do you good

### Grant project addresses rural America's unique health care challenges

By Angela Lutz



*Bryant Smalley met Health and Human Services Secretary Kathleen Sebelius during a recent White House Rural Council meeting.*

Many people in rural Southeast Georgia say they lack the basic resources and support to manage their chronic health conditions.

That's what Bryant Smalley, PhD, PsyD, discovered when he started working on the Community Health Access Network for Grassroots Education and Screening (CHANGES) project in 2009.

"We discovered more and more community members who had previously been diagnosed with diabetes but didn't feel they had the support they needed in managing the behavioral and lifestyle changes necessary for effective management of their condition," Smalley says. "Our entire service area is a primary care health professional shortage area, and the availability of diabetes education programs in particular is heavily limited."

Smalley is co-executive director of the Rural Health Research Institute and professor and director of clinical training in psychology at Georgia Southern University in Statesboro. He and his partners at the university received a \$308,000 Rural Health Outreach Grant through the Health Resources and Services Administration's Office of Rural Health Policy (ORHP) to fund CHANGES from

2009 to 2012.

With the funds, they attended health fairs to conduct health screenings and educate patients on how to manage common, chronic mental and physical ailments, such as obesity, depression, anxiety and diabetes. Through their efforts, many rural residents gained access to the same basic health care services that are available in the state's population centers and learned effective strategies for managing their conditions. The project also provided referrals to doctors and mental health care providers when necessary.

"The health ministry building activities focused on increasing access to support for diet and exercise change, including establishing a walking program and promoting overall wellness activities," says Valerie Darden, U.S. Public Health Service captain and ORHP project officer, who provided support to CHANGES. "The project also sought to link participants to appropriate health care providers through the university-run community psychology clinic and [provide referrals]."

**"Much of the program's activities are conducted by volunteer students from the parent university, which allows us to combine their passion for giving back with the needs within the community."**

**Bryant Smalley, Rural Health Research Institute co-executive director and Georgia Southern University professor and director of clinical training in psychology**

CHANGES is one example of how Rural Health Outreach Grants allow rural communities to take advantage of government resources to design and implement projects tailored to their unique needs. Most other federal grants require that specific needs are identified before funds will be awarded, which can be challenging in rural areas, where needs can differ vastly from one area to the next, according to Kathryn Umali, ORHP community-based deputy director and outreach program coordinator.

"The needs of a rural community in Mississippi may be vastly different than the needs of a rural community in Alaska," Umali says. "As a result, categorical funding defined the community's need rather than the need defining the response. The outreach program provided the non-categorical funding mechanism that rural communities needed."

*continues*

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The program was founded in 1991, and in 2012, 71 grants were awarded. Each grantee will receive approximately \$450,000 over a three-year period to improve health care services and outreach to populations including, but not limited to, low-income families and individuals, the elderly, pregnant women, infants, adolescents, minorities and individuals with special health care needs. The outreach grant projects emphasize health outcomes and sustainability. Whether the project can be replicated and used as a model for other rural communities is also an important component.

“Proposed projects have an outcomes-oriented approach that will enhance and sustain the delivery of effective health care in rural communities by tracking specific health indicators that will demonstrate the impact of their project at the end of their grant period,” Umali says. “They are based on evidence-based or promising practice models in order to avoid reinventing the wheel.”

Smalley designed CHANGES with sustainability in mind by utilizing his most valuable and readily available resource: students at Georgia Southern University.

“We are thrilled to have been able to sustain all of the grant’s activities by building for sustainability from the inception of the project,” he says. “Much of the program’s activities are conducted by volunteer students from the parent university, which allows us to combine their passion for giving back with the needs within the community.”

Through their work with CHANGES, Smalley and his team were able to establish a trusted presence within the communities they serve, which enabled them to secure another three-year outreach grant to fund a new project, the Applied Diabetes Education Program using Telehealth (ADEPT). They will receive \$450,000 from 2012 to 2015 to serve the four-county region surrounding Bulloch County, Ga., with a population of nearly 90,000.

According to Smalley, ADEPT “will use interactive teleconferencing software to connect a distance-based diabetes educator with patients in clinic locations that would typically require hours of travel to reach.” Many of ADEPT’s education and outreach efforts will take place at federally qualified health centers. Technology will also

track patients’ progress to identify specific areas in which they might require support, including rural-specific education and self-management.

“We combined the demonstrated need with community input and the known positive impacts of telehealth approaches in rural communities to develop the model that will be implemented in Project ADEPT,” Smalley says. “By centralizing access to a diabetes educator who can provide technology-facilitated education to patients in several rural counties the transportation burden that is so prevalent in rural areas can be substantially lessened both for the patient and for the educator.”

Though ADEPT is still in its implementation phases, Smalley is already looking toward sustainability, particularly by encouraging diabetes educators to complete pre-certification hours to become certified diabetes instructors, which then allows them to bill for services. Smalley and his team will also be measuring short- and long-term outcomes to help demonstrate to each individual community the importance of maintaining the program. They can’t wait to get started.

“We are still in the early phases of implementing Project ADEPT, and it has been extremely rewarding to see the energy and excitement of all of the partners in getting everything up and running,” Smalley says. “The need within the community was so large that everyone is just thrilled to see things coming together.” 

## Rural health care in the House

The National Rural Health Association was there when rural health stakeholders were invited to the White House earlier this year to meet with members of the White House Rural Council, created by President Barack Obama in 2011 to enhance federal programs serving rural communities.

The group of only 24 rural health leaders also included Bryant Smalley, co-executive director of the Rural Health Research Institute and professor and director of clinical training in psychology at Georgia Southern University.

Smalley is part of a team at Georgia Southern University that has received two Rural Health Outreach Grants through the Health Resources and Services Administration’s Office of Rural Health Policy to reduce health care disparities and provide education and outreach in rural Southeast Georgia.

At the meeting, hosts Kathleen Sebelius, U.S. Health and Human Services secretary, and Tom Vilsack, U.S. Department of Agriculture secretary, announced new rural health care innovations, discussed rural America’s unique health care challenges and explained the role of the Affordable Care Act in addressing those challenges. Other attendees included rural physicians, nurses, mental health experts and hospital administrators from across the country. NRHA CEO Alan Morgan was also there.

“We are pleased that the Administration has taken an active role in the future of rural health care through the creation of the Rural Council,” Morgan says. “NRHA is honored to represent the interests of its members and rural America at the White House.”

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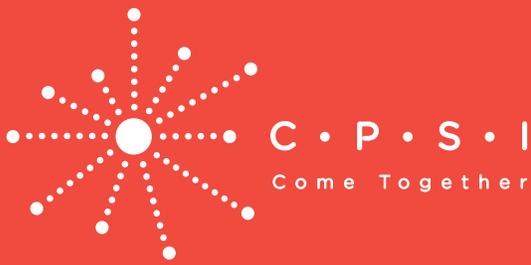
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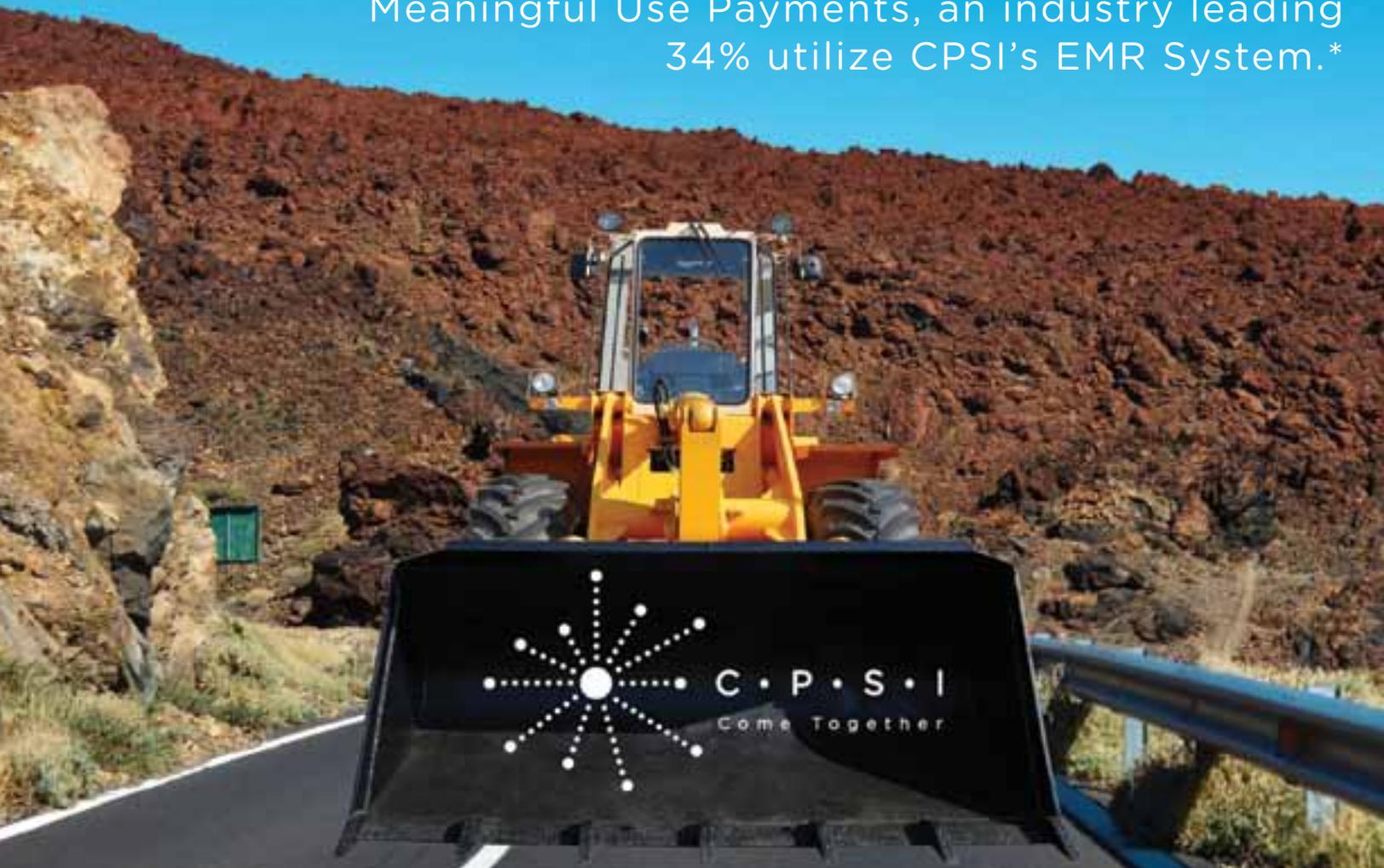


