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Cover photo: Kearny County Hospital physician Arlo Reimer holds twins he delivered at the rural Kansas hospital.

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Raymond Christensen

Treasuring rural life

Personal journeys are poignant reminders of the treasures of rural America.

As we prepare for the labor and scurry of the fall harvest, we reflect on the work of the spring and summer. As summer draws to a close, we focus on family and community, both solid foundations of rural infrastructure.

Family reunions, community celebrations, gatherings of faith, illness and disaster draw families and communities together. Personal roots are reexamined and renewed. Families and communities celebrate, heal old scars and instill their heritage in children. Great-great-grandpa's old Model A and T are fired up, and for a moment yet another generation can touch and relive the past.

Communities are built and sustained through personal contribution, collaboration, shared services and the introduction of new skills, which are necessary for community support services, utilities, public health and health care.

Thank you from rural America for your dedication, community service and leadership in providing health care and quality of life.

Please pause and enjoy your/our rural family and community.

Have a great fall!

A handwritten signature in blue ink, appearing to be 'Ray'.

Raymond Christensen, MD
2014 NRHA president

pit stop

5 things I picked up in this issue:

1. Kansas City Mo., home of NRHA's next conference, has more barbecue restaurants per capita than any other city in the nation. *page 38*
2. Thanks to the Telehealth Network Grant Program, more than 760,000 patients across the country now have access to care. *page 25*
3. Out of 35 Senate members, only seven represent rural districts in Colorado. *page 32*
4. Kearny County Hospital in Lakin, Kan., serves patients of approximately 30 nationalities speaking at least 16 languages. *page 7*
5. The majority of rural residents live in a state that has not expanded Medicaid. *page 47*

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In 2013, physicians at Kearny County Hospital delivered 195 babies from nine Kansas counties and one Colorado county. By next year, that number could increase by 75 percent.

Home on the range

Pioneer Baby project advances prenatal care in rural Kansas

By Angela Lutz

When Benjamin Anderson took over as CEO of Kearny County Hospital in Lakin, Kan., last June, he saw a lot of room for growth, particularly in the obstetrics department.

Mothers, he says, make the vast majority of health care decisions for their families, including their children, spouses, parents and spouse's parents. He wanted the women in remote southwest Kansas to know someone had their backs as well.

continues on page 9

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“Mothers spend much of their lives caring for other people,” Anderson says. “We are deliberately taking care of moms because moms take care of everyone else.”

The timing for Anderson’s focus on obstetrics is spot on. In 2013, the 25-bed critical access hospital delivered 195 babies from nine Kansas counties and one Colorado county. Due to a recent partnership with United Methodist Mexican-American Ministries (UMMAM) in Garden City, which recently lost a midwife, Anderson estimates this number will continue to grow by as much as 75 percent in the coming year.

“We want to communicate to moms that we support them and we love them. They love everyone else, so our call is to love them.”

Benjamin Anderson, Kearny County Hospital CEO

To address this growing need, Kearny County Hospital has partnered with the University of Kansas School of Medicine to kick-start the Pioneer Baby project, a multi-phase initiative to upgrade equipment, recruit new staff, improve training, and determine the health care needs of women in the area.

Several phases are well underway: In February, the hospital received a grant from the Children’s Miracle Network to purchase new equipment, and in the last year they have recruited two more family practice doctors for surgical obstetrics training.

Quality care closer to home

Many of the providers the hospital has recruited share a common background: Almost all of them have volunteered abroad. Due to the presence of a Tyson Foods slaughterhouse in nearby Holcomb, the region’s population is very diverse – through the hospital’s partnership with UMMAM, Anderson says they serve approximately 30 nationalities speaking at least 16 languages. The ability to provide culturally compassionate care and speak multiple languages helps physicians to connect with their patients, many of whom have trouble adjusting to life in Kansas.

“Many of them get off the plane with two suitcases and sandals in the middle of winter,” Anderson says. “They experience a lot of social challenges. Our doctors



Kearny County Hospital physician Drew Miller holds an infant he delivered by C-section.

have spent their vacation time in some of the places these people are from. By going to those countries and serving internationally, [the physicians] are better equipped to serve right here at home.”

More physicians and state-of-the-art equipment is good news for women like Andra Peters, who delivered twins at the hospital seven years ago. She experienced a number of pregnancy complications, and she was told that she would need to be flown to Wichita or transferred to Garden City to deliver. Instead she chose to give birth at Kearny County Hospital.

“I’m a hometown girl,” Peters says. “When it came right down to it, I didn’t want to go to Garden City. I didn’t want to go to Wichita. I knew all the people at the hospital. These are my friends and neighbors, and I knew they would work hard for me.”

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Like most of the physicians he recruits, Kearny County Hospital CEO Benjamin Anderson regularly volunteers abroad.

Many area women agree with Peters; according to Anderson, moms-to-be will drive more than two hours to give birth at Kearny County Hospital, which is often their nearest point of access to care.

“Moms don’t always make it [to the hospital],” Anderson says. “Sometimes they deliver in the back of a vehicle on the side of the road. We’re very remote. But we’re honored and humbled by the fact that women are driving two hours one way to have their baby here, and we take that responsibility very seriously.”

A public health concern

Another key issue the Pioneer Baby project aims to address is the region’s high rate of gestational diabetes mellitus (GDM). While gathering pilot data to apply for grants, Lisette Jacobson, PhD, University of Kansas School of Medicine Department of Preventive Medicine and Public Health faculty member and researcher, discovered the GDM rate for patients at Kearny County Hospital is 11 percent, nearly twice the national average.

This, she says, may be associated with the diversity of

the population, as GDM occurs disproportionately among Hispanic, Asian, American Indian and African American women. It is also a growing public health concern: Women who have GDM are more likely to develop type 2 diabetes within five to 10 years after pregnancy, and type 2 diabetes puts patients at a high risk for coronary heart disease.


“One thing leads to another,” Jacobson says. “You want to address GDM as soon as you know you have a high GDM rate, because if you don’t, 15 to 20 years from now you may have a bigger problem on your hands.”

In order to expand the Pioneer Baby project and develop an initiative to address GDM in the region, Jacobson is working with Jennifer Duong, a “very ambitious” master’s in public health candidate at the University of Kansas. Duong is gathering pilot data that will be used to apply for grants by conducting literature reviews and surveying women in the region to determine their health and nutrition needs.

Jacobson and Duong have found that very few initiatives exist that address GDM specifically – and almost none of them focus on rural areas. Jacobson says Pioneer Baby will focus on three major components: weight management, nutrition and physical activity.

“Customizing an intervention to reduce GDM in a rural area is virtually unheard of,” Jacobson says. “This is kind of a new area we’re moving in to.”

Jacobson says the Pioneer Baby team plans to apply for grant funding this fall. As the project continues to evolve, Anderson is recruiting more physicians to join the Kearny County Hospital staff. He wants his hospital to be “the safest, most attractive place to have a low-risk baby in Kansas,” noting that rural hospitals can’t and shouldn’t do everything, “but what we do, we can do very well.”

“Until the line at the door disappears, we’re going to keep recruiting,” Anderson says. “We want to communicate to moms that we support them and we love them. They love everyone else, so our call is to love them.” 

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Members of the Ho-Chunk Nation, a Native American tribe in Jackson County, Wis., are taking charge of their health by growing their own vegetables.

Motivated by low health rankings, a rural county gets growing

By Angela Lutz

Using seeds, dirt and just a few simple tools, the rural community of Jackson County, Wis., is reclaiming its health.

