

rural roads

Spring 2015 National Rural Health Association



Show and tell

School-based telemedicine brings docs to students

How a rural county pioneered population health

Network helps rural seniors age in place

Connecting rural veterans to specialists

SEND FOR OUR FREE HANDBOOK.

SEE WHY YOU SHOULD BE
ACCREDITED BY AAHHS



Designed for Smaller Hospitals

The Accreditation Association for Hospital and Health Systems (AAHHS) offers an accreditation program designed for and field-tested by rural, critical access (CAH) and specialty/surgical hospitals. All our surveyors are health care professionals who live and breathe the rural hospital environment - carefully recruited and rigorously trained.

Your hospital is a source of pride for your community. And there's no better way to demonstrate that your patient care is world class than with AAHHS accreditation. For your FREE Accreditation Handbook, contact **Meg Gravesmill** at **847-853-6073** or at mgravesmill@aahhs.org.

Helping hospitals help their communities

www.aahhs.org



ACCREDITATION ASSOCIATION FOR
HOSPITALS / HEALTH SYSTEMS

Rural Roads is a quarterly publication of the National Rural Health Association, a nonprofit association with 21,000 members who share a common interest in the advancement of rural health.

Advertise

For information on advertising in NRHA publications, email ads@NRHArural.org or call 816-716-5216.

Acceptance of advertisement does not constitute an endorsement.

Subscribe

Domestic *Rural Roads* subscriptions are \$20 per year. To subscribe, email editor@NRHArural.org or send a check to NRHA *Rural Roads* editor, 4501 College Blvd. #225, Leawood, KS 66211.

NRHA Board of Trustees officers

Jodi Schmidt, president
Dave Pearson, treasurer
Tommy Barnhart, secretary
Raymond Christensen, past president

Rural Roads staff

Alan Morgan, NRHA CEO
Lindsey Corey, editor in chief
Debra Phillips, art director
Angela Lutz, editorial assistant
Alex Olson, editorial assistant
Kacie Fodness, editorial intern

Write us

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

Send your letter to editor@NRHArural.org or NRHA *Rural Roads* editor, 4501 College Blvd. #225, Leawood, KS 66211.



Your voice. Louder.

National Rural Health Association

RuralHealthWeb.org
816-756-3140

Show and tell	7
School-based telemedicine brings docs to rural students	
Home is where the health is	12
Community network helps rural seniors age in place	
Rural Maine county pioneers population health	16
Telehealth links rural veterans with HIV to specialty care	21
Public health campaigns for wastewater recycling may help drought-stricken areas	24
Rural Lens	30
Photographers capture rural America in third annual contest	
Side Trip	34
Fall in love with Philadelphia with an NRHA tour guide	
Beginnings and Passages	36
Tales from an NRHA fellow and a veteran rural health researcher	
Street Smarts	40
Benefits of vaccinations outweigh risks	
Memory Lane	42
Rural advocates set record in DC	
Mile Markers	44
NRHA hosts documentary premiere	
Shortcuts	51
Get your ringside seat in Philly	

Cover photo: School nurse Yvonne Hardin and a patient consult with a physician via telemedicine — all without leaving their school.

We're mobile.

NRHA recently redesigned the online version of *Rural Roads* into a digital magazine. It's now easier than ever to access, navigate and share your favorite articles on the go. Visit RuralRoadsOnline.com on your mobile device, tablet or iPad to try it out. It's a page-turner.

Please share or recycle this magazine.

RuralRoadsOnline.com

Is rural America prepared for Ebola?

The National Rural Health Association has long advocated that we are either all prepared to deal with emerging public health crises, or as a nation, we are simply not prepared at all. Such is the case for the emergence of the Ebola virus.

Decades of rural public health underinvestment raise serious concern as to the ability of a rural community to handle an Ebola-positive patient.

“For far too long, rural public health has been underfunded.”

Each rural community needs to assess and determine inherent risks and capacities that can be brought to bear in responding to any public health threat. Ebola is no exception.

From a rural perspective, the ability to identify

and diagnose and the contact-tracing role of local public health officials are the great unknowns at this point.

Health professionals, first responders/volunteers and the public must be educated to better identify, respond to, and prevent the health consequences Ebola presents and to promote the visibility and availability of health professionals in the communities they serve.

For far too long, rural public health has been underfunded. As a result, the infrastructure is thin. Training and the ability to properly diagnose before the infection gains a foothold in a rural community will be key.