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# Beginnings & Passages



David Blackley

“Rural public health systems are asked to respond to unique local needs, but without solid data, these communities can’t fully understand the challenges they face.”

## Looking beyond access to care

By David Blackley

I first became aware of “rural health” as a career during a presentation by Tom Morris of the Office of Rural Health Policy (ORHP). I’d recently started graduate school, and knew nothing about policy, but I was intrigued.

I asked Tom about internship opportunities, and within weeks I was planning for a summer in Washington. At ORHP, I was exposed to the policy side of rural health, and I left considering other ways to get involved closer to home.

The next year, I applied to study epidemiology at East Tennessee State University and started working with Bruce Behringer, a national authority on rural health matters. We developed datasets to characterize health disparities in the Appalachian region, focusing on chronic conditions like lung cancer, heart disease and diabetes. For most outcome measures, the same clusters of rural Appalachian counties were the worst performers. Many of these counties were among the least healthy in the nation.

Most rural health initiatives focus on improving access to care. This is important, but assessment and prevention are often ignored. Reliable statistics on the health of Appalachian residents are scarce. Rural public health systems are asked to respond to unique local needs, but without solid data, these communities can’t fully understand the challenges they face.

America’s early public health infrastructure focused on “urban” problems associated with poor sanitation and cramped living conditions. Rural areas were largely ignored. It was assumed that rural residents, living in the pastoral countryside, didn’t require the same attention. This was not true then, and it’s definitely not true now. Residents of rural Appalachia face daunting challenges like skyrocketing chronic disease rates and a rapidly aging population; they deserve access to the same quality of preventive health services as their urban counterparts.

Appalachia is a region of unparalleled natural beauty, inhabited by a proud people with distinct heritage. We’ve fallen behind on important economic, educational and health measures, but I’m looking forward to a career devoted to improving public health capacity in the region. I hope to call these mountains home for a long time.

*David Blackley is a doctoral candidate in epidemiology at East Tennessee State University. His research interests include lung cancer, cancer screening and public health in Appalachia.*

Innovative rookies and seasoned professionals share their experiences.

“It’s a crooked path from covering high school football to running the Office of Rural Health Policy, but the latter would never have happened without the former.”



Tom Morris

## From football to physicians: Small-town sportswriter turns rural advocate

By Tom Morris

It’s not the usual career ladder, but my road to rural health started with sports writing.

I came out of college in 1986 and began work as a sportswriter at a small daily newspaper in Greenville, N.C. Small-town newspapers are a lot like small-town hospitals. You end up being a “jack of all trades” and wearing multiple hats. It wasn’t long before I was also writing news and feature stories and one of the issues that fascinated me the most was health care.

For a kid who grew up in the suburbs of Charlotte, living and working in a rural area like eastern North Carolina was eye opening. It never dawned on me that you could have a county without a physician or that you might have to travel several hours to see a dentist. But in my travels around that region I learned about these disparities first hand. I visited small clinics, interviewed country docs and met folks who faced almost insurmountable barriers in getting access to even basic health care services.

I also saw firsthand the gap between public policy and reality and the impact poverty and culture can have on a community’s health. I started hearing about the great work

done by Jim Bernstein and the other staff at the North Carolina Office of Rural Health and began to think it might be time for a career change.

I wondered if there was a way to match my writing skills to a job in health care so I went to graduate school at East Carolina University and got a master’s in public administration and community health. That led to being selected as a presidential management intern at the Department of Health and Human Services.

Along the way, the folks at the federal Office of Rural Health Policy took pity on me and allowed me to do an unpaid internship. After one summer, I was officially hooked and never left.

So, it’s a crooked path from covering high school football to running the Office of Rural Health Policy, but the latter would never have happened without the former.

*Tom Morris has been the Office of Rural Health Policy associate administrator since 2008.*

Are you relatively new to rural health or looking back on years of serving rural America?  
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Jack Roberts, Director of Information Systems  
Twin County Regional Healthcare

# An open letter on a closed chapter

By Dustin Summers



Dustin Summers

I know exactly where the letter is. From the moment it was pushed in my direction across the dean's desk, it has remained folded into thirds and tucked inside the jacket pocket of my best suit.

Whenever I go

to interviews, I can feel it crinkling and pressing against my chest.

It says things like “due to poor academic performance,” “regret to inform you” and “no longer a member of.”

It says “dismissed.”

No one goes into medical school with the intention of failing, yet it happens. Every year students begin with the best of intentions, study for ungodly hours, endure the sacrifices of relationships and outside interests and some still fall short.

I am one of those people.

From the start, medical school was a struggle. I plowed through as many obstacles as I could, but in the end, it wasn't enough. However, I regret nothing. Aside from more-than-several multiple choice answer selections, there is little I would change about my year in med school. I stuck to what I believed was right, I pursued interests that I know are essential to the overall development of a physician, I worked, I questioned, and I leave as a tougher person than I was before I began.

My pursuit of medical school lasted for nine years longer than my tenure in medical school itself. During that time, I earned several degrees, moved to Washington, D.C., and learned a great deal more about myself and the world than I would have had if I had not left Paris, Tenn. I had the opportunity to work for the National Rural Health Association where I met dedicated health care providers from across the country, where my understanding of the unique health care needs inherent of rural communities was broadened and honed.

**“Anyone who has ever been in school knows the work doesn't end when class is dismissed. The final bell is not a cue to quit or call it a day. It's a chance to move on...”**

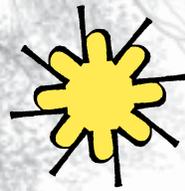
During that time, I discovered talents and abilities that I know can be utilized in the struggle to improve rural health care delivery. From the way technology is used in a clinical setting, to the way legislation is developed, to the way medical schools are organized, to the way student doctors are trained, improvements can be made and innovations should be implemented.

I thank Heaven for the friends that I made in the last year, and am compelled to reference the opposite of Heaven in regards to my enemies. But I'll push forward and search for new opportunities and new challenges.

Anyone who has ever been in school knows that the work doesn't end when class is dismissed. The final bell is not a cue to quit or to call it a day. It's a chance to move on, a chance to exercise what you have learned along the way, a chance to meld the classroom lessons with the real world lessons. This is an end for me, but this is also a beginning. It's a time to venture forward and to seek new avenues for the improvement of rural health care. I anticipate what comes next, and hope you do as well.

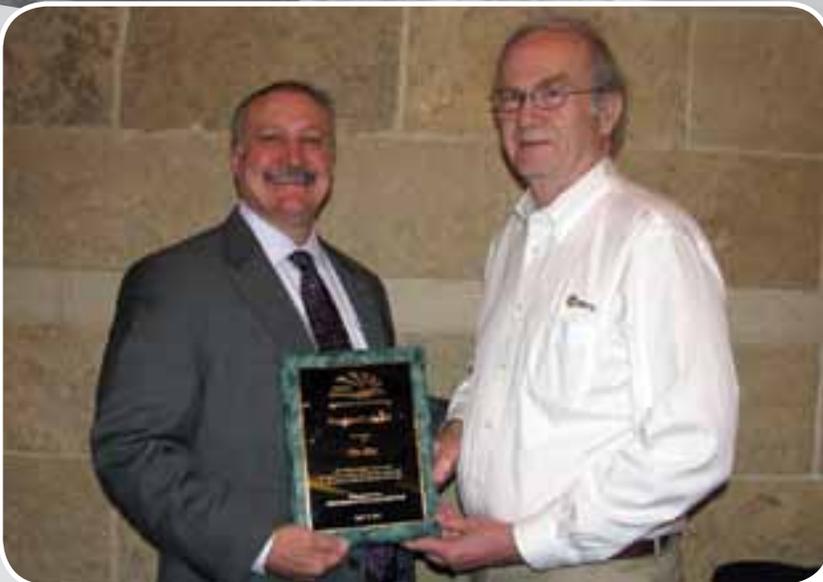
Dismissed.