After recent health rankings placed Jackson County 68th out of 72 counties in the state, Lisa Listle, project director at Together for Jackson County Kids, a community partnership promoting healthy lifestyle choices, says something had to be done.

A partnership was formed with the Jackson County Public Health Agency, the University of Wisconsin, the Black River School District and Black River Memorial Hospital, a 25-bed critical access hospital, and the Jackson in Action Coalition (JIAC) was born in 2012.

Using hospital-community partnership grant funding from the Wisconsin Office of Rural Health, the coalition sought to address obesity, poor eating habits and sedentary lifestyles with a particular focus on high-risk populations, such as the Ho-Chunk Nation, a local Native American tribe.

“Native Americans have a high rate of diabetes within their community,” Listle says. “I don’t think Jackson County is considered a food desert, but there are a lot of fast food places here, and it’s easy to go there.”

JIAC’s first challenge was making fresh produce accessible and affordable for Jackson County residents – and nothing gets vegetables closer to the dinner table than growing them in the backyard.

Thanks to the coalition’s two-year-old pallet garden project, nearly 30 members of the Ho-Chunk Nation and Department of Health and Human Services Women, Infants and Children program participants grew fresh produce at home this summer.

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Master gardener Ron Gasoske (right) provided pointers for building and planting pallet gardens.



The Jackson in Action Coalition seeks to address the health concerns of high-risk populations in rural Jackson County, Wis.

On the advice of master gardener Ron Gasoske, JIAC provided each resident with a fabric-lined wooden pallet, soil and seeds, as well as a separate bucket to grow tomatoes. If elderly or disabled residents required extra assistance, Gasoske and other JIAC volunteers were there to help. The low-maintenance gardens are perfect for small spaces, focusing primarily on vegetables that can be cut and eaten immediately, like lettuce and spinach.

“I know for sure my grandchildren and I will have a blast creating our gardens. I look forward to more holistic, down-to-earth projects in the future to keep our Ho-Chunk families engaged with one another and healthy. After all, we were great gardeners once upon a time.”


Jean Stacy-Snow, Ho-Chunk Department of Personnel Elder Community Work Project administrator

“People can harvest right away,” Listle says. “It doesn’t take long for that stuff to grow, and you can cut it down and it grows right back.”

The pallet gardens have also brought Ho-Chunk families and communities within the county closer together by giving them the opportunity to work on common projects with a shared goal. This not only teaches people how to eat healthier, Listle says, but it passes that knowledge on to future generations.

“I know for sure my grandchildren and I will have a blast creating our gardens,” says Jean Stacy-Snow, Ho-Chunk Department of Personnel Elder Community Work Project administrator. “I look forward to more holistic, down-to-earth projects in the future to keep our Ho-Chunk families engaged with one another and healthy. After all, we were great gardeners once upon a time. I remember planting gardens with my grandma Stella

Stacy, herbs and mushrooms too. Makes me want to cry tears of joy that you brought those memories to the surface for me – good times back then that I want to create with my grandchildren.”

To extend outreach and education efforts further, JIAC hosts Harvest of the Month events where residents sample two different recipes and take copies of each home to try. For the Ho-Chunk Nation, JIAC has lead demonstrations at their tribal office building. 

Get your hands dirty

Pallet gardens are a simple way to grow fresh produce when you have limited time and space. Here’s how to make your own in five easy steps.

You’ll need:

- a wooden pallet
- weed cloth or landscaping fabric
- a staple gun and sandpaper
- two large bags of potting soil
- plants (lettuce, spinach and peppers work well)

1. Clean your pallet and sand down any rough spots.
2. Cover the bottom, back and sides of your pallet with weed cloth and staple it in place. Also staple along the spine of the pallet and anywhere soil might fall out.
3. Pour the potting soil onto the pallet and push it through the slots.
4. Plant approximately six plants into each open pallet slot, making sure to tightly pack the soil.
5. Water your garden regularly and prepare for harvest.

Electronic records: The costly, time-consuming process for small, rural hospitals

By Chelsea Keenan



Karla Welch works on charts at a mobile work station at the Regional Medical Center in Manchester, Iowa. Photo by Liz Martin.

At Regional Medical Center in Manchester, Iowa, there's a room filled with file after file of patients' medical records.

But since 2010, the hospital has been slowly working to make these paper records electronic – and it's nearly complete.

"When we first went to electronic medical records (EMRs), the space needed to store them was twice as big," says Rose Mary Hunt, medical services director at the hospital. "We have about 85,000 patient records total, and we've definitely trimmed that down."

Hunt said all the paper records in the room have been transferred – the hospital now needs to take the necessary precautions before it destroys them.

EMRs provide a comprehensive patient history that

allows hospitals to track data, better monitor patients and improve quality of care.

As part of the American Recovery and Reinvestment Act of 2009, the federal government mandated that all hospitals implement electronic records by 2015 and that EMR systems be capable of certain tasks that constitute "meaningful use."

To ensure that universal adoption throughout the health care industry actually works, the government has set thresholds that hospitals and professionals must meet to prove they are actively using the records. Those that do can apply for incentives.

And those hospitals that don't will face penalties, including a decrease in the amount of Medicare reimbursements.

Big or small

But implementing EMRs is a huge undertaking that involves large investments of time and money.

“The industry is struggling; it doesn’t matter if you’re big or small,” says Kurt Kramer, information systems manager at Regional Medical Center, a 25-bed critical access hospital. Critical access hospitals differ from acute care facilities in that they meet Medicare conditions of participation, which include having no more than 25 inpatient beds.

For smaller, rural hospitals, implementing EMRs can be a huge expense to purchase the software and hardware, and to train employees.

“It was a significant investment,” Kramer says.

Brock Slabach, senior vice president for member services at the National Rural Health Association, says access to capital is a challenge for rural hospitals, especially if they can’t qualify for a loan. EMRs can cost anywhere between \$800,000 to \$1.5 million, he says.

One big issue going forward, Slabach notes, will be how hospitals can pay maintenance and upkeep fees for the software once the government incentives end in 2015.

“The industry is struggling; it doesn’t matter if you’re big or small.”

Kurt Kramer, Regional Medical Center information systems manager

Kim Gau, CEO of Guttenberg Municipal Hospital, says the 20-bed critical access hospital had to shell out more than \$1.2 million for the hardware and an additional \$33,000 for training. That was a big cost for the hospital, which has an annual operating margin of about \$200,000, she says.

“It has definitely been a journey,” Gau says.

The hospital, a UnityPoint Health affiliate, started making the switch to Epic, an EMR system based in Wisconsin, in 2010. Gau says the hospital’s affiliation with a large health system gave it resources, including a rural access team, which helped train the clinical users.

More work to do

“An extra 50 people basically moved into the community when we went live” in June 2013, Gau says.

Now that the EMRs are mostly implemented, the hospitals are working on changing workflows. Registration of new patients can take a bit longer because more information is required, and doctors and nurses need to input information in real time, hospital administrators say.

“As nurses are taking someone’s blood pressure or asking questions, they have to put in information – they can’t get backlogged,” Gau says.

The state of Iowa also is working on a health information exchange,

which will allow hospitals and clinics to easily exchange patient data. So if a patient in Manchester needs to see a specialist at the University of Iowa, the doctors electronically can exchange information if they are not using the same systems.


But Kramer says there is still a lot of work to be done before that is up and running.