As a nation, we must be prepared for a future Ebola case to present in a small, rural community. As such, local, state and federal authorities need to have a plan in place for this potential outcome. The solution will likely involve a local, state and federal response, and how all these parts of our health system interact will be key to a successful outcome.

NRHA will continue to advocate for rural public health, patients and providers.

Raymond Christensen, MD
2014 NRHA president

Write us

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

Send your letter to editor@NRHArural.org or NRHA *Rural Roads* editor, 4501 College Blvd. #225, Leawood, KS 66211.

Share your story.

Should you or a colleague be featured in the next issue of *Rural Roads*?

Contact Lindsey Corey at editor@NRHArural.org to share your ideas, innovations and experiences. Editorial suggestions must not be advertisements.



Jodi Schmidt

Weathering the storm

“I wish I had a storm warning. I wish I had a sign. I wish I had a little heads up, little leeway, little more time.” — Hunter Hayes

A year ago I quoted these lyrics in a column for our local newspaper, explaining the challenges our hospital and rural clinics faced and the changes planned to help us weather them.

Unfortunately, this “storm” has hit a growing number of rural communities across the country, many losing access to local health care.

The National Rural Health Association has taken the challenge head on, launching an offensive designed to generate national attention. Judging by the amount of media focus on rural health issues, the first phase of their plan is working.

We are fortunate to have an outstanding team of professionals leading our efforts to defend the programs and funding so critical to rural patients and providers. But NRHA needs our help. If you haven’t talked with your legislators lately, now is the time. If you haven’t talked with your community members, now is the time.

“Your voice. Louder.” isn’t simply NRHA’s motto; it’s how we accomplish our shared goals, amplifying our vital message.

Thank you for being part of NRHA’s collective voice.

Jodi Schmidt

2015 NRHA president

pit stop

things I picked up in this issue:

1. Forty years of data illustrates that health improvements in rural Maine are no fluke: The population health initiative there works, and just about everybody can do it with resources they already have. *page 16*
2. Steve North got the idea to create a school-based telemedicine program for rural students from his time with Teach for America and experiences during a medical residency. He now serves 8,000 people by connecting school nurses at 22 schools in three western North Carolina counties to remote clinicians. *page 7*
3. “Saturday Night Live” alumnus Sen. Al Franken presented at NRHA’s 26th Rural Health Policy Institute, telling advocates he’d like them to think of him as a partner in improving rural health. *page 42*
4. One rural Mississippi resident took her goal to help seniors remain in their homes as they age to city hall and established a community access network for the elderly. *page 12*
5. Roughly 25 percent of rural veterans with HIV live more than an hour away from the nearest infectious disease clinic. But telehealth may help shrink the distance between veterans and the care they need. *page 21*



"We operate a hospital so we don't go out and get financing to build buildings all the time. AgStar guided us from A to Z. They are 100 percent a true partner!"

— Brad Anderson
CFO, Community Memorial Hospital
Cloquet, Minnesota

Financing Community Revitalization

Hospitals are the heartbeat of the rural communities they serve. They drive community revitalization, specialize in exceptional patient care and offer vital employment opportunities. By providing both construction and permanent financing – including long-term fixed-rate financing – AgStar Rural Capital Network helps rural hospitals thrive. Discover how AgStar Rural Capital Network is enhancing life in rural America at AgStarRuralCapitalNetwork.com.

AgStar Rural Capital Network Team



John Monson
Senior
Vice President
Investments
612-756-3983



Robert Madsen
Associate
Vice President
507-381-4455



Todd Kampa
Senior Rural
Capital Network
Executive
320-258-2973



Aaron Knewtson
Associate
Vice President
612-756-2955



AgStarRuralCapitalNetwork.com
866-577-1831



AgStar Financial Services is an equal opportunity employer and provider. © 2014 All rights reserved.

Show and tell

School-based telemedicine brings docs to rural students

By Angela Lutz



School nurse Yvonne Hardin examines a patient while Steve North, MD, observes using telemedicine.

When school nurse Yvonne Hardin examines a patient's heart and lungs with her stethoscope, she's not the only one listening.

Thanks to MY Health e-Schools, a school-based telemedicine program serving 8,000 people at 22 schools in three western North Carolina counties, Hardin's clinic at South Toe Elementary in Burnsville is connected to the Center for Rural Health Innovation in Spruce Pine, where president and founder Steve North, MD, can see and hear everything Hardin does.