*Dustin Summers worked in the National Rural Health Association's government affairs office from 2009 to 2011 and was a medical student at Lincoln Memorial University in Harrogate, Tenn., from 2011 to 2012. To read more of his journey, visit the Rural Roads archives at [RuralRoadsOnline.com](http://RuralRoadsOnline.com).*



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*Lance Keilers, 2012 NRHA President  
presents Tim Size, RWHC Executive Director  
with the President's Award.*

"Behind every great organization there are great leaders. Today I have the honor to award the 2012 NRHA President's Award to an individual that has dedicated his career to improving rural health." *Lance Keilers, 2012 NRHA National Conference*

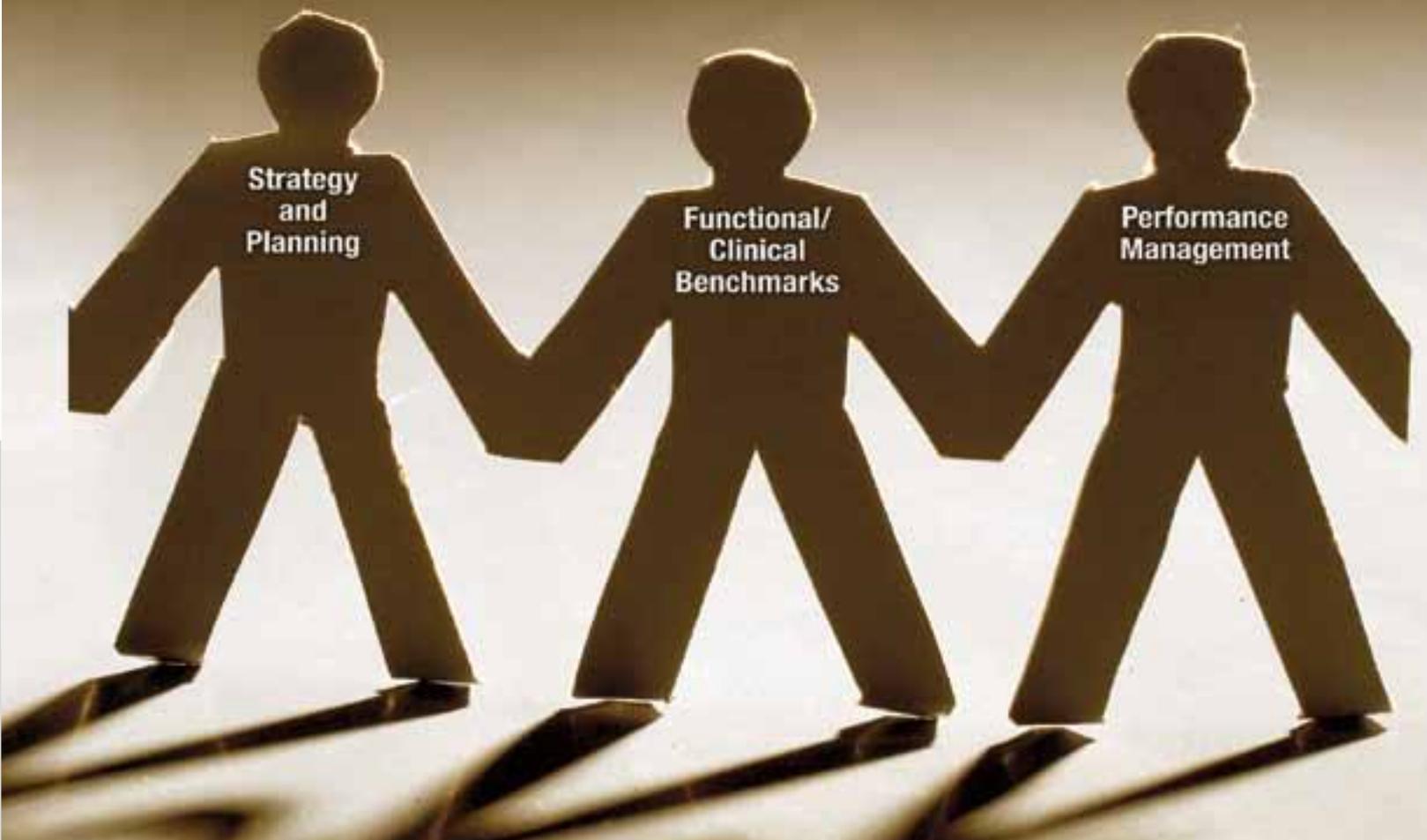


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# Explore Asheville

with NRHA member Eron Manusov, MD

Side trip



Eron Manusov

Asheville, N.C., is one of my favorite cities in the world. Nestled in the Smoky Mountains, it boasts easy access from anywhere in North Carolina.

The University of North Carolina-Asheville is situated at the base of the mountains near some of the most beautiful hiking, kayaking, walking, riding and exploring on the planet. Minutes away is downtown Asheville, an eclectic bundle of art deco and good times.



Downtown Asheville. Photo courtesy of Asheville Convention and Visitors Bureau.

The surrounding landscape is a picturesque mixture of pine trees, rhododendrons, rushing rivers and mountains. Visitors will always find a blue smoky backdrop to an artist's palette, rich with multiple shades of greens, yellows, browns and reds.

The mountain folk are peaceful and remind me of northern Californians with their love of health, freedom and a "live and let live" attitude. Organic, natural and delicious food can be found in the smallest of restaurants that fill the area and vie for your sampling efforts.

## Take a hike, window shop and bang the drum

You might spend all your time walking around downtown Asheville exploring the local shops, artisans, bookstores and art galleries. Close by you'll find the Asheville Symphony, an art museum and multiple small museums.

You can walk down Haywood Street, a shopper's paradise, bop into the shops on Lexington Avenue reminiscent of a life in 1960s America, climb through the Grove arcade, or tour studios in the Rivers Art District and experience art inspired by the majestic

scenery of western North Carolina. I would be remiss to not mention the Town Center Drum Circle where anyone can bring a percussion instrument, and join in the fun.

### Fill up on favorites

With more than 97 restaurant choices, I hesitate to make suggestions. We rarely go back to any one restaurant because there are so many delicious places to sample. You could blindfold the decision-maker in your group and point at a list, and you would be ecstatic with the outcome.

Asheville even made Trip Advisor's list of top 10 U.S. food and wine destinations last year. The Tupelo Honey Café and Mellow Mushroom Pizza are some iconic town favorites. Other foodie spots include Mela Indian Restaurant, Heiwa Shokudo, 12 Bones Smokehouse and the Asheville Brewing Company. Local greats Chorizo, Modesto Trattoria and Thai Basil, Asheville also receive rave reviews.



Candlelight evening at the Biltmore. Photo courtesy of [ashvillechristmas.com](http://ashvillechristmas.com).

### Candlelight and other holiday sites

The timing of the National Rural Health Association's Rural Multiracial and Multicultural Health Conference allows you to check out the 29th Annual Candlelight Evenings at the Biltmore. Not only is the mansion impressive with its own bowling alley, massive libraries and English-inspired landscape, but during December the Biltmore is uniquely decorated for the holiday season. The experience is breathtaking even for me, a Christmas curmudgeon, and it happens to be close to the conference hotel.

And don't miss the 5th Annual Sculpture for the Garden and the Polar Express at the Great Smoky Mountains Railroad. Finally, make time to skip over to the Grove Park Inn and see the huge walk-in fireplace

and amazing Gingerbread House Competition. I built a gingerbread house once; it took me two weeks and could fit into the closet of some of these edible architectural masterpieces. We should also all gather for the the Brews Cruise and at the Biltmore Town Square.

### Carolina connections

And the reason Asheville was selected for our 18th annual Rural Multiracial and Multicultural Health Conference? The Mountain Area Health Education Center (AHEC) and Rural Family Medicine Residency focus on care for the underserved in Western North Carolina. The Charles George Veterans Administration Medical Center offers care to our soldiers with emphasis on the homeless, rehabilitation and minority veterans. And the University of North Carolina-Chapel Hill started a campus for their medical school that emphasizes care for the underserved, minority and rural populations.

Asheville is the idyllic campus for our conference.

Not only will we share knowledge, research and cutting-edge experiences in rural health, but we can refuel in one of the most amazing natural paradises in the world.

I look forward to seeing everyone in December. 

*Eron G. Manusov, MD, is the Southern Regional Area Health Education Center (SR-AHEC) vice president and Duke SR-AHEC family medicine residency program director. He joined NRHA in 2009 and is a member of the association's Multiracial and Multicultural Council.*

## Educate and collaborate

Join rural health colleagues and national experts for the 18th annual Rural Multiracial and Multicultural Health Conference Dec. 4-6 in Asheville, N.C.

At the nation's only conference focused on improving health for under-represented rural populations, you'll discover:

- how to best promote equity and wellness in rural multiracial and multicultural communities
- creative approaches and lessons learned in delivering health services in rural and frontier communities from Alaska to the U.S.-Mexico border
- how to develop policy and implement programs to improve health access and outcomes
- leadership development, grant writing and community health worker insights

Also participate in discussions on cultural sensitivity, health promotion and disease prevention for underserved groups.

Go to [RuralHealthWeb.org/mm](http://RuralHealthWeb.org/mm) for event details, scholarship opportunities and discounted rates.

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“Amerinet helped make our vision a reality. Not only did we save 50.8 percent on the purchase of capital equipment using TargetBuys; Amerinet also provided technical expertise and negotiation strategies that were invaluable during the early phase of the project.”