And hospitals still have goals to meet. The rollout has been done in stages, with different hospitals at different stages depending on when they moved to EMRs.

The Centers for Medicare and Medicaid Services recently extended stage two another year, putting off the start of stage three, Slabach says.

“As you move stages, it raises the level of complexity,” he says. “The bar gets raised.”

Regional Medical Center, which is in stage two, is working on a portal that allows patients to view their medical records online. Hospitals must have at least 5 percent of patients using the portal.

“In a rural area, that’s more difficult,” Kramer says. “We have a lot of elderly patients who don’t have email or access to a computer. We’ve seen that other hospitals are struggling with that and I expect we will too.” 

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On the record

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Mental health by wire

Telepsychiatry gains momentum at academic medical centers reaching out to rural

By David Rath

There are 8,300 child and adolescent psychiatrists practicing in the United States, and 400 residents graduate each year. But psychiatry continues to experience a provider shortage, particularly in child and adolescent psychiatry.

“There is no way we can meet the societal need with the present care model,” says David Pruitt, MD, director of child and adolescent psychiatry at the University of Maryland (UM).

Specifically, telepsychiatry can extend the reach of providers to help them serve clients in rural areas, in schools that do not have staff on site or in areas where integrated care is being used. Pruitt spoke about the potential of telepsychiatry at the recent American Telemedicine Association meeting in Baltimore.

Delivery of remote behavioral health services using technology is a key component in the University of Maryland’s approach to community engagement.

“We teach residents how we in psychiatry can be relevant in the new medical/behavioral care environment,” says Pruitt.

Proof of concept

Michele Fallon Travers, MD, chief of telepsychiatry at University of Florida (UF) Health in Gainesville, launched a telepsychiatry program last year.

“As of a year ago, I was surprised to learn that no one was doing telepsychiatry at UF. In fact, no one was doing telemedicine at all, so I volunteered to do it,” she says.

She worked with UF information technology teams on the first proof of concept for telemedicine, and it served as a model for the entire university. The project focused on student mental health in the campus Counseling and Wellness Center.

The team chose to start there because the billing would be easier and because students were likely to embrace the technology, Travers says.

“College students pay health fees as part of their tuition, so collecting revenue was not an issue,” she adds.

Also, college students are comfortable using Skype, Facetime and mobile devices regularly. They are more comfortable using technology than the doctors are, Travers says.

HIPAA-compliant videoconferencing was offered free for college students, initially on campus, then anywhere in Gainesville, and later anywhere in the state of Florida.

The new setup has other benefits. For example, the infirmary, where students receive primary care, is quite a distance from the counseling center. Previously, in an emergency situation, UF would have to activate the campus police department to transport a student to the psychiatry department for consultations, Travers says.

“There is no way we can meet the societal need with the present care model.”

David Pruitt, University of Maryland director of child and adolescent psychiatry

Now the primary care doctor can hold an emergency consultation through the use of telemedicine, rather than moving the patient.

UF has begun several research projects to gauge its program, including studying student perceptions.

“In our first study, the students rated the acceptability of telepsychiatry high compared to group therapy,” Travers says. “In fact, many preferred it to face-to-face meetings.”

As providers increasingly seek reimbursement for the virtual services, the Florida legislature is examining the issues with a state telepsychiatry task force, which Travers was asked to chair.

“At UF, our focus has been on improving convenience factors. But now that we have our sea legs, we are starting to pursue fee-for-service and contract work,” she says. “We are in negotiation with several clinics and hospitals that have asked us to provide emergency and forensic services via contract.”

Collaborative care model

Patrick O'Neill, MD, director of telepsychiatry at Tulane University in New Orleans, says his institution has been working on telepsychiatry for several years.

Six years ago, Tulane was approached by a region of the state that was underserved.

"We developed a system that piggybacks on the state intranet," O'Neill explains. "We have Polycom desktop sets and sell our faculty time in four-hour blocks."

Tulane has gradually built up to clinical services.

"We average 180 hours a week, not including the VA [Veterans Affairs] and forensic work we do," he says.

Among other programs, Tulane provides telepsychiatry services to the grant-funded Integrated Behavioral Health Program for federally qualified health centers in Louisiana.

The program employs a collaborative care model, in which the primary care provider, behavioral health specialist, patient navigator and consulting psychiatrist work together to address a patient's mental health issues within the primary care setting.

Robert Caudill, MD, associate professor of psychiatry at the University of Louisville, directs its telepsychiatry program. It has grown to offer 64 hours per week of clinical services to several rural community health agencies in underserved areas of the commonwealth.

"Kentucky has 120 counties with 14 community mental health centers. Each has its own internal politics and governance structures," Caudill says. "We have active programs in two [centers], and will have a third up and running soon."

Rather than seeking grant funding, the program has worked to develop institutional contracts to be self-supporting.

"We can offer two hours a week to an isolated rural clinic," he said. "We offer a fixed hourly rate with agreed-upon clinical parameters, such as how many patients per hour."

Still under investigation for future offerings are emergency department coverage, medical-surgical hospital consultations, asynchronous services, home-based patients, nursing homes and day treatment programs, Caudill says.

Fostering participation

At the University of Maryland, faculty teach a community-based liaison model of how to work with teams and how to integrate treatment.

"There are 6.5 million children with attention deficit hyperactivity disorder (ADHD) diagnoses, and 3.5 million children take ADHD

continues on page 23

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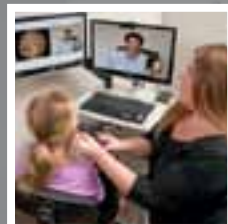
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medications. Many will be seen by 54,000 practicing pediatricians,” Pruitt says. “How will the primary care provider, child psychiatrist, school clinician and community provider participate and interact? What will be the role of tele-mental health in fostering participation and interaction?”

UM’s focus is on the underserved, both rural and high-density urban.

The Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP) is a collaboration between the Maryland Department of Health and Mental Hygiene, the State Department of Education, Johns Hopkins Bloomberg School of Public Health, the University of Maryland School of Medicine and the Salisbury University Department of Social Work.

The core component is a phone consultation service to help the primary care provider to effectively deliver more mental health services. There is no cost to providers or patients and no insurance required. It also offers referral services to link families to services in their community, county by county, and statewide and co-location of


social workers with primary care providers.

“Our telephone consultation is anonymous to the patient. It has become clear that the primary care provider at times needs more direct patient evaluation. We plan to develop this capacity immediately through telehealth,” Pruitt says.

B-HIPP is expanding sites into Maryland counties with few or no child psychiatrists.

“There is a huge societal need for more mental health care for children and adolescents,” Pruitt says. “Seventy to 80 percent of children receive mental health services through schools. Psychiatry is the most needed service in school mental health. We provide telepsychiatry consultations in both rural and urban schools in Maryland. We are in 70 schools across the state, and in 27 Baltimore schools.”

Pruitt described plans to move to a school mental health model that is a hybrid, where a child psychiatrist does the initial evaluation face to face with telehealth follow-ups.

“The philosophy is to have the right person in front of the patient at the right time with evidence-based treatment using the right technology,” he says. 

This article, which originally appeared in Behavioral Healthcare in June 2014, is reprinted with permission from the American Telemedicine Association.

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Statistics show telehealth's value in rural America

By Carlos Mena

The Office for the Advancement of Telehealth (OAT) coordinates telehealth grant programs and provides technical assistance to help rural communities create new telehealth programs or enhance existing ones.