"It's just like sitting there talking to him," says Hardin, who has been a school nurse for 17 years. "We put the stethoscope up to their chest, and he can hear exactly what I'm hearing and see exactly what I'm seeing. The only thing he can't do is touch them."

In addition to South Toe, Hardin also works at Micaville Elementary in Burnsville. For students and parents at both of these Yancey County schools, a trip to the doctor to treat a minor illness can be a daunting proposition. According to Hardin, many students in Mitchell

continues on page 9

Helping rural health systems deliver more efficient patient care — The Paragon® HIS

**Easy information access
for faster, better patient
care decisions**

As a rural hospital, you do not have to settle for a system that doesn't fit your needs. The top-of-the-line Paragon system is designed for hospitals and health systems of all sizes and offers your organization:

- An intuitive, Windows®-based system
- Comprehensive clinical and financial applications in one system that simplifies IT and vendor management
- A modern, single database, Microsoft®-based platform that helps reduce operating costs and enhances patient safety

**To find out more and hear directly
from Paragon customers, visit
www.mynewHIS.com**

"I appreciate how easy Paragon is to use. In the emergency room, quick and easy is what you need. I can get to patient information quickly and in a couple of clicks I can be ordering labs and medicines. It allows me to be much more efficient."

Daniel Dahle, M.D.
Emergency Medicine Director
Mayers Memorial Health District
Fall River Mills, CA

and Yancey counties are uninsured, and parents who are lucky enough to be employed cannot afford to take time off work.

“We live in an economically very depressed place,” Hardin says. “When the parents do have a job, they really don’t want to leave that job to come pick up the kid and go to the doctor – it almost takes an entire day.”

That’s why Hardin says the MY (Mitchell-Yancey) Health e-Schools telemedicine program has been vital in helping get care to the kids who need it most. The technology enables students to receive a diagnosis and prescription for treatment from North or a remote nurse practitioner without leaving school – regardless of insurance status.

“Having this available for parents in this economy, especially up here, is absolutely a godsend,” Hardin says. “Telemedicine not only takes care of students, it takes care of our staff. We are cutting down on absenteeism. I love the fact that I can treat everybody, especially children who aren’t normally able to get medical care.”

Comprehensive evaluation

Since 2011, MY Health e-Schools has become a national model for rural school-based telemedicine programs – and it’s put Mitchell and Yancey counties on the map.

But according to North, getting started wasn’t easy. He first became acquainted with school-based health care in 1993, when he volunteered with Teach for America in rural Edgecombe County.

“I realized my kids didn’t have great access to health care, and it was impacting their ability to learn,” he says.

Witnessing this need inspired North to pursue medicine, leading to his discovery of school-based telemedicine during a residency in Rochester, N.Y. When he and his wife, also a physician, returned to her hometown in Appalachian North Carolina in 2006, he began taking steps to implement a similar telemedicine program in area school districts.

“He decided to look into it and see if we could make something work in a rural area,” says Amanda Martin, Center for Rural Health Innovation executive director. “He quickly realized there were a lot of kids he was never going to see in his office, and their needs were great.”



Telemedicine technology allows school nurses to examine students at school while consulting with a remote clinician who can provide diagnoses and prescriptions.

In 2011, thanks largely to grant funding, MY Health e-Schools began providing school-based telemedicine at three sites. Initially, the technology was met with skepticism and confusion, as most parents and school staff had never heard of telemedicine.

“We were changing the place people received care and the way they received care,” Martin says. “People immediately had concerns about privacy. They’d ask, ‘What can you really do from the other side of a computer screen?’ We’ve found that we have to explain what we mean when we say telemedicine. We don’t mean telephone, and we don’t mean Skype. We’re talking about a comprehensive ability to evaluate.”