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## Ready to listen and lead

### Get to know incoming NRHA president Sandra Durick



Sandra Durick

Sandra Durick will lead the National Rural Health Association in 2013. She has worked for the South Dakota Office of Rural Health since 1999, when she joined NRHA, and has led the office since 2007.

#### What are your goals for next year?

My goals are to create new partnerships in advocating for rural health issues, to facilitate the development of a new leadership program and to engage NRHA members.

As president, I will strive to listen and lead.

#### What advice do you have for new NRHA members?

Get involved! Join a constituency group.

Come to conferences to interact and network with colleagues working across the country on various aspects of rural health.

And begin your pathway to a leadership position in the organization. Applying to become a Rural Health Fellow is a great way to start.

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

I have finished one marathon and a number of half marathons.

My favorite fall activity is walking the corn and stubble fields with my family and friends while hunting pheasants and deer. I enjoy the fresh air and the marksmanship – and patience – required. Our family has been hunting pheasants since I was very young. I remember hunting the road ditches for pheasants with my grandfather.

#### Tell us about your family.

My husband Mike Durick and I celebrated 40 years of marriage this past summer. We have three children, Kara and her husband Tim, who live in Andover, Minn.; Damon and his wife Stephanie, who live in Crooks, S.D.; and Brett and his wife Jennifer, who live in Jersey City, N.J.

We also have three darling grandchildren, Caden, Ashley and Cooper, and one on the way. We all enjoy fishing and spending time boating together.

#### What are your favorite ways to relax?

My favorite ways to relax are fishing with my husband on the Missouri River, tending to my roses and cooking dinner for friends. Everybody's favorite is fresh walleye and garlic mashed potatoes.

And since we're lucky enough to live on the river, I enjoy just sitting on the patio or porch watching the sun set over the river bluffs.

## Members on the move

### Kaiser leads Oklahoma Office of Rural Health



Corie Kaiser

Corie Kaiser is the Oklahoma Office of Rural Health's new director.

She's worked for the office for seven years, most recently in the assistant director position.

"Since becoming the director, I have been working directly with our grants and budgets as well as becoming more in tuned with the Office of Rural Health Policy's requirements and expectations of state offices of rural health," Kaiser says. "I look forward to the future of the Oklahoma Office of

Rural Health and the programs we will put in place to provide support for our rural hospitals and providers."

Kaiser calls the National Rural Health Association "a great resource."

"The annual conferences are always educational and relevant to my current needs," she says. "I will continue to turn to NRHA for advice whenever I have questions about particular policies and how they will affect my rural constituents."

Kaiser joined NRHA in 2006.

### Mills promoted to head Colorado nonprofit



Michelle Mills

Michelle Mills was recently named the Colorado Rural Health Center's new CEO.

She began working for the center in 2010 as director of programs overseeing its critical access hospital, rural health clinic and emergency preparedness initiatives.

"As CEO, I am looking forward to building on the relationships the Colorado Rural Health Center has established with other organizations, funders and rural health care leaders," she says. "I am dedicated to helping synergize efforts for rural communities and will work closely with our rural communities and providers to make a positive impact on rural health delivery and improve access for all Coloradans."

Mills says she appreciates the opportunities to collaborate that the National Rural Health Association offers.

"Through the assistance of NRHA, I will have the necessary support to provide to our membership support in these times of health care reform, which will be a great challenge," she says.

Mills joined NRHA in 2010.

### Worden represents rural on pharmacy board



John Worden

John Worden, PharmD, was recently appointed to the Kansas Board of Pharmacy.

Worden has served as McPherson Hospital's director of pharmacy for the past five years in rural

McPherson, Kan, and will serve a four-year term on the pharmacy board.

"I look forward to working with the other board members to advance our vision for the state of Kansas and the opportunity to serve our great state," says the National Rural Health Association member.

Worden says he hopes to represent rural residents in this new role.

"Working in a facility and community that serves rural patients gives me the opportunity to have firsthand experience with the unique needs of rural Kansas," he says. "My involvement with NRHA helps me understand the needs of other rural providers throughout our country and hear success stories of providing health care services in rural areas. My goal is to continue to work with NRHA on communicating the critical role that pharmacy plays in caring for patients in our local communities and for the overall infrastructure of our health care system."

Worden joined NRHA in 2009.

Send your career updates to [editor@NRHArural.org](mailto:editor@NRHArural.org).

## NRHA news

### Next conference to focus on serving underserved

The National Rural Health Association's Rural Multiracial and Multicultural Health Conference will be Dec. 4-6 in Asheville, N.C.

"People often ask me if there are opportunities to hear about what others are doing in their communities to address minority health issues," says Sandra Pope, West Virginia Area Health Education Center director and NRHA Multiracial and Multicultural Council chair. "This conference is the perfect venue for learning about and sharing successful projects and initiatives that can be replicated in your community."

This will be the 18th year for nation's only conference to focus on eliminating health disparities and improving access to quality health care services for rural underserved populations.

This year, multiple sessions focus on capacity building, including grant writing, leadership skills and partner development. Attendees will also gain valuable insight on border, oral and behavioral health, health literacy and health disparities, Pope says. And a Rural Healthy People 2020 project update will be presented.

"One of our goals to increase awareness of grassroots efforts to improve the health of our minority populations," Pope says. "Join us in this important educational, networking and advocacy event to make your voice louder."

Visit [RuralHealthWeb.org](http://RuralHealthWeb.org) for the full agenda and to register, and see page 42 for a member's advice on turning your trip to Asheville into a winter vacation. NRHA is offering a discounted road trip rate for attendees from Kentucky, North Carolina, South Carolina, Tennessee, Virginia and West Virginia.

### NRHA to accept award nominations

The National Rural Health Association will accept nominations for its 2013 Rural Health Awards at [RuralHealthWeb.org](http://RuralHealthWeb.org) Dec. 7 through Feb. 14.

Winners will be selected by a committee of NRHA members and honored during the 36th Annual Rural Health Conference May 7-10 in Louisville, Ky.

Each student award winner will also receive complimentary conference registration, a one-year NRHA membership and \$500 from John Snow Inc.

### Member survey yields positive responses, new benefit

The National Rural Health Association's biennial survey of members showed improvements in every category.

In July, there were 329 responses to multiple questions regarding NRHA services and performance.

"Thank you to everyone who took the time to complete this survey in order to help us serve you better," says Brock Slabach, NRHA member services senior vice president.

NRHA's performance ratings went up in every category compared to the same survey conducted online in 2010.

Members indicated advocacy was NRHA's most important service, and 91 percent of respondents reported that NRHA was very strong in this area. And 95 percent of respondents agreed NRHA is a "valuable national advocate for rural health."

NRHA's Board of Trustees reviewed these results at its planning retreat in August.

"I'm pleased that members are satisfied with many areas of our association," said Lance Keilers, 2012 NRHA president. "However, there are valuable services that we can improve, namely in the area of networking and collaboration, where 78 percent indicated NRHA was strong or very strong. We have committed resources to improve our performance in this area by adding the mobile application to NRHA Connect. I hope members take the opportunity to add this app to their smartphones."

See the next page for instructions on how to obtain the free NRHA Connect app.

"As always, members are welcome to contact NRHA staff to let us know how we can help you solve the real-world problems you're facing," Slabach adds.

*continues*

*continued*

## NRHA announces mobile app

Ever lost a colleague's business card after a conference? Need to access an exclusive NRHA webinar that starts in five minutes? Want an easier way to catch up on rural health news or committee minutes via smartphone? Now you're in luck, thanks to the new NRHA Connect mobile app.

"This member-only benefit connects our members with each other, even on-the-go," says Brock Slabach, NRHA member services senior vice president. "NRHA is excited to be on the leading edge of social networking technology and offer this benefit to our members."

Whether you have an iOS or Android-powered phone, members can get better connected with NRHA by downloading this free app through your phone's marketplace.

Here is how to get started:

- Go to the app store on your mobile device.
- Search for "MemberCentric," and download the app.
- Once complete, open the app and select NRHA from the list of organizations.
- Login with your credentials and enjoy.

The app is available to those with an existing NRHA Connect account, which members can create online at [connect.NRHArural.org](http://connect.NRHArural.org). NRHA Connect content is only available to members, so become a member at [RuralHealthWeb.org](http://RuralHealthWeb.org), or call 816-756-3140 to check your status or sign up and start receiving this and other membership benefits.

# accelerating advocacy

## Fight to protect rural health funding at 2013 Policy Institute

The speeches are over, the political ads are off the air, and a new Congress will be roaming the halls of the Capitol in January.

Yet as we prepare for more change in Washington, D.C., our struggles to protect rural health care funding remain unchanged. In fact, the funding challenges that perennially persist cause one to wonder whether Nov. 6 was Election Day or Groundhog Day.

As the federal budget battles continue, assaults on rural health funding - from Republicans and Democrats alike - will also continue. Funding for critical access hospitals and rural prospective payment system hospitals will be threatened, and cuts to vital rural health federal appropriations programs seem a certainty in 2013.

Once strongly supported on a bipartisan basis in Congress, rural health programs and the spending for these programs are being questioned on a bipartisan basis like never before.

Why has congressional support for the rural health safety net quelled? Record federal deficits and the public outcry against

spending have, in large part, tied the hands of members of Congress. Both Republicans and Democrats are calling for many federal programs to receive closer scrutiny.