Part of the federal Office of Rural Health Policy, OAT's core funding activity is the Telehealth Network Grant Program (TNGP), which aims to improve access to specialty care services in rural communities through the use of telehealth.

"Telehealth can help improve access to needed services, reduce rural practitioner isolation, improve health system productivity and efficiency, and improve patient outcomes," says Sherilyn Pruitt, OAT director.

According to the Health Resources and Services Administration's summary report for 2004-10, telehealth encounters through the TNGP have brought many needed services to rural communities, with more than 760,000 patients receiving care thanks to the technology.

Grantees were also able to recruit new referring and consulting practitioners to serve patients via telemedicine in a wide variety of settings, with hospital outpatient facilities (34.6 percent) and patients' homes (32.1 percent) being the most common locations.

The program also allows health care students and trainees in isolated areas to receive mentoring and training. More than 33,000 formal and informal mentoring sessions occurred as a result of TNGP funds during the six-year survey period.

"What's really exciting is that 98 percent of TNGP grantees continued to be sustainable after funding ended," Pruitt says. "All of this progress and value is a result of the hard work our rural communities put into increasing access to care through telehealth."



Eric Higgins, University of Kentucky Department of Ophthalmology clinical faculty, demonstrates how the Kentucky Telehealth Networks's automated diabetic retinopathy screening camera works with Rebecca Craft-Carlos, University of Kentucky physician liaison. The machine does not need to be operated by a trained ophthalmology technician.

OAT also helps rural communities leverage technology by connecting providers with telehealth resource centers. There are 14 grant-funded/supported resource centers across the country, available to match clinical needs to the right telehealth application and work through other issues, such as licensure or getting the right piece of equipment.

"These experts in the field help rural providers figure out how best to leverage telehealth technology," Pruitt says.

Learn more about OAT grant opportunities by visiting hrsa.gov/ruralhealth/about/telehealth. 

Carlos Mena is a public health analyst for the Office for the Advancement of Telehealth.

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Easter Seals, NRHA create free guide for rural transportation planning

By Rachel Beyerle



Cowlitz Indian Tribe Transit Service in Washington State offers boarding assistance and lift equipment to make travel easier for those who use wheelchairs and mobility devices or have difficulty navigating steps.

“Through this pocket guide, we hope to reach people who may need to plan ahead to meet their personal transportation needs,” says Carol Wright, Easter Seals assistant vice president of transportation and mobility. “In addition, Easter Seals Project ACTION’s [ESPA] partnership with the National Rural Health Association for this resource will help us reach a larger number of rural communities to help them advance accessible transportation options. As the former associate director of the Small-Urban and Rural Transit Center, Upper Great Plains Transportation


Most people in rural areas depend on driving their personal car or truck to get around, but what happens when medical circumstances temporarily or permanently affect that option?

People with newly acquired disabilities or mobility-limiting medical conditions who live in rural areas must seek out other transportation modes, and if possible it is important to do so before the need occurs.

Developed by Easter Seals Project ACTION (Accessible Community Transportation in Our Nation) and the National Rural Health Association, *Planning for Transportation After Medical Services Pocket Guide: Rural Edition* is a free tool for physicians and patients to prompt discussion about specific transportation options before or after a medical procedure. With a series of questions, the pocket guide leads patients through the process of considering and researching types of transportation available in their communities, ranging from asking family and friends for help to using public transportation.

Institute at North Dakota State University, I saw firsthand how integral technical assistance can be for rural areas seeking to better coordinate or improve their transportation options on tight budgets, and ESPA is the perfect source for providing that assistance.”

An overview of the rural-relevant guide and other Easter Seals products and services was presented to the NRHA State Association Council and the Virginia Rural Health Association earlier this year.

Physician offices, health care agencies and other interested parties may order or download the guide in English or Spanish at projectaction.org. 

Rachel Beyerle is the Easter Seals Project ACTION communications director.

Beginnings & Passages



Katrina McTigue

“This summer has been a perfect start to what I hope to be an exciting and meaningful career working with underserved communities in the health care field.”

NRHA intern hopes to improve health care closer to home

By Katrina McTigue

This past March on a spring break service trip, I found myself immersed in my first real-world public health experience in the rural community of El Ojochal, Honduras.

After months of preparation, our group of 16 students was finally in-country, interacting with families, building sanitary spaces and learning about a place thousands of miles from home.

I had anticipated culture shock, but throughout the week, I quickly realized that our team and the locals we worked with were truly more the same than different. Empowered with health education, the community was grateful for our efforts and eager to make sustainable improvements.

Back on campus a few weeks later, I learned about a free medical clinic in Appalachian Virginia during a unit on health care reform. I was honestly shocked by the conditions my fellow Virginians presented with and equally struck by how grateful they were for treatments as basic as a pair of eyeglasses. Learning about the medical and socioeconomic challenges faced by these people reminded me too much of my time abroad. While I knew I could not afford to spend all my time in developing countries, I realized there must be a way to improve access to health care closer to home.

I found such an opportunity at the National Rural Health Association. Interning here allowed me to make a real difference in people's health and has opened my eyes to future possibilities in the field.

A great example of this is a project I worked on with my fellow intern Sarah Porter. The task was to create a webpage where communities can easily refer to rural-relevant sources when faced with disaster. After launching the page this summer, Sarah and I were introduced to a CDC official who was impressed with our work and offered his guidance as we continue to improve the page. Through this project I learned about unique issues affecting rural communities while also getting to see a project materialize and evolve.

As I begin my sophomore year this fall, I am keeping an open mind when it comes to post-graduation plans. However, this summer has been a perfect start to what I hope to be an exciting and meaningful career working with underserved communities in the health care field.

Katrina McTigue is an undergraduate student at the College of William & Mary majoring in Hispanic studies and kinesiology with a pre-medical concentration. She became a National Rural Health Association intern at the D.C. office in May. McTigue's specific interests include border health and HIV/AIDS in the United States, both of which she was able to incorporate into her NRHA internship.

Are you relatively new to rural health or looking back on years of serving rural America?
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“I am not so much a rural advocate as an advocate for rural. And for me, that is a job made in heaven.”



Tim Size

Advocating for neighbors, caring for neighbors

By Tim Size

I was once asked, “How do you cope with all your failures?” Responding honestly, I said, “I didn’t realize I had that many.”

When I started counting them up, I realized that I had a longer list than this man could possibly have known. The “aha” moment was that he was counting failures, and I was counting successes.

Luckily, I had changed how I “kept score” early in my career. This led to a transition from working at a university hospital to the Rural Wisconsin Health Cooperative (RWHC), where calculated risk taking was needed – even expected.

Thirty-five years ago, while being interviewed by RWHC’s initial board, we each had a concern. I thought that a board of hospital CEOs might tend to step over the line and micromanage me. They thought that I (a “hot shot” from the state capital) wouldn’t be interested in hanging around for very long. I am grateful they didn’t and I did.

I was and am attracted to working with the rural hospitals in RWHC (then five, now 39), not because they are rural but because of the passion they bring as neighbors caring for neighbors.

The conventional wisdom was, then and now, that bigger is better. I’d had just enough experience with consortia to know

that people working together, if done well, could help level the playing field – and my cranky nature has always led me to root for the underdog.

Some of my most vivid memories of growing up in the late 1950s are the endless kitchen arguments with my devout Baptist mother on the theory of evolution. Like many women of her generation raised in the shadow of the old South, she had a finely tuned nature, smiling and cajoling while not giving an inch. I think she was creating an advocate long before I realized it.