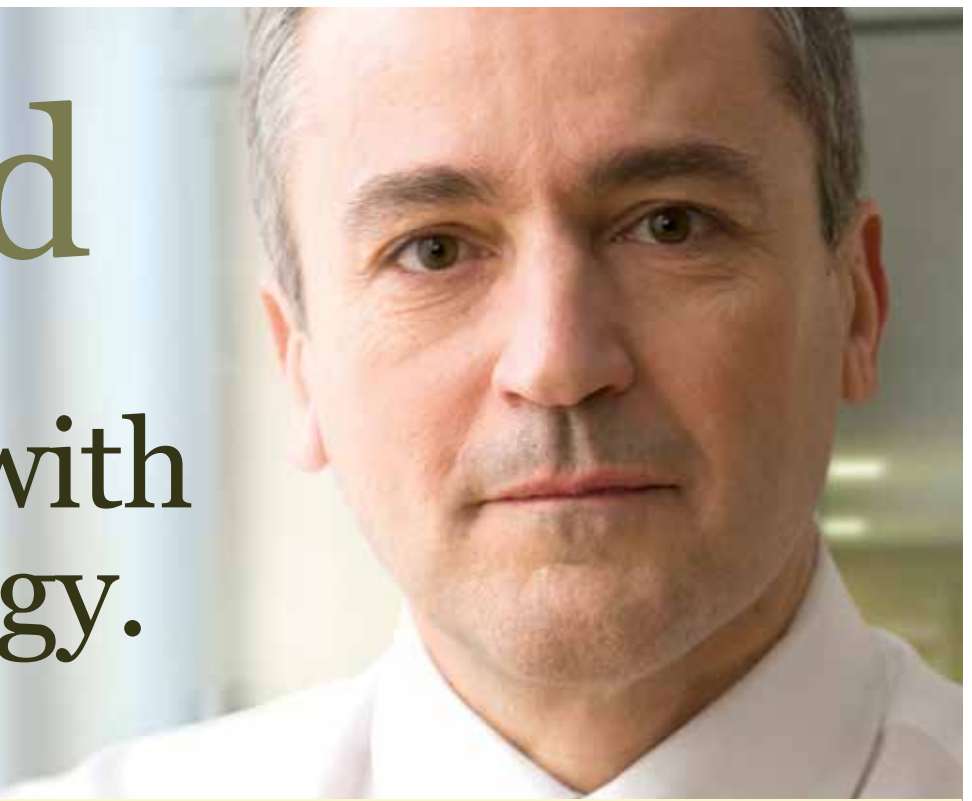
“Kids think it’s the coolest thing in the world. They want to touch everything and do everything themselves. They think it’s the best thing to be able to see the doctor over the computer instead of going to the office.”
Yvonne Hardin, South Toe Elementary School nurse

Despite initial apprehension, Martin says that once people try the technology, they’re on board – and they often tell their friends. In Mitchell and Yancey counties, news travels quickly by word of mouth, so Martin says parents’ testimonials are a powerful way to increase usage of school-based telemedicine – and teachers are perhaps the most valuable advocates of all.

“Once the teacher has experienced it, and they didn’t have to get a sub or miss half a day of work, when one of their students’ parents asks about it, the teacher is ready to advocate for it, because they know exactly what it is

continues on page 11

I need to stay current with technology.



Is **renting** or **buying** best for me?



Equipment Rental...

would be a great option for you if you want to acquire equipment/technology at the lowest possible cost to your institution. Renting allows you to scale up or down depending on your hospital needs. Renting may also allow you to provide NEW revenue generating services helping you offer needed treatment in your community.



Buying equipment...

is right when you know today, this equipment acquisition will last for at least 7 years.

Either way, Kingsbridge Healthcare Finance is ready to help. We provide flexible financing solutions to help the healthcare community make the best decisions regarding equipment acquisition. We are the best at making new technology more affordable by maximizing the utilization of the asset while minimizing its cost.

Kingsbridge Healthcare Finance is unrivaled at combining in-house resources that include the financial stability of an institution with the responsiveness of an independent.

The end result? You get the funding and equipment you need with the financial structure best for your unique needs.

With no surprises.

Dave Stuart is our NRHA expert. He is ready to discuss your needs at **407.619.2250** or dstuart@kingsbridgeholdings.com.

KINGS BRIDGE
HEALTHCARE FINANCE®

Financial Health **Assurance**

KingsBridge Healthcare Finance is a Division of KingsBridge Holdings, LLC.

You can also get more information on Kingsbridge Healthcare Finance at the NRHA partner website listed under Gold Level Partner.



and how it works,” Martin explains. “I wish every one of them would come use it at least once.”

Out of everyone involved, children have been the most enthusiastic adopters by far. MY Health e-Schools encounters patients ranging in age from kindergarten to community college students, with Hardin’s tech-savvy elementary school patients accepting the technology almost immediately.

“It’s a pretty tough crowd here of skeptical people who are not in general really open to newfangled ideas – but it’s working here. They’ve welcomed us with open arms and worked to make this an amazing model.”