Rural providers win the cost-justification and taxpayer benefit debate every time. In fact, providing identical quality care to a senior in a rural health care facility costs the Medicare program 3.7 percent less than if that care were provided in an urban facility.

Nevertheless, billions of dollars are in jeopardy that directly impact the delivery of rural care. Cuts in the rural health safety net to hospitals, rural health clinics, community health centers and all other rural providers will mean many facilities will reduce services, or worse, close their doors, resulting in a devastating impact on rural Americans across the country.

Help NRHA make your voice louder. Join NRHA and its policy partners Feb. 4-6 in Washington, D.C., for the largest rural health advocacy event in the nation, the NRHA Policy Institute.

— *Maggie Elehwany, NRHA government affairs and policy vice president*

CUBICIN IS IN THE 2010 IDSA GUIDELINES FOR MRSA cSSSI AND BACTEREMIA<sup>1</sup>

## For suspected MRSA cSSSI or bacteremia, consider CUBICIN first

- Rapid bactericidal activity against MRSA *in vitro*\*
- Over 99% of *Staphylococcus aureus* isolates are susceptible to CUBICIN *in vitro*\* according to global surveillance studies<sup>2</sup>
- Does not require drug-level monitoring
- Once-a-day, 2-minute IV injection or 30-minute IV infusion

\*Clinical relevance of *in vitro* data has not been established.



### Indications and Important Safety Information

#### INDICATIONS

- CUBICIN® (daptomycin for injection) is indicated for the following infections:  
Complicated skin and skin structure infections (cSSSI) caused by susceptible isolates of the following Gram-positive bacteria: *Staphylococcus aureus* (including methicillin-resistant isolates), *Streptococcus pyogenes*, *Streptococcus agalactiae*, *Streptococcus dysgalactiae* subspecies *equisimilis*, and *Enterococcus faecalis* (vancomycin-susceptible isolates only).  
*S. aureus* bloodstream infections (bacteremia), including those with right-sided infective endocarditis, caused by methicillin-susceptible and methicillin-resistant isolates.

#### LIMITATIONS OF USE

- CUBICIN is not indicated for the treatment of left-sided infective endocarditis due to *S. aureus*. The clinical trial of CUBICIN in patients with *S. aureus* bloodstream infections included limited data from patients with left-sided infective endocarditis; outcomes in these patients were poor. CUBICIN has not been studied in patients with prosthetic valve endocarditis.
- CUBICIN is not indicated for the treatment of pneumonia.

#### WARNINGS AND PRECAUTIONS

- Anaphylaxis/hypersensitivity reactions have been reported with the use of antibacterial agents, including CUBICIN, and may be life-threatening. If an allergic reaction to CUBICIN occurs, discontinue the drug and institute appropriate therapy.
- Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal (ULN), has been reported with the use of CUBICIN. Rhabdomyolysis, with or without acute renal failure, has been reported. Patients receiving CUBICIN should be monitored for the development of muscle pain or weakness, particularly of the distal extremities. In patients who receive CUBICIN, CPK levels should be monitored weekly, and more frequently in patients who received recent prior or concomitant therapy with an HMG-CoA reductase inhibitor or in whom elevations in CPK occur during treatment with CUBICIN. In patients with renal impairment, both renal function and CPK should be monitored more frequently than once weekly. In Phase 1 studies and Phase 2 clinical trials, CPK elevations appeared to be more frequent when CUBICIN was dosed more than once daily. Therefore, CUBICIN should not be dosed more frequently than once a day. CUBICIN should be discontinued in patients with unexplained signs and symptoms of myopathy in conjunction with CPK elevations to levels >1,000 U/L (~5× ULN), and in patients without reported symptoms who have marked elevations in CPK, with levels >2,000 U/L (≥10× ULN). In addition, consideration should be given to suspending agents associated with rhabdomyolysis, such as HMG-CoA reductase inhibitors, temporarily in patients receiving CUBICIN.

- Eosinophilic pneumonia has been reported in patients receiving CUBICIN. In reported cases associated with CUBICIN, patients developed fever, dyspnea with hypoxic respiratory insufficiency, and diffuse pulmonary infiltrates. In general, patients developed eosinophilic pneumonia 2 to 4 weeks after starting CUBICIN and improved when CUBICIN was discontinued and steroid therapy was initiated. Recurrence of eosinophilic pneumonia upon re-exposure has been reported. Patients who develop these signs and symptoms while receiving CUBICIN should undergo prompt medical evaluation, and CUBICIN should be discontinued immediately. Treatment with systemic steroids is recommended.
- Cases of peripheral neuropathy have been reported during the CUBICIN postmarketing experience. Therefore, physicians should be alert to signs and symptoms of peripheral neuropathy in patients receiving CUBICIN.
- *Clostridium difficile*-associated diarrhea (CDAD) has been reported with the use of nearly all systemic antibacterial agents, including CUBICIN, and may range in severity from mild diarrhea to fatal colitis. CDAD must be considered in all patients who present with diarrhea following antibacterial use. Careful medical history is necessary because CDAD has been reported to occur more than 2 months after the administration of antibacterial agents.
- Patients with persisting or relapsing *S. aureus* bacteremia/endocarditis or poor clinical response should have repeat blood cultures. If a blood culture is positive for *S. aureus*, minimum inhibitory concentration (MIC) susceptibility testing of the isolate should be performed using a standardized procedure, and diagnostic evaluation of the patient should be performed to rule out sequestered foci of infection. Appropriate surgical intervention (e.g., debridement, removal of prosthetic devices, valve replacement surgery) and/or consideration of a change in antibacterial regimen may be required. Failure of treatment due to persisting or relapsing *S. aureus* bacteremia/endocarditis may be due to reduced daptomycin susceptibility (as evidenced by increasing MIC of the *S. aureus* isolate).
- There are limited data available from the cSSSI clinical trials regarding the clinical efficacy of CUBICIN treatment in patients with creatinine clearance (CrCL) <50 mL/min; only 6% (31/534) patients treated with CUBICIN in the intent-to-treat (ITT) population had a baseline CrCL <50 mL/min. The clinical success rates in CUBICIN (4 mg/kg q24h)-treated patients with CrCL 50-70 mL/min and CrCL 30-50 mL/min were 66% (25/38) and 47% (7/15), respectively. The clinical success rates in comparator-treated patients with CrCL 50-70 mL/min and CrCL 30-50 mL/min were 63% (30/48) and 57% (20/35), respectively. In a subgroup analysis of the ITT population in the *S. aureus* bacteremia/endocarditis trial, clinical success rates in the CUBICIN-treated patients were lower in patients with baseline CrCL <50 mL/min.

#### ADVERSE REACTIONS

- The most clinically significant adverse reactions observed with CUBICIN 4 mg/kg (cSSSI trials) and 6 mg/kg (*S. aureus* bacteremia/endocarditis trial) were abnormal liver function tests, elevated CPK, dyspnea, and pneumonia.

**References:** 1. Liu C, Bayer A, Cosgrove SE, et al. Clinical practice guidelines by the Infectious Diseases Society of America for the treatment of methicillin-resistant *Staphylococcus aureus* infections in adults and children. *Clin Infect Dis*. 2011;52:e18-e55. 2. Data on file. Cubist Pharmaceuticals, Inc.

**Please see Brief Summary of Prescribing Information on adjacent page.**



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Once-A-Day  
**CUBICIN**<sup>®</sup>  
(daptomycin for injection)

## CUBICIN® (daptomycin for injection)

### Brief Summary of Prescribing Information

**INDICATIONS AND USAGE** CUBICIN is indicated for the treatment of the following infections. **Complicated Skin and Skin Structure Infections (cSSSI)** caused by susceptible isolates of the following Gram-positive bacteria: *Staphylococcus aureus* (including methicillin-resistant isolates), *Streptococcus pyogenes*, *Streptococcus agalactiae*, *Streptococcus dysgalactiae* subsp. *equisimilis*, and *Enterococcus faecalis* (vancomycin-susceptible isolates only). ***Staphylococcus aureus* Bloodstream Infections (Bacteremia), Including Those with Right-Sided Infective Endocarditis, Caused by Methicillin-Susceptible and Methicillin-Resistant Isolates.** **Limitations of Use** CUBICIN is not indicated for the treatment of pneumonia. CUBICIN is not indicated for the treatment of left-sided infective endocarditis due to *S. aureus*. The clinical trial of CUBICIN in patients with *S. aureus* bloodstream infections included limited data from patients with left-sided infective endocarditis; outcomes in these patients were poor [see *Clinical Trials* in full prescribing information]. CUBICIN has not been studied in patients with prosthetic valve endocarditis. **Usage** Appropriate specimens for microbiological examination should be obtained in order to isolate and identify the causative pathogens and to determine their susceptibility to daptomycin. To reduce the development of drug-resistant bacteria and maintain the effectiveness of CUBICIN and other antibacterial drugs, CUBICIN should be used only to treat infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy. Empiric therapy may be initiated while awaiting test results.