But as a beloved and somewhat curmudgeonly board member frequently reminds me, having a pond in my backyard in downtown Madison doesn’t make me rural. He is right; I am not so much a rural advocate as an advocate for rural. And for me, that is a job made in heaven.

Tim Size was the Rural Wisconsin Health Cooperative’s first employee and has lead RWHC since 1980. He was president of the National Rural Health Association in 1997 and is co-chair of NRHA’s Rural Health Foundation.



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Shrinking rural representation at state capitals means growing role for advocates

By Alicia Haywood



Alicia Haywood

Changing demographics in legislature matter to rural communities.

Colorado is not unique; with each election, the proportion of rural-to-urban legislators decreases, and with term limits, the institutional knowledge of rural issues built over time disappears.

As we lose rural representation under the gold dome in Denver, we also lose knowledge, experience and understanding of the realities of life in a rural community. This means that we, as advocates, must be diligent as we represent our communities and constituents and educate our urban elected officials so the understanding of rural life is not lost.

Increasingly, the definition of rural at the Capitol

means towns like Pueblo or Grand Junction. To provide context, these towns with populations of 161,000 or 59,000, respectively, may feel small, but they are certainly not rural. They have hospitals and public transportation. They have gyms and access to specialists.

A better example of a rural community might be Walden, which is 60 miles from anything. An ambulance sits in the parking lot of North Park Medical Center, a rural health clinic, because if there is an emergency, there often isn't time for an ambulance to make the 120-mile round trip to pick up a patient and return to the hospital. This "norm" may feel unimaginable to some of the policymakers at the Capitol. Rural is not a smaller version of urban, and each rural community has its own unique circumstances and characteristics that need to be addressed.

That's not to say our elected officials cannot be educated about the needs of rural communities; they absolutely can. But we all know that decisions are made at a fast and furious pace during legislative sessions, and there aren't enough rural representatives to sit on every

committee. Without adequate rural representation at the table, legislation can be crafted that disenfranchises or has unintended consequences for rural residents and health care facilities.


This means that we, as advocates, must build relationships not only with rural politicians, but urban as well, so that when the time comes to make decisions at the Capitol that have the potential to affect rural communities, legislators understand the full impact of their vote.

After a particularly contentious 2013 session, many rural Colorado residents said they felt left out. Some even accused the Democratic-controlled legislature of waging a war on rural Colorado.

The 2014 legislative session opened with a different tone. Opening-day speeches in both chambers, with leadership on both sides of the aisle, used the word "rural" frequently. Addressing rural was the new kissing babies on the political PR circuit. Jokes aside, the opening speeches and creation of a new rural caucus provide hope that awareness of rural needs might shift in 2014.

Senator Larry Crowder, a Republican from the San Luis Valley with the largest district in Colorado in terms of landmass, says there were some improvements this past year, such as the expansion of Internet into rural areas – but he says we need to keep putting the pressure on.

He's right, and this is where advocates must step in. With less rural representation in office, we need to speak louder to educate our electeds about rural issues and experiences to make sure the needs of rural residents are met.

As Crowder aptly states, "Rural Colorado folks are very much a part of this state and deserve the same benefits as any other citizen in this state." 

Alicia Haywood has been the Colorado Rural Health Center's policy and advocacy manager since 2010. She was a National Rural Health Association Rural Health Fellow in 2013.

By the numbers

Of the 65 Colorado state House members, 12 represent rural districts.

Out of 35 Senate members, seven represent rural districts.

Two years ago, Colorado redrew district lines in accordance with the latest census numbers. In the decade prior to that, there were 13 House members representing rural districts and eight Senate members representing rural districts.

In 2014, 15 Colorado legislators are term limited, and several are running for a different office or voluntarily leaving the legislature.

Out of 100 House and Senate seats, 83 are up for election in November.



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Record attendance in Atlanta

Nearly 200 people assembled in Atlanta for the National Rural Health Association's State Rural Health Association Leadership Conference and 10th annual Rural Quality and Clinical Conference in July.

Attendees praised the "helpful and practical sessions." "I left with new contacts and resources to sustain my learning," wrote one participant.

David Callahan, MD, of the Centers for Disease Control and Prevention, gave the keynote presentation. As an epidemiologist, Callahan has responded to the 2010 Gulf oil spill, the 2009 H1N1 pandemic, Hurricane Katrina and terrorist events and anthrax bioterrorism attacks in the fall of 2001.

Thirty state rural health associations (SRHAs) and 39 federal quality improvement program grantees were represented at the leadership event

including presidents, executive directors, board members and representatives from developing state associations.

"It's extremely valuable to be able to share successful initiatives, struggles and solutions with other state associations across the country," says Beth O'Connor, Virginia Rural Health Association executive director. "As always, I took home strategies and ideas I can put into motion right away."

Plan now to join NRHA for the 2015 SRHA meeting July 14-15 and the Rural Quality and Clinical Conference July 15-17 in Minneapolis.



More friendly faces

Continue your trip down Memory Lane or see what you missed with more photos from the 10th Annual Rural Quality and Clinical Conference and other NRHA events at flickr.com/nrha.

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Fill up on food, fun and culture in Kansas City with student member Mac Shipley

Side trip



Mac Shipley at Oklahoma Joe's Bar-B-Que

Welcome to barbecue heaven!

When I moved to Kansas City from small-town Lakin, Kan., three years ago, I was excited to discover that my new home has more barbecue restaurants per capita than any other city in the country.

They're all good, so choosing can be a little overwhelming. Here are a few of my favorite spots for you to try while you're in town for the National Rural Health Association's Rural Health Clinic (Sept. 30-Oct. 1) and Critical Access Hospital Conferences (Oct. 1-3).

Oklahoma Joe's may be located inside a gas station, but make no mistake – this legendary restaurant serves award-winning barbecue. The ribs here are amazing, and I would also recommend the famous Z-man sandwich to anyone with a smaller appetite. You don't have to take my word for it: President Obama and actors Paul Rudd and Jason Sudeikis also give Oklahoma Joe's rave reviews.

At **Gates Bar B.Q.**, the mixed plate is a fantastic way to try a little of everything – and the burnt ends are great as well.

Fiorella's Jack Stack is a classy place with a long history. The lamb ribs are a fun, interesting flavor, and the beans are the best in town.

If you're not in the mood for mounds of meat, the hot wings at the **Peanut**, Kansas City's oldest bar, are the best in the city – enough said.

If you get a chance, you should also try the gumbo or crawfish fettuccine at **Jazz Louisiana Kitchen**. Gritty and full of charm, this is the only place in town that reminds me of New Orleans. Happy hour is from 3-6 p.m., and live music starts at 7. I would suggest going on Thursday to see the Grand Marquis put on a show while you dine.

After stuffing your belly with food, fill your other senses with a little local culture. **The Nelson-Atkins Museum of Art** is a truly incredible museum. With its extensive collection, you'll be amazed admission is free, but a small donation at the front door is a nice gesture.

The Negro Leagues Baseball Museum offers a one-of-a-kind experience in a unique part of the city. The **18th and Vine** area has a deep history built around jazz, which the neighborhood still reflects.

With 75 acres that include fountains, green space, playgrounds, walking trails and a rose garden, **Jacob L. Loose Park** is a great place to go for a relaxing stroll. 🌳

Mac Shipley is a student at the University of Kansas Medical Center's master's program in hospital administration. He has been a National Rural Health Association member since 2013 and has volunteered at NRHA's Critical Access Hospital Conference.