Amanda Martin, Center for Rural Health Innovation executive director

“Kids think it’s the coolest thing in the world,” she says. “They want to touch everything and do everything themselves. So I let them – I don’t want them to be afraid of it. They think it’s the best thing to be able to see the doctor over the computer instead of going to the office.”

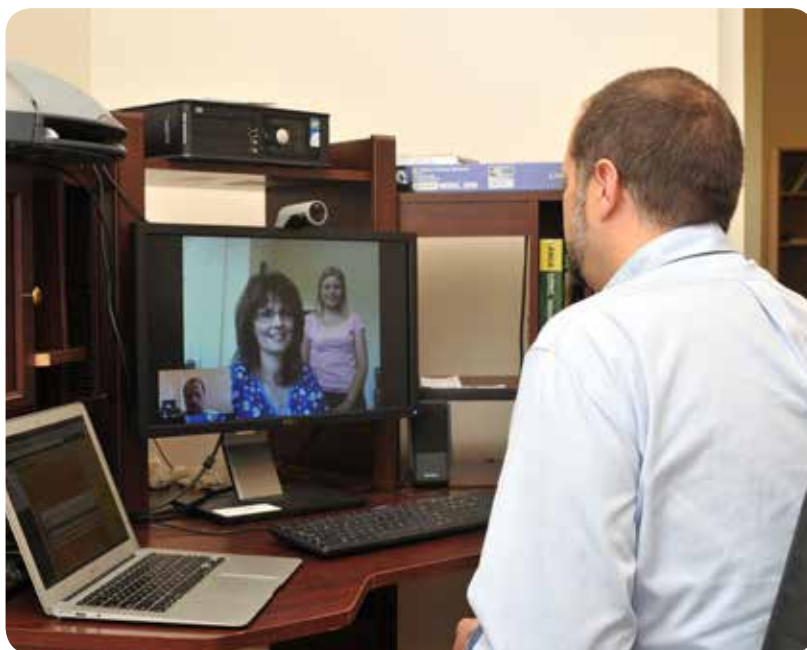
Learning curve

For rural communities hoping to implement a similar school-based telemedicine program, Martin suggests learning as much as possible from communities that have done it already.

“My biggest advice would be to learn from those of us who have already done it, even though there are only a few of us out there, and don’t recreate the wheel,” she says. “Also, if you don’t have operations figured out, don’t waste money on equipment.”

What she means: Even with support, there’s a learning curve. Martin says one of MY Health e-Schools’ earliest lessons was the need to introduce the equipment to staff and explain how it works, often more than once.

“People get fixated on the equipment, and they don’t build the program,” she explains. “You can’t just buy equipment and roll it into a school and expect that it will be used. There’s at least as much work that goes into explaining and talking and facilitating – and



Physician Steve North consults with school nurse Yvonne Hardin and a young patient.


re-explaining and re-facilitating.”

As important as determining logistics is getting school staff on board. North says school nurses are vital to a program’s success. At two of MY Health e-Schools’ first three sites, North and his colleague saw very few students because the school nurses were opposed to telemedicine.

And according to Bryan Arkwright, director of the Mission Center for Telehealth, which provides support for telehealth sites all over the state including schools in Mitchell and Yancey counties, backing from other key stakeholders in a community is also imperative.

“What’s the health care community support like?” he says. “What about school board support and county leaders’ support? These things are very important for success and also where you hit your barriers. If you don’t have support from key stakeholders, it might not be good for that county.”

The good news: Martin is convinced that if school-based telemedicine can work in Appalachian North Carolina, it can work anywhere.

“It’s a pretty tough crowd here of skeptical people who are not in general really open to newfangled ideas – but it’s working here,” she says. “We chose a pretty difficult place to try this, but they’ve encouraged us. They’ve welcomed us with open arms and worked to make this an amazing model.” 

Seeing is believing

Learn more about MY Health e-Schools and other successful rural telehealth programs at NRHA’s Annual Rural Health Conference April 14-17 in Philadelphia.

View the full agenda, register and save at RuralHealthWeb.org/annual.

Home is where the health is

Community network helps rural seniors age in place

By Angela Lutz



Georgia Murphy and Mary Atkinson Smith hope their community access network for the elderly can be replicated across Mississippi.

Instead of remaining active in retirement, Georgia Murphy went one step further. She became an activist – and she encourages other seniors in her community to do the same.

The longtime resident of rural Starkville, Miss., spent three years establishing a community access network for the elderly (CANE) to help seniors remain in their homes as they age. Recognizing the challenges faced by older people in rural areas, Murphy and several of her peers began attending town hall meetings to see how they could help.