**CONTRAINDICATIONS** CUBICIN is contraindicated in patients with known hypersensitivity to daptomycin.

**WARNINGS AND PRECAUTIONS** **Anaphylaxis/Hypersensitivity Reactions** Anaphylaxis/hypersensitivity reactions have been reported with the use of antibacterial agents, including CUBICIN, and may be life-threatening. If an allergic reaction to CUBICIN occurs, discontinue the drug and institute appropriate therapy [see *Adverse Reactions*]. **Myopathy and Rhabdomyolysis** Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal (ULN), has been reported with the use of CUBICIN. Rhabdomyolysis, with or without acute renal failure, has been reported [see *Adverse Reactions*]. Patients receiving CUBICIN should be monitored for the development of muscle pain or weakness, particularly of the distal extremities. In patients who receive CUBICIN, CPK levels should be monitored weekly, and more frequently in patients who received recent prior or concomitant therapy with an HMG-CoA reductase inhibitor or in whom elevations in CPK occur during treatment with CUBICIN. In patients with renal impairment, both renal function and CPK should be monitored more frequently than once weekly [see *Use in Specific Populations* in this summary and *Clinical Pharmacology* in full prescribing information]. In Phase 1 studies and Phase 2 clinical trials, CPK elevations appeared to be more frequent when CUBICIN was dosed more than once daily. Therefore, CUBICIN should not be dosed more frequently than once a day. CUBICIN should be discontinued in patients with unexplained signs and symptoms of myopathy in conjunction with CPK elevations to levels  $>1,000$  U/L ( $5\times$  ULN), and in patients without reported symptoms who have marked elevations in CPK, with levels  $>2,000$  U/L ( $\geq 10\times$  ULN). In addition, consideration should be given to suspending agents associated with rhabdomyolysis, such as HMG-CoA reductase inhibitors, temporarily in patients receiving CUBICIN [see *Drug Interactions*]. **Eosinophilic Pneumonia** Eosinophilic pneumonia has been reported in patients receiving CUBICIN [see *Adverse Reactions*]. In reported cases associated with CUBICIN, patients developed fever, dyspnea with hypoxic respiratory insufficiency, and diffuse pulmonary infiltrates. In general, patients developed eosinophilic pneumonia 2 to 4 weeks after starting CUBICIN and improved when CUBICIN was discontinued and steroid therapy was initiated. Recurrence of eosinophilic pneumonia upon re-exposure has been reported. Patients who develop these signs and symptoms while receiving CUBICIN should undergo prompt medical evaluation, and CUBICIN should be discontinued immediately. Treatment with systemic steroids is recommended. **Peripheral Neuropathy** Cases of peripheral neuropathy have been reported during the CUBICIN postmarketing experience [see *Adverse Reactions*]. Therefore, physicians should be alert to signs and symptoms of peripheral neuropathy in patients receiving CUBICIN. ***Clostridium difficile*-Associated Diarrhea** *Clostridium difficile*-associated diarrhea (CDAD) has been reported with the use of nearly all systemic antibacterial agents, including CUBICIN, and may range in severity from mild diarrhea to fatal colitis [see *Adverse Reactions*]. Treatment with antibacterial agents alters the normal flora of the colon, leading to overgrowth of *C. difficile*. *C. difficile* produces toxins A and B, which contribute to the development of CDAD. Hypertoxin-producing strains of *C. difficile* cause increased morbidity and mortality, since these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibacterial use. Careful medical history is necessary because CDAD has been reported to occur more than 2 months after the administration of antibacterial agents. If CDAD is suspected or confirmed, ongoing antibacterial use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibacterial treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated. **Persisting or Relapsing *S. aureus* Bacteremia/Endocarditis** Patients with persisting or relapsing *S. aureus* bac-

teremia/endocarditis or poor clinical response should have repeat blood cultures. If a blood culture is positive for *S. aureus*, minimum inhibitory concentration (MIC) susceptibility testing of the isolate should be performed using a standardized procedure, and diagnostic evaluation of the patient should be performed to rule out sequestered foci of infection. Appropriate surgical intervention (e.g., debridement, removal of prosthetic devices, valve replacement surgery) and/or consideration of a change in antibacterial regimen may be required. Failure of treatment due to persisting or relapsing *S. aureus* bacteremia/endocarditis may be due to reduced daptomycin susceptibility (as evidenced by increasing MIC of the *S. aureus* isolate) [see *Clinical Trials* in full prescribing information]. **Decreased Efficacy in Patients with Moderate Baseline Renal Impairment** There are limited data available from the cSSSI clinical trials regarding clinical efficacy of daptomycin treatment in patients with CrCL  $<50$  mL/min; only 6% (31/534) patients treated with daptomycin in the intent-to-treat (ITT) population had a baseline CrCL  $<50$  mL/min. In the ITT population of the Phase 3 cSSSI trials, the clinical success rates in daptomycin (4 mg/kg q24h)-treated patients with CrCL 50-70 mL/min and CrCL 30- $<50$  mL/min were 66% (25/38) and 47% (7/15), respectively. The clinical success rates in comparator-treated patients with CrCL 50-70 mL/min and CrCL 30- $<50$  mL/min were 63% (30/48) and 57% (20/35), respectively. In a subgroup analysis of the ITT population in the *S. aureus* bacteremia/endocarditis trial, clinical success rates, as determined by a treatment-blinded Adjudication Committee [see *Clinical Trials* in full prescribing information], in the daptomycin-treated patients were lower in patients with baseline CrCL  $<50$  mL/min. A decrease of the following magnitude was not observed in comparator-treated patients. In the ITT population of the *S. aureus* bacteremia/endocarditis trial, the Adjudication Committee clinical success rates at the test-of-cure visit in daptomycin (6 mg/kg q24h)-treated bacteremia patients with CrCL  $>80$  mL/min, CrCL 50-80 mL/min, and CrCL 30-50 mL/min were 60% (30/50), 46% (12/26), and 14% (2/14), respectively. The clinical success rates in daptomycin (6 mg/kg q24h)-treated right-sided infective endocarditis (RIE) patients with CrCL  $>80$  mL/min, CrCL 50-80 mL/min, and CrCL 30-50 mL/min were 50% (7/14), 25% (1/4), and 0% (0/1), respectively. The clinical success rates in comparator-treated bacteremia patients with CrCL  $>80$  mL/min, CrCL 50-80 mL/min, and CrCL 30-50 mL/min were 45% (19/42), 42% (13/31), and 41% (7/17), respectively. The clinical success rates in comparator-treated RIE patients with CrCL  $>80$  mL/min, CrCL 50-80 mL/min, and CrCL 30-50 mL/min were 46% (5/11), 50% (1/2), and 100% (1/1), respectively. Consider these data when selecting antibacterial therapy for use in patients with baseline moderate to severe renal impairment. **Drug-Laboratory Test Interactions** Clinically relevant plasma concentrations of daptomycin have been observed to cause a significant concentration-dependent false prolongation of prothrombin time (PT) and elevation of International Normalized Ratio (INR) when certain recombinant thromboplastin reagents are utilized for the assay [see *Drug-Laboratory Interactions*]. **Non-Susceptible Microorganisms** The use of antibacterials may promote the overgrowth of non-susceptible microorganisms. If superinfection occurs during therapy, appropriate measures should be taken. Prescribing CUBICIN in the absence of a proven or strongly suspected bacterial infection is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

**ADVERSE REACTIONS** The following adverse reactions are described, or described in greater detail, under *Warnings and Precautions*: anaphylaxis/hypersensitivity reactions, myopathy and rhabdomyolysis, eosinophilic pneumonia, peripheral neuropathy. The following adverse reaction is described in greater detail under *Warnings and Precautions* and *Drug-Laboratory Test Interactions*: increased International Normalized Ratio (INR)/prolonged prothrombin time. Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug and may not reflect the rates observed in practice. **Clinical Trials Experience** Clinical trials enrolled 1,864 patients treated with CUBICIN and 1,416 treated with comparator. **Complicated Skin and Skin Structure Infection Trials** In Phase 3 complicated skin and skin structure infection trials, CUBICIN was discontinued in 15/534 (2.8%) patients due to an adverse reaction, while comparator was discontinued in 17/558 (3.0%) patients. The incidence (%) of adverse reactions, organized by body system, that occurred in  $\geq 2\%$  of patients in the CUBICIN 4 mg/kg (N=534) treatment group and  $\geq$  the comparator (N=558) treatment group in Phase 3 cSSSI trials was as follows [comparators were vancomycin (1 g IV q12h) and anti-staphylococcal semi-synthetic penicillins (i.e., nafcillin, oxacillin, cloxacillin, flucloxacillin; 4 to 12 g/day IV in divided doses)]: **Gastrointestinal disorders**: diarrhea 5.2% and 4.3%; **Nervous system disorders**: headache 5.4% and 5.4%; dizziness 2.2% and 2.0%; **Skin/subcutaneous disorders**: rash 4.3% and 3.8%; **Diagnostic investigations**: abnormal liver function tests 3.0% and 1.6%; elevated CPK 2.8% and 1.8%; **Infections**: urinary tract infections 2.4% and 0.5%; **Vascular disorders**: hypotension 2.4% and 1.4%; **Respiratory disorders**: dyspnea 2.1% and 1.6%. Drug-related adverse reactions (possibly or probably drug-related) that occurred in  $<1\%$  of patients receiving CUBICIN in the cSSSI trials are as follows: **Body as a Whole**: fatigue, weakness, rigors, flushing, hypersensitivity; **Blood/Lymphatic System**: leukocytosis, thrombocytopenia, thrombocytosis, eosinophilia, increased International Normalized Ratio (INR); **Cardiovascular System**: supraventricular arrhythmia; **Dermatologic System**: eczema; **Digestive System**: abdominal distension, stomatitis, jaundice, increased serum lactate dehydrogenase; **Metabolic/Nutritional System**: hypomagnesemia, increased serum bicarbonate, electrolyte disturbance; **Musculoskeletal System**: myalgia, muscle cramps, muscle weakness, arthralgia; **Nervous System**: vertigo, mental status change, paresthesia; **Special Senses**: taste disturbance, eye irritation. ***S. aureus* Bacteremia/Endocarditis Trial** In the *S. aureus* bacteremia/endocarditis trial, CUBICIN was discontinued in 20/120 (16.7%) patients due to an adverse reaction, while comparator was discontinued in 21/116 (18.1%) patients. Serious