Hungry for knowledge

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Join experts and colleagues from across the country for NRHA's annual Rural Health Clinic (Sept. 30-Oct. 1) and Critical Access Hospital (Oct. 1-3) Conferences in Kansas City, Mo.

View the event agendas, and register for both conferences to save big at RuralHealthWeb.org/kc.



Gates Bar B.Q. Photo: wikipedia.com



Jazz Louisiana Kitchen. Photo: kck.jazzkitchens.com



Negro Leagues Baseball Museum. Photo: nlbm.mlblogs.com

Members on the move

NRHA fellow founds National Rural ACO



Lynn Barr

After serving for two years as chief information officer at the Tahoe Forest Health District in Truckee, Calif., Lynn Barr founded the National Rural ACO last year.

The accountable care organization aims to transform rural health care from fee-based to value-based systems by creating an affordable, replicable framework that provides quality, low-cost care to communities and strengthens the rural health safety net.

In her new role, Barr is helping rural health providers better serve their communities and get paid more by managing population health.

“Working on the Government Affairs Council at NRHA helped me realize that we needed to find a way to help rural providers move forward under health care reform, and that could only happen if we could help them work together to pool lives and resources,” Barr says. “NRHA introduced me to innovative rural thought leaders across the country who collaborated to form the National Rural ACO.”

Barr joined the National Rural Health Association in 2012 and was an NRHA Rural Health Fellow that year.

Longtime rural medical educator honored with Rural Health Hero award



James Boulger

James Boulger, PhD, a charter faculty member at the University of Minnesota Medical School in Duluth and director of the Center for Rural Mental Health Studies, recently received the Minnesota Department of Health and Minnesota Rural Health Association’s Rural Health Hero award.

Boulger has dedicated more than four decades to educating and mentoring family medicine physicians. He has taught at the Duluth campus since 1973; thanks to Boulger’s efforts, the school produces a greater percentage of rural physicians than any other medical school in the

nation, making it a model for other institutions.

Boulger has also been an active National Rural Health Association member since 1986. He has served on the association’s *Journal of Rural Health* editorial board and the Rural Medical Educators executive board.

“[NRHA’s] annual conferences, the Rural Medical Educators group, the *Journal of Rural Health*, the lobbying and congressional activities of the organization – all are and have been tremendously supportive of and necessary to our efforts,” Boulger says. “We have never been more needed, and I do hope that the membership expands further so that we can see further effects of ‘Our voice. Louder.’”

NRHA member hospitals among top in nation

Each year, iVantage Health Analytics names its top 100 critical access hospitals (CAHs) based on market, value-based and financial indicators.

The National Rural Health Association honors the top 20 among those hospitals during its annual Critical Access Hospital Conference.

NRHA salutes our members (in alphabetical order) that achieved the top 20 distinction for 2014:

- Boone County Health Center**, Albion, Neb.
- Hudson (Wis.) Hospital and Clinic**
- Kittitas Valley Healthcare**, Ellensburg, Wash.
- Madison (S.D.) Community Hospital**
- Martha’s Vineyard Hospital**, Oak Bluffs, Mass.
- Mayo Clinic Health System – Red Cedar**, Menomonie, Wis.
- Orange City (Iowa) Area Health System**
- Pike County Memorial Hospital**, Louisiana, Mo.
- Star Valley Medical Center**, Afton, Wyo.
- Transylvania Regional Hospital**, Brevard, N.C.
- Washakie Medical Center**, Worland, Wyo.
- West River Regional Medical Center**, Hettinger, N.D.

During NRHA’s CAH Conference Oct. 1-3 in

Kansas City, Mo., Charlie Button, Star Valley Medical Center CEO, will present on how his rural hospital structured a cultural transformation and achieved higher employee engagement, patient satisfaction, operating effectiveness and community involvement.

For the full agenda, which includes other top 20 hospital-led sessions, visit RuralHealthWeb.org/kc.

List of notable rural hospital CEOs includes 22 NRHA members

This year, *Becker's Hospital Review* compiled its inaugural list of 50 rural hospital CEOs to know from facilities nationwide that included 22 National Rural Health Association members.

"I was humbled to be included on a list with many people I respect for their great work in rural communities across in the country," says Art Blank, president and CEO of Mount Desert Island Hospital in Bar Harbor, Maine. "My interactions with these colleagues and others through NRHA has exposed me and my team to innovations and creative approaches to challenges that we share. I am confident our patients and community have benefited greatly from this knowledge."

The following NRHA members made the final cut:

- Benjamin Anderson**, Kearny County Hospital, Lakin, Kan.
- Arthur Blank**, Mount Desert Island Hospital, Bar Harbor, Maine
- Nicole Clapp**, Grant Regional Health Center, Lancaster, Wis.
- Marcia Dial**, Scotland County Hospital, Memphis, Mo.
- James Dickson**, Copper Queen Community Hospital, Bisbee, Ariz.
- Dennis Franks**, Neosho Memorial Regional Medical Center, Chanute, Kan.
- John Gardner**, Yuma (Colo.) District Hospital
- Margot Hartmann**, Nantucket (Mass.) Cottage Hospital

Robert Houser, Blue Mountain Hospital, John Day, Ore.

Harold Krueger Jr., Chadron (Neb.) Community Hospital and Healthcare Services

Michael K. Lally, Calais (Maine) Regional Hospital

Robert Letson, South Peninsula Hospital, Homer, Alaska

Tommy Mullins, Boone Memorial Hospital, Madison, W.Va.

Dan Odegaard, Bigfork (Minn.) Valley Hospital

Becky Pape, Samaritan Lebanon (Ore.) Community Hospital

Mike Schafer, Spooner (Wis.) Health System

Rob Schmitt, Gibson Area Hospital and Health Services, Gibson City, Ill.

Rick Schroeder, North Big Horn Hospital, Lovell, Wyo.

Bryan Slaba, Wagner (S.D.) Community Memorial Hospital

Susan Starling, Marcum and Wallace Memorial Hospital, Irvine, Ky.

Philip Stuart, Tomah (Wis.) Memorial Hospital

Al Vogt, Cook (Minn.) Hospital

Read more about Benjamin Anderson's latest project on page 7.

Virginia association elects new leadership

The Virginia Rural Health Association (VRHA) recently elected new volunteer leaders, and two National Rural Health Association members were among the new officers.

VRHA president Mary Crandall, University of Virginia Health System medical center director, has been an NRHA member since 2011.

"NRHA inspired me to become an active member of our board because I was able to see the tremendous impact NRHA has throughout the U.S., and I knew I wanted to contribute by volunteering my time to help our state continue the legacy that NRHA started," Crandall says. "NRHA offers me not only ideas as a leader, but also inspiration by highlighting what states are specifically doing that may help us in Virginia."

VRHA vice president Suzanne Lo, a research faculty member at the Virginia Tech Institute for Policy and Governance, joined NRHA in 2014.

"I am committed to effectively contributing to public health research, practice and policy to solve societal problems, eliminate disparities and create healthier communities," Lo says. "I am excited to serve on the VRHA board to effectively utilize theories, principles and concepts from a variety of disciplines to make precise conclusions and sound recommendations that will enhance the health and quality of life of rural Virginians."