“The mayor spoke in one meeting, and one of the city representatives spoke in another, and we asked both what the city could do for retirees,” Murphy recalls. “They both suggested – I guess, as politicians do – ‘Well, form a committee.’ I guess they thought we’d go

away. But we did form a committee – and we’re still here three years later.”

After initially struggling to find support, CANE gained traction last year when the Mississippi Rural Health Association (MRHA) and Mississippi State University (MSU) became involved. College Town Village was officially founded this January with a goal of helping aging seniors maintain their independence.

“When people get to live at home, research shows they live longer, even though they may have chronic ailments,” Murphy says. “They get to maintain their own responsibility, and that’s more purposeful, of course. They stay involved in their community and live a longer, more viable life by being responsible for themselves.”

‘Dark side of the moon’

According to Ron Cossman, PhD, MSU Social Science Research Center research professor and Mississippi Center for Health Workforce director, the primary issues College Town Village seeks to address are social isolation and transportation. When seniors lose the ability to drive they become “stranded,” Cossman says, particularly in rural communities like Starkville that lack public transportation or even sidewalks. This isolation can lead to a rapid decline in health, he explains.

“When you can’t get out on your own terms on a fairly frequent basis, that leads to social isolation, and that leads to depression, and that leads to physical conditions,” Cossman says. “For instance, my mother lives probably two or three miles out of town – but she might as well be on the dark side of the moon after taking away transportation. There’d be no way she could get into town on her own.”

“My mother lives probably two or three miles out of town – but she might as well be on the dark side of the moon after taking away transportation.”

Ron Cossman, Mississippi Center for Health Workforce director and Mississippi State University Social Science Research Center research professor

Cossman’s mother remains independent, driving herself to bridge games, hair appointments and the local diner several days a week. But even seniors who retain their mobility often need help with household tasks, like changing a light bulb or cleaning up debris after a storm. According to Mary Atkinson Smith, DNP, Starkville Orthopedic Clinic and University of Mississippi Medical Center nurse practitioner and MRHA board member, College Town Village also provides assistance with these chores by connecting seniors with volunteers or service providers in the area.

“They know if there’s something they need – even something small – they can call, and we’ll see if it’s something we can send a volunteer out to help with,” Smith says.

Because many seniors “do not have a computer and do not have Internet – and do not care to,” Cossman says, seniors connect with College Town Village by calling a dedicated phone number, allowing them to do everything from hire a house painter to coordinate rides to physician and hair appointments. The village also encourages seniors to help each other with transportation when possible.

“A lot of the seniors in this town know each other already, but they may or may not feel comfortable calling and asking for a ride,” Cossman says. “We’re formalizing the social networks that already exist in small towns. This is the advantage these small communities have: Everybody knows everybody, unlike urban areas, where you can live there a long time and not even meet your next-door neighbor.”

continues



ENVIRONMENTAL SERVICES | HOSPITAL HOUSEKEEPING



5-Star Patient Experience Program for environmental services

Give your patients a 5-star experience.

Make your hospital known for delivering a world-class patient experience day in and day out with our 5-Star Patient Experience Program for environmental services.

Delivering EVS Outcomes



Reduced
HAIs



Increased
Patient
Satisfaction



Improved
Throughput



Cost
Savings



OPS360 Automated Tracking Program



Our automated tracking program, OPS360, ensures we provide consistent, quality environmental services.



ATP Monitoring



We monitor ATP levels before and after cleaning to ensure effective disinfection procedures, reinforce training and collect data.



UV-C Disinfection



Our UV-C disinfection system is used to supplement our cleaning procedures to keep the patient environment free from harmful microorganisms and reduce the risk of infection.



Manager Training



We customize training to each manager’s needs and goals. Hands-on training is complemented by our online training tool, SMS Xchange, which provides thousands of management courses.



AIDET Scripting Model



Using the AIDET scripting model, housekeepers establish a strong rapport with patients.

Get a Free Hospital Assessment

Contact Ned Van Allan, Director of Business Development
nvanallan@smshealthcare.com | 615-418-0844
www.smshealthcare.com

HOW MUCH TELECOM MONEY...

...ARE YOU LEAVING ON THE TABLE EVERY YEAR?

\$20,000? \$50,000 or more?

Thanks to the Rural Health Care Program, rural hospitals and health care centers are eligible to receive a 65% subsidy for their telecom, data and internet service expenditures.