Gram-negative infections (including bloodstream infections) were reported in 10/120 (8.3%) CUBICIN-treated and 0/115 comparator-treated patients. Comparator-treated patients received dual therapy that included initial gentamicin for 4 days. Infections were reported during treatment and during early and late follow-up. Gram-negative infections included cholangitis, alcoholic pancreatitis, sternal osteomyelitis/mediastinitis, bowel infarction, recurrent Crohn's disease, recurrent line sepsis, and recurrent urosepsis caused by a number of different Gram-negative bacteria. The incidence [n (%)] of adverse reactions, organized by System Organ Class (SOC), that occurred in  $\geq 5\%$  of patients in the CUBICIN 6 mg/kg (N=120) treatment group and  $\geq$  to the comparator (N=116) treatment group in the *S. aureus* bacteremia/endocarditis trial was as follows [comparators were vancomycin (1 g IV q12h) and anti-staphylococcal semi-synthetic penicillins (i.e., nafcillin, oxacillin, cloxacillin, flucloxacillin; 2 g IV q4h), each with initial low-dose gentamicin]: *Infections and Infestations*: sepsis not otherwise specified (NOS) 6 (5%) and 3 (3%); bacteremia 6 (5%) and 0 (0%); *Gastrointestinal disorders*: abdominal pain NOS 7 (6%) and 4 (3%); *General disorders and administration site conditions*: chest pain 8 (7%) and 7 (6%); edema NOS 8 (7%) and 5 (4%); *Respiratory, thoracic, and mediastinal disorders*: pharyngolaryngeal pain 10 (8%) and 2 (2%); *Skin and subcutaneous tissue disorders*: pruritus 7 (6%) and 6 (5%); sweating increased 6 (5%) and 0 (0%); *Psychiatric disorders*: insomnia 11 (9%) and 8 (7%); *Investigations*: blood creatine phosphokinase increased 8 (7%) and 1 (1%); *Vascular disorders*: hypertension NOS 7 (6%) and 3 (3%). The following reactions, not included above, were reported as possibly or probably drug-related in the CUBICIN-treated group: *Blood and Lymphatic System Disorders*: eosinophilia, lymphadenopathy, thrombocytopenia, thrombocytopenia; *Cardiac Disorders*: atrial fibrillation, atrial flutter, cardiac arrest; *Ear and Labyrinth Disorders*: tinnitus; *Eye Disorders*: vision blurred; *Gastrointestinal Disorders*: dry mouth, epigastric discomfort, gingival pain, hypoesthesia oral; *Infections and Infestations*: candidal infection NOS, vaginal candidiasis, fungemia, oral candidiasis, urinary tract infection fungal; *Investigations*: blood phosphorus increased, blood alkaline phosphatase increased, INR increased, liver function test abnormal, alanine aminotransferase increased, aspartate aminotransferase increased, prothrombin time prolonged; *Metabolism and Nutrition Disorders*: appetite decreased NOS; *Musculoskeletal and Connective Tissue Disorders*: myalgia; *Nervous System Disorders*: dyskinesia, paresthesia; *Psychiatric Disorders*: hallucination NOS; *Renal and Urinary Disorders*: proteinuria, renal impairment NOS; *Skin and Subcutaneous Tissue Disorders*: pruritus generalized, rash vesicular. Other Trials In Phase 3 trials of community-acquired pneumonia (CAP), the death rate and rates of serious cardiorespiratory adverse events were higher in CUBICIN-treated patients than in comparator-treated patients. These differences were due to lack of therapeutic effectiveness of CUBICIN in the treatment of CAP in patients experiencing these adverse events [see *Indications and Usage*]. *Laboratory Changes Complicated Skin and Skin Structure Infection Trials* In Phase 3 cSSSI trials of CUBICIN at a dose of 4 mg/kg, elevations in CPK were reported as clinical adverse events in 15/534 (2.8%) CUBICIN-treated patients, compared with 10/558 (1.8%) comparator-treated patients. Of the 534 patients treated with CUBICIN, 1 (0.2%) had symptoms of muscle pain or weakness associated with CPK elevations to greater than 4 times the upper limit of normal (ULN). The symptoms resolved within 3 days and CPK returned to normal within 7 to 10 days after treatment was discontinued [see *Warnings and Precautions*]. The incidence [n (%)] of CPK elevations from Baseline through End of Therapy, organized by change in CPK, that occurred in either the CUBICIN 4 mg/kg (N=430) treatment group or the comparator (N=459) treatment group in all patients in the Phase 3 cSSSI trials was as follows [comparators were vancomycin (1 g IV q12h) and anti-staphylococcal semi-synthetic penicillins (i.e., nafcillin, oxacillin, cloxacillin, flucloxacillin; 4 to 12 g/day IV in divided doses)]: *No increase*: 390 (90.7%) and 418 (91.1%); *Maximum Value >1x Upper Limit of Normal (ULN)*; defined as 200 U/L: 40 (9.3%) and 41 (8.9%); *Max Value >2x ULN*: 21 (4.9%) and 22 (4.8%); *Max Value >4x ULN*: 6 (1.4%) and 7 (1.5%); *Max Value >5x ULN*: 6 (1.4%) and 2 (0.4%); *Max Value >10x ULN*: 2 (0.5%) and 1 (0.2%). In patients with normal CPK at baseline, the incidence [n (%)] of CPK elevations, organized by change in CPK, that occurred in either the CUBICIN 4 mg/kg (N=374) treatment group or the comparator (N=392) treatment group was as follows: *No increase*: 341 (91.2%) and 357 (91.1%); *Max Value >1x ULN*: 33 (8.8%) and 35 (8.9%); *Max Value >2x ULN*: 14 (3.7%) and 12 (3.1%); *Max Value >4x ULN*: 4 (1.1%) and 4 (1.0%); *Max Value >5x ULN*: 4 (1.1%) and 0 (0.0%); *Max Value >10x ULN*: 1 (0.2%) and 0 (0.0%). Note: Elevations in CPK observed in patients treated with CUBICIN or comparator were not clinically or statistically significantly different. *S. aureus Bacteremia/Endocarditis Trial* In the *S. aureus* bacteremia/endocarditis trial, at a dose of 6 mg/kg, 11/120 (9.2%) CUBICIN-treated patients, including two patients with baseline CPK levels  $>500$  U/L, had CPK elevations to levels  $>500$  U/L, compared with 1/116 (0.9%) comparator-treated patients. Of the 11 CUBICIN-treated patients, 4 had prior or concomitant treatment with an HMG-CoA reductase inhibitor. Three of these 11 CUBICIN-treated patients discontinued therapy due to CPK elevation, while the one comparator-treated patient did not discontinue therapy [see *Warnings and Precautions*]. **Post-Marketing Experience** The following adverse reactions have been identified during postapproval use of CUBICIN. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to estimate their frequency reliably or establish a causal relationship to drug exposure. *Immune System Disorders*: anaphylaxis; hypersensitivity reactions, including pruritus, hives, shortness of breath, difficulty swallowing, truncal erythema, and pulmonary eosinophilia [see *Contraindications and Warnings and Precautions*]; *Infections and Infestations*: *Clostridium difficile*-associated diarrhea [see *Warnings and Precautions*]; *Musculoskeletal Disorders*: myoglobin increased; rhabdomyolysis (some reports involved patients treated concurrently with CUBICIN and HMG-CoA reductase inhibitors) [see *Warnings and Precautions*].

*tions and Drug Interactions* in this summary, and *Clinical Pharmacology* in full prescribing information]; *Respiratory, Thoracic, and Mediastinal Disorders*: cough, eosinophilic pneumonia [see *Warnings and Precautions*]; *Nervous System Disorders*: peripheral neuropathy [see *Warnings and Precautions*]; *Skin and Subcutaneous Tissue Disorders*: serious skin reactions, including Stevens-Johnson syndrome and vesiculobullous rash (with or without mucous membrane involvement); *Gastrointestinal Disorders*: nausea, vomiting.