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NRHA member organizations among nation's "most wired" hospitals

Each year, the American Hospital Association's *Hospitals & Health Networks* conducts a survey to determine which hospitals across the nation are the "most wired." The survey measures IT adoption in U.S. hospitals and health systems, and data is used to determine industry standards for measuring IT adoption. The 2014 Most Wired Hospitals list includes the following National Rural Health Association members:

Most wired hospitals (overall):

Abraham Lincoln Memorial Hospital, Lincoln, Ill.

Columbia Memorial Hospital, Astoria, Ore.

Crawford Memorial Hospital, Robinson, Ill.

Fort Madison (Iowa) Community Hospital

Henry County Health Center, Mount Pleasant, Iowa

Indiana University Health Blackford Community Hospital,

Hartford City, Ind.

Kalkaska (Mich.) Memorial Health Center

Lincoln Hospital & North Basin Medical Clinics, Davenport, Wash.

Mason General Hospital, Shelton, Wash.

Nemaha County Hospital, Auburn, Neb.

New London (N.H.) Hospital

Othello (Wash.) Community Hospital

Pullman (Wash.) Regional Hospital

Sanford Health Network (S.D.)

Spooner (Wis.) Health System

Sunnyside (Wash.) Community Hospital

Syringa Hospital and Clinics, Grangeville, Idaho

Tri-State Memorial Hospital, Clarkston, Wash.

Small and rural wired hospitals:

Cibola General Hospital, Grants, N.M.

Grundy County Memorial Hospital, Grundy Center, Iowa

NRHA news

NRHA trains 300 community health workers



The National Rural Health Association hosted its fifth and sixth community health worker trainings this summer.

NRHA has been offering the free events for three years and has now trained more than 300 workers who serve rural areas of the U.S.-Mexico border.

"We're proud to help empower these attendees to take on such an important role in their communities," says Gaby Boscan, NRHA program services manager.

NRHA's most recent trainings were in El Paso, Texas, and San Diego, Calif., in August and enriched participants' leadership skills as well as providing them with diabetes prevention and treatment tools.

The bilingual trainings are supported by the Office of Rural Health Policy (ORHP).

While in southern California, NRHA also hosted its fifth annual Border Health Initiative meeting, also funded by ORHP.

"It was an excellent opportunity to touch base with our partners along the border and to establish a strategic plan for the next five years of this important initiative," says Amy Elizondo, NRHA program services vice president.

Staff from each of the four border states' offices of border health participated along with a representative from the U.S.-Mexico Border Health Commission and rural health researchers.

Send your career updates
to editor@NRHArural.org.

Task force meets with HRSA leadership

The National Rural Task Force, a joint-task force of the National Rural Health Association and the National Association of Community Health Centers (NACHC), convened in D.C. in July for its annual meeting.

Comprised of NRHA and NACHC members, the task force members in attendance represented eight states, state offices of primary care and rural health, community health center executives and nonprofit community health center support organizations.

They came together to discuss rural workforce issues and what role frontier and rural community health centers are, can, should, and/or will play in the continued implementation of the Affordable Care Act and, if applicable, Medicaid expansion in their areas.

The task force met with several Health Resources and Services Administration (HRSA) leaders including Tom Morris, Office of Rural Health Policy head, administrators from HRSA's new Bureau of Health Workforce and a representative from the Health and Human Services secretary's office.

Through combining task force members' shared professional experiences and observations, the information provided by the speakers, and the open discussion amongst members, the task force drafted prioritized suggested action steps for NRHA and NACHC.

Clinic, hospital conferences return to KC

Chart your facility's success by joining experts and colleagues from across the country for the National Rural Health Association's Rural Health Clinic (Sept. 30-Oct. 1) and Critical Access Hospital (Oct. 1-3) Conferences in Kansas City, Mo.

Presenters will share effective practices, policies and information and provide insights and practical solutions addressing many of the access, quality and

patient safety issues confronted by rural hospitals and clinics.

Take advantage of the educational and networking opportunities designed for clinic and hospital professionals and board members serving rural patients.

Save \$100 by attending both conferences, and visit RuralHealthWeb.org/kc to register early and save even more. Check out page 37 for a local member's guide to Kansas City.

Journal seeks editorial board members

The *Journal of Rural Health*, a quarterly journal published by the National Rural Health Association, is seeking nominations for its editorial board.

The academic journal serves to advance professional practice, research, theory development and public policy by serving as a medium for communication among health scientists and professionals.

Candidates must have significant rural health experience and an established record of publication.

Terms for open positions begin Jan. 1, and board members serve three-year terms. Duties include selecting editorial content, soliciting manuscripts, reviewing manuscripts and recruiting reviewers.

The editorial board meets once annually in conjunction with NRHA's Annual Rural Health Conference and via teleconference each quarter.

Applications will be accepted at RuralHealthWeb.org through Oct. 31.

Multicultural conference approaches 20th year; call for presentations open

The National Rural Health Association's Rural Multicultural and Multiracial Health Conference will be April 14, just before NRHA's 38th Annual Rural Health Conference in Philadelphia.

This 20th annual conference is designed for those who are dedicated to bringing quality health care and services to underserved and often under-represented portions of the rural population.

One of the only meetings in the nation to focus on rural multiracial and multicultural health issues, this event offers attendees the opportunity to meet with peers and experts who share unique concerns and interests.

Submit session proposals at Ruralhealthweb.org/mm by Sept. 30.

continues

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Watch your inbox for ballot

Voting for the National Rural Health Association's volunteer leadership positions will occur in November.

"Your vote is an important member benefit and helps determine who will provide the leadership for our organization as we work to improve health care in rural America," reminds NRHA CEO Alan Morgan.

The ballot for NRHA's new 2015 officers, including president-elect and treasurer, will be delivered by email to all NRHA members.

Award nominations accepted soon

Rosemary McKenzie's passion for rural health care and dedication to multicultural and multiracial populations were unparalleled.

She served as the National Rural Health Association's minority liaison and program services manager for 27 years. She died in 2011 due to complications from pancreatic cancer.

To carry on McKenzie's legacy and honor her memory, NRHA established the Rosemary McKenzie Legacy Award to be presented annually during the Rural Multiracial and Multicultural Health Conference.

Nominations for the award will be accepted beginning Oct. 1 via RuralHealthWeb.org.

Tax-deductible contributions to help fund the 2015 award and scholarship may be sent to NRHA honoring Rosemary, 4501 College Blvd. #225, Leawood, Kan., 66211.

accelerating advocacy

Lack of Medicaid expansion leaves more rural residents without insurance

Two summer events highlighted the critical importance of health insurance to rural Americans, who are disproportionately less likely to have health care coverage than their urban and suburban counterparts.

The first was a July report by the North Carolina Rural Health Research and Policy Analysis Center, which for the first time detailed the harsh reality for rural patients who happen to be in states that opted not to expand Medicaid coverage.

The findings, though not entirely shocking, are nevertheless extraordinarily disturbing. The research revealed three key items:

1. The majority of rural residents live in a state that has not expanded Medicaid;
2. The poorer the rural state, the less likely it will expand Medicaid; and
3. Interstate variation in Medicaid expansion decisions has led to a wider rural-urban disparity in insurance coverage than existed before the Affordable Care Act (ACA) became law or would exist under universal Medicaid expansion.

Let me repeat that: There is a greater rural-urban divide in insurance coverage than before health reform became law. The rural-urban divide has actually been exacerbated due to so many poor, rural states opting to not expand Medicaid.