Depending on the size of your facilities that can amount to tens of thousands of tax-free dollars each and every year.

And all you have to do is apply for it. That's where Spectracorp can help.

Why Spectracorp?

Spectracorp has assisted health care providers in securing funding since 2008. As your representative, Spectracorp and its filing partners will work to ensure that your applications are complete, deadlines are met and funding awards are processed accurately. We currently manage filings for more

than 2,000 rural healthcare facilities that received in excess of \$7.5 million in subsidy money last year. Today, 1 out of 4 requests is managed by our organization.

What would your facility do with an extra \$50,000 or more?

- Improve advanced communication services technology?
- Implement or expand EMR deployment?
- Enhance electronic imaging capability?
- Expand staff and/or internal resources?
- Build new facilities or improve existing ones?
- Deploy state-of-the-art technology?

The important thing to know is that the money is there right now, ready for you to use. All you have to do is call us and we'll handle the application and renewal application process for you.



SPECTRACORP TECHNOLOGIES GROUP

spectracorp.com | Toll Free: 877-695-7945



It takes a village

According to Smith, once the College Town Village pilot program has secured sufficient funding and support, MRHA hopes CANE can be replicated in rural communities across Mississippi. The international Village to Village Network has already helped more than 120 communities develop and manage similar villages – but many of these are in metropolitan areas, unlike Starkville, population 24,775.

“We face the challenges of being spread out and not having the critical mass,” Cossman says. “We don’t have hundreds of seniors who are looking for these services, so we’ve got to make it work on a smaller, more diffuse scale.”

The community might be small, but elderly residents have shown interest in joining College Town Village. When Smith and Murphy organized a public forum last fall, about 60 people attended, and all of them wanted to participate. Smith hopes to reach more individuals at churches, and she anticipates news of the village will also spread by word of mouth.

“In small, southern towns, especially amongst the elderly, everyone says, ‘Hey, take a look at this,’” Smith explains.

If Starkville’s other seniors are anything like Murphy, sharing the news

won’t be a problem. She says most senior residents want to retire in Starkville, so she believes College Town Village will continue to gain momentum, especially as the number of retired seniors continues to increase.

“Most villages started like we did, with just a grassroots group of retirees saying, ‘What can we do to take care of ourselves?’” Murphy says. “Oftentimes we need help, but that can be given by people in the community who are willing to volunteer. We’re looking forward to our community being a caring place where people care for other people.” 

Access and aging

Learn more about College Town Village and community access networks, plus other programs for rural elderly populations, at NRHA’s Annual Rural Health Conference April 14-17 in Philadelphia, Pa.

Visit RuralHealthWeb.org/annual for the full agenda and to register.

THE C.A.R.E. CHANNEL

TRANSFORMING CARE AT THE BEDSIDE

The premier 24-hour relaxation programming for patient television

THE C.A.R.E. CHANNEL WILL:

- Cut costs by reducing Pain/Sleep RX
- Cut costs by reducing nursing calls
- Protect speech privacy
- Integrate within existing TV network

This highly effective therapeutic tool provides comfort, eases suffering, supports sleep, and improves outcomes.



Toll Free 800.348.0799
Office 775.827.0300

info@healinghealth.com
www.healinghealth.com

Rural Maine county pioneers population health

By John Commins



Staff from the Healthy Community Coalition at the annual Blueberry Festival in Wilton, Maine, provide health screenings and education to festival attendees via a 34-foot mobile health unit.

Health improvements in sparsely populated Franklin County are no fluke.

Forty years of data illustrates that population health works, and that just about everybody can do it with resources they already have.

All the talk around population health makes it sounds like a new concept even though it's been around for nearly half a century.

One pioneer movement for population health in the United States began in Franklin County, Maine, a sparsely populated, rural, inland expanse north of Portland. Many of the county's 30,000 residents are older, sicker and poorer than the overall population of the state.

Yet, when it comes to certain conditions, particularly cardiovascular health, the residents of Franklin County enjoy the same or better health status than their fellow

Mainers in counties with younger, wealthier populations.

This is no fluke. Rather, it is the payoff from decades of community health outreach. In the late 1960s, physicians in the county seat of Farmington joined with the hospital and community leaders to improve and coordinate care for the county's poor.

"It started by recognizing that there weren't very many physicians in the county, that they were all getting older and that there were virtually no specialists," says Roderick E. Prior, MD, a semi-retired primary care physician who has spent the last 38 years working with the county's population health effort.