**DRUG INTERACTIONS HMG-CoA Reductase Inhibitors** In healthy subjects, concomitant administration of CUBICIN and simvastatin had no effect on plasma trough concentrations of simvastatin, and there were no reports of skeletal myopathy [see *Clinical Pharmacology* in full prescribing information]. However, inhibitors of HMG-CoA reductase may cause myopathy, which is manifested as muscle pain or weakness associated with elevated levels of creatine phosphokinase (CPK). In the Phase 3 *S. aureus* bacteremia/endocarditis trial, some patients who received prior or concomitant treatment with an HMG-CoA reductase inhibitor developed elevated CPK [see *Adverse Reactions*]. Experience with the coadministration of HMG-CoA reductase inhibitors and CUBICIN in patients is limited; therefore, consideration should be given to suspending use of HMG-CoA reductase inhibitors temporarily in patients receiving CUBICIN. **Drug-Laboratory Test Interactions** Clinically relevant plasma concentrations of daptomycin have been observed to cause a significant concentration-dependent false prolongation of prothrombin time (PT) and elevation of International Normalized Ratio (INR) when certain recombinant thromboplastin reagents are utilized for the assay. The possibility of an erroneously elevated PT/INR result due to interaction with a recombinant thromboplastin reagent may be minimized by drawing specimens for PT or INR testing near the time of trough plasma concentrations of daptomycin. However, sufficient daptomycin concentrations may be present at trough to cause interaction. If confronted with an abnormally high PT/INR result in a patient being treated with CUBICIN, it is recommended that clinicians: 1. Repeat the assessment of PT/INR, requesting that the specimen be drawn just prior to the next CUBICIN dose (i.e., at trough concentration). If the PT/INR value obtained at trough remains substantially elevated above what would otherwise be expected, consider evaluating PT/INR utilizing an alternative method. 2. Evaluate for other causes of abnormally elevated PT/INR results.

**USE IN SPECIFIC POPULATIONS Pregnancy** Teratogenic Effects: Pregnancy Category B. Reproductive and teratology studies performed in rats and rabbits at doses of up to 75 mg/kg (2 and 4 times the 6 mg/kg human dose, respectively, on a body surface area basis) revealed no evidence of harm to the fetus due to daptomycin. There are, however, no adequate and well-controlled trials in pregnant women. Because animal reproduction studies are not always predictive of human response, CUBICIN should be used during pregnancy only if the potential benefit outweighs the possible risk. **Nursing Mothers** It is not known whether daptomycin is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when CUBICIN is administered to nursing women. **Pediatric Use** Safety and effectiveness of CUBICIN in patients under the age of 18 years have not been established. **Geriatric Use** Of the 534 patients treated with CUBICIN in Phase 3 controlled clinical trials of complicated skin and skin structure infections (cSSSI), 27% were 65 years of age or older and 12% were 75 years of age or older. Of the 120 patients treated with CUBICIN in the Phase 3 controlled clinical trial of *S. aureus* bacteremia/endocarditis, 25% were 65 years of age or older and 16% were 75 years of age or older. In Phase 3 clinical trials of cSSSI and *S. aureus* bacteremia/endocarditis, clinical success rates were lower in patients  $\geq 65$  years of age than in patients  $<65$  years of age. In addition, treatment-emergent adverse events were more common in patients  $\geq 65$  years of age than in patients  $<65$  years of age. The exposure of daptomycin was higher in healthy elderly subjects than in healthy young subjects. However, no adjustment of CUBICIN dosage is warranted for elderly patients with creatinine clearance ( $CL_{CR}$ )  $\geq 30$  mL/min [see *Dosage and Administration* in full prescribing information and *Clinical Pharmacology* in full prescribing information]. **Patients with Renal Impairment** Daptomycin is eliminated primarily by the kidneys; therefore, a modification of CUBICIN dosage is recommended for patients with  $CL_{CR} < 30$  mL/min, including patients receiving hemodialysis or continuous ambulatory peritoneal dialysis (CAPD). In patients with renal impairment, both renal function and creatine phosphokinase (CPK) should be monitored more frequently than once weekly [see *Dosage and Administration* in full prescribing information, *Warnings and Precautions* in this summary, and *Clinical Pharmacology* in full prescribing information].



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# Smart choices with smartphones

Many fitness and nutrition companies have joined the growing smartphone app world and are offering tools to help you either begin or maintain a healthy lifestyle.

“myfitnesspal” is a free service that allows users to calculate calories and exercise into a personalized daily fitness plan. Subscribers can share fitness milestones with friends also using the program and take advantage of its large nutritional information database. While this app is designed for use on a handheld device, “myfitnesspal” does have a version for your internet browser. Similar free apps include “Livestrong” and “Calorie Counter.”

Whether you need a recipe free of gluten, one that’s diabetic-friendly, are looking for a healthy alternative to a favorite dish, or want to know what you can make with the ingredients in your kitchen, there’s an app for that.

You can also access healthy apps – many of which are free – containing everything from yoga tutorials to a sleep tracker. You can map your run, track your pregnancy, or review first aid technique. There’s even an app – “Quitter” – to help you kick a bad habit by displaying the amount of money you save daily without buying that coffee, pack of cigarettes or soda.



## shifting gears

### Fall into green

Even though the leaves gave up their spring colors, you can still have a green fall.

- Ensure your home’s insulation is ready for the chill in the air. By guaranteeing the efficiency of your heater, you’ll avoid high electric bills while also preventing excess energy usage.
- When preparing for holiday parties, choose organic cleaning supplies at your local store. Not only are they eco-friendly, the health benefits are numerous when compared to their often-toxic counterparts.
- Depending on your part of the country, experts say that autumn can be the ideal time to plant trees. The combination of greater rainfall and less extreme heat that accompany fall, might just be the key for trees.

### Off the beaten path

## Corny destination

Every year, a team of designers and local artists work to construct the annual – and transient – corn facade on the world’s only Corn Palace in Mitchell, S.D., population **15,254**.



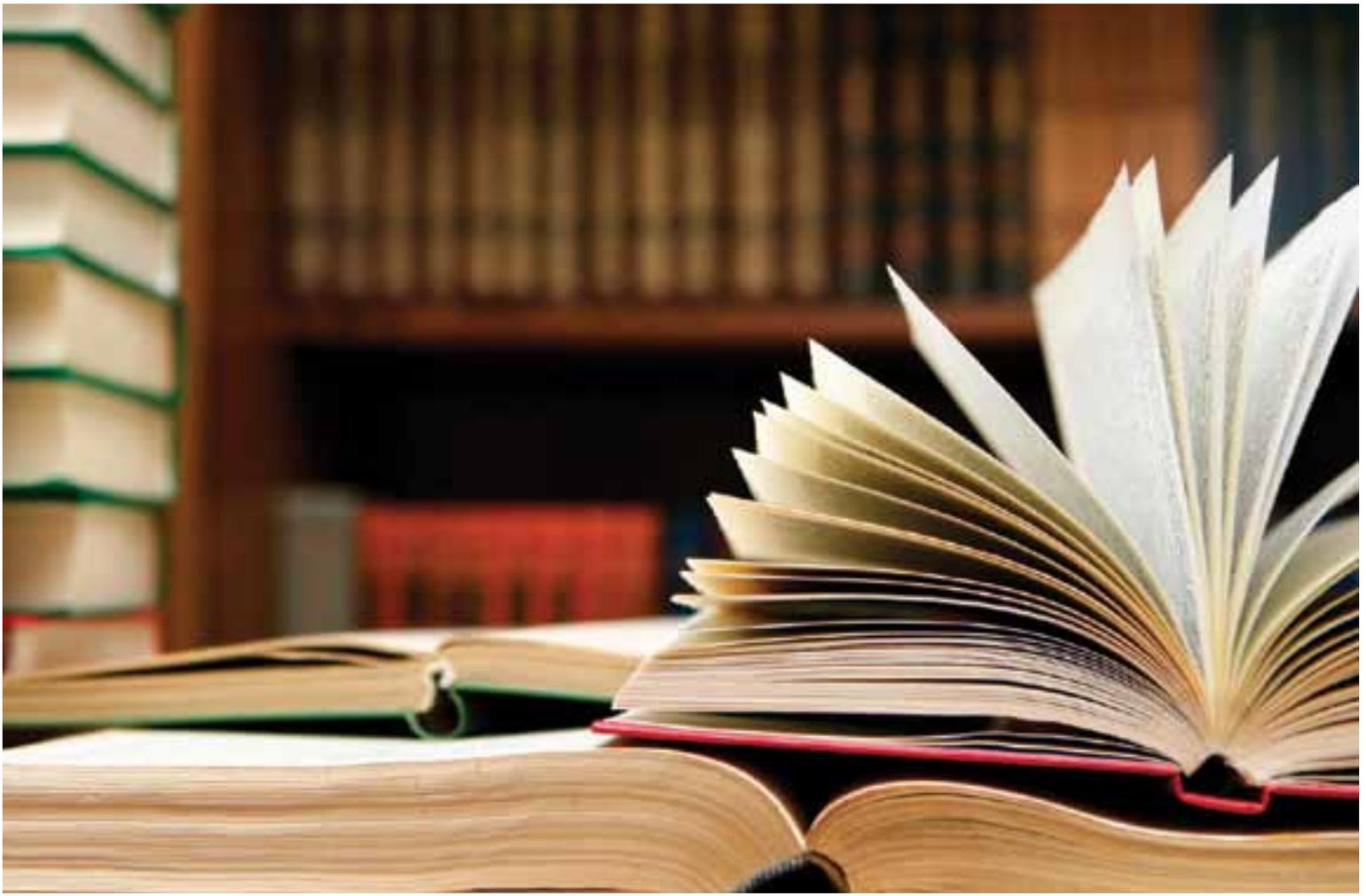
Corn Palace

This Midwest marvel was completed in **1921** after its initial construction in **1904** for the City of Mitchell’s failed attempt to usurp Pierre as South Dakota’s capital. Though Mitchell’s bid was unsuccessful – **aw, shucks!** – the Corn Palace has proven to be a staple of their community for decades and is vital to South Dakota tourism efforts.

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