The second event happened in the courtroom. In July, in crazy but dramatic style, two U.S. appeals courts issued contradictory rulings on health exchange subsidies within hours of each other. The first dealt a huge blow to the president's health law by striking subsidies down for

millions of Americans covered through the Health Insurance Marketplace. This would, in effect, cripple the law. A couple of hours later, a second court ruling sided in an opposite manner.

These cases are among several lawsuits in which individuals or state officials are challenging the Obama Administration's authority to grant subsidies in the form of tax credits to low- and middle-income Americans buying health coverage through the federal-run exchanges. Because two federal appeals courts have acted in opposite manners, this nearly guarantees review by the Supreme Court.

As these cases are decided, millions of rural patients, who disproportionately qualify for federal exchange subsidies, are at risk. Rural America is older, poorer and sicker and therefore in greater need of tax assistance to help afford coverage.

No matter what your political persuasion, creating greater health disparities and less affordable health care is counter to any health reform. Congress must overcome the legal hurdles and politics of ACA that are harming rural patients. Help the National Rural Health Association right the path. Join our grassroots efforts.

— Maggie Elehwany, NRHA government affairs and policy vice president



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By Kacie Fodness



Big time

While you're in town for the National Rural Health Association's Rural Health Clinic (Sept. 30-Oct. 1) and Critical Access Hospital (Oct. 1-3) Conferences, be sure to plan a visit to Kansas City's Nelson-Atkins Museum of Art. Not only do its walls house extensive art collections that span the globe and the centuries, the lawn displays one of the largest collections of outdoor sculptures in the country.

Of particular interest this year is *Shuttlecocks*, a lawn installation by Claes Oldenburg and Coosje van Bruggen. This series, installed in 1994, features four giant badminton shuttlecocks, each 18 feet tall and comprised of 5,500 pounds of plastic and aluminum.

These birdies are a sought-after photo backdrop for tourists and locals alike.

Whether your motive is art appreciation or the ultimate Kansas City selfie, you won't want to miss *Shuttlecocks*' 20th anniversary this fall.

Off the beaten path

Store without a door



Photo by Elmgreen & Dragset

They say the devil wears Prada. While Route 90 isn't exactly the highway to hell, it can get extremely hot on this West Texas stretch of land. Here, just minutes outside of Valentine, Texas, sits *Prada Marfa*, a scaled replica of a Prada storefront.

Created in 2005 outside the town of 2,400, the building has been described as a "sculpture" by its Belgian visionaries, Michael Elmgreen and Ingar Dragset. This biodegradable "land art" installation draws thousands of visitors per year, despite its isolated location. While most passersby trust the architects' original motives, some visitors remain convinced of its link to alien activity.

In response to recurring vandalism at the site, the project's architects replaced the "store's" merchandise with right-foot-only pumps and handbags without bottoms. Although this store does not have a door, it does have the support — and even the input — of Prada designer Miuccia Prada.

shifting gears

Green 101: Eco-friendly tips for college students

Ebooks: When possible, use electronic versions of textbooks and submit assignments online. If you need to print, be sure to store and recycle old papers when you are finished with them.

Unplug: When electronic devices (especially laptops, tablets and cell phones) are charged, unplug them. Even when fully charged, significant energy is expended if they are left plugged in.

Dish up: Avoid paper utensils and plates. Invest in washable glassware and silverware sets instead.

Be cool: Using cold water instead of hot for your laundry can cut down energy usage by as much as 90 percent. Letting clothes air dry is also great for the environment (and your clothes).

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Shawn M. Riley

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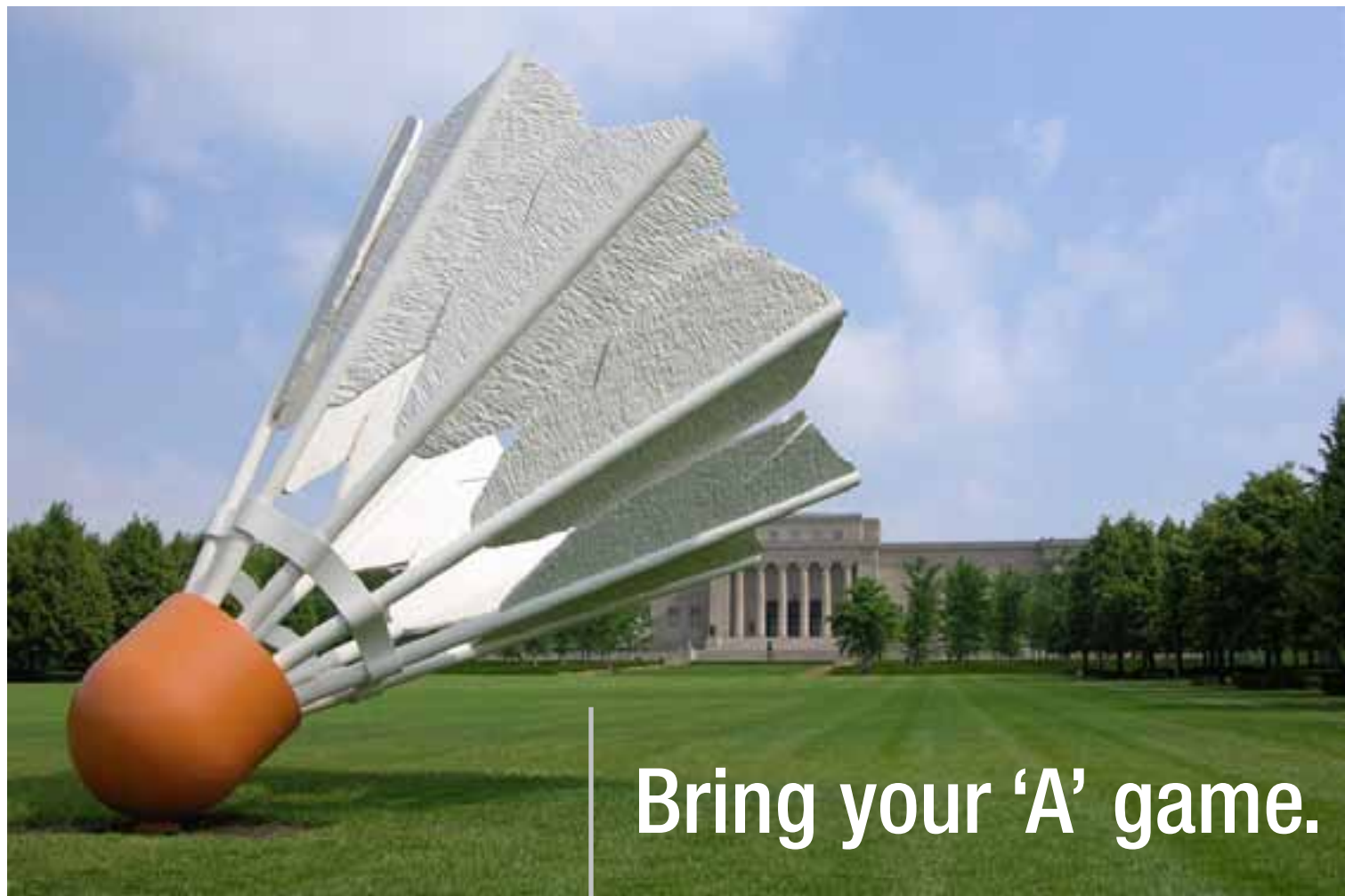
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Claes Oldenburg and Coosje van Bruggen's "Shuttlecocks" was installed at KC's Nelson-Atkins Museum of Art 20 years ago.

Photo by Emily Bruhn