"This was all before my time," Prior says. "This was the time of the Great Society in the 1960s. The Office of Economic Opportunity had been started and they were looking at health care. They encouraged those folks to think bigger."

Initially, the federal government provided funding to create comprehensive health and dental care for 3,000 people in the county.

"That was 15 percent of the population of the county," Prior says.

"All of a sudden our uninsured rates went down. Access to care became much more available. The other thing that happened was some real interest in outreach. Organizations started some rural health clinics, which eventually became federally qualified health centers. We started using mid-level nurses. We were one of the first training grounds for the physician assistant profession," he says.

Prior says the pioneering physicians in Franklin County understood that they were not practicing medicine in a vacuum, and that they needed to work with government, schools and other community organizations to coordinate care. They worked with the University of Maine at Farmington to create a training program for community outreach workers.

"They were thinking about things like transportation — [whether] people could travel to get their health care," Prior says. "Traditionally, if the patient doesn't show up the doctor says, 'I can't treat you if I you don't come in,' without recognizing that most people can't come for whatever reason; the car is broken down, or they don't have gas or the employer says they have to work, or if the kids are sick."

"But it was an organized, community-based effort that started looking at where the problems were and went beyond just providing a doctor and medicine to reaching out, finding people who had health problems, and

then getting involved with them, monitoring them,” Prior says.

“When I use the word ‘community,’ I mean that people need to identify their community, which means the people for whom you and your colleagues are willing to take responsibility for their health,” he adds.

40 years of results

Over the decades, the funding has ebbed and flowed, but the program has endured and transcended generations of patients and providers.

To get an idea of the effect of the care coordination, Prior and his colleagues examined the data around 40 years of work to improve cardiovascular health in Franklin County. The results were recently published in the *Journal of the American Medical Association*.

Before the population health efforts began, Franklin County had higher death rates for heart attack and stroke than the statewide average. Once the population health efforts began, however, Franklin County was the only county in the state with consistently lower-than-expected mortality rates for heart disease and stroke.

“When I use the word ‘community,’ I mean that people need to identify their community, which means the people for whom you and your colleagues are willing to take responsibility for their health.”

Roderick E. Prior, primary care physician

The county has also seen a steady uptick in smoking cessation and cholesterol control. Researchers estimate that the improved health of the population saved about \$70 million through reduced hospitalizations from 1994 to 2006.

A large caveat

That bit of good news comes with a large caveat that explains why population health has yet to catch on in a fee-for-service world.

“There is nobody in Franklin County who is clearly making money from doing this,” Prior says. “The savings are going to the insurers. It’s Medicaid and Medicare. And, if you look at the way private insurance companies price their products, they don’t look at the mortality and hospitalization rates of Franklin County and give all the employers a cost break.”

That is a topic for another day.

For now, the lesson from Franklin County is that population health works, and that just about everybody can do it with resources they already have.

Prior says “it’s easy” to identify the health risks in any community down to the county level by using publicly available data found on the Centers for Disease Control and Prevention website. At the risk of oversimplifying, identify the health care needs of the people you serve, and then find a way to deliver the care once that need is identified. If you can demonstrate the need, the community support will follow.

continues

COMPUMED

Revolutionizing Rural Healthcare Delivery

TELECARDIOLOGY & TELERADIOLOGY

Top Clinical Care at Reduced Costs

CompuMed’s Rural Health Solution leverages world-class specialists and state-of-the-art cloud technology for:

- **IMPROVED** Clinical Care
- **LOWER COSTS** of Healthcare Delivery
- **FASTER** Turnaround Time of Diagnostic Exams

www.compumedinc.com



OFFICIAL PARTNER



CPAs & BUSINESS ADVISORS

IT'S TIME TO PUT AWAY THE CRYSTAL BALL MEDICARE SETTLEMENTS SHOULD BE MORE THAN A "BEST GUESS"

Brian Bertsch
Principal, Health Care Consulting



Expect More from Your CPA Firm


When Joni Gisleson, Palmer Lutheran Health Center – Finance, needed timely, accurate, hospital-specific reimbursement data to evaluate the impact to their Medicare settlement, she turned to Eide Bailly. *"Eide Bailly has helped us work more efficiently by identifying where our resources would be most effective. We've been able to use their advice for when we should start certain programs and when we should end them. Through advanced tools like the CAH Reimbursement Model, we have much more accurate interim financial statements, which enhance the board's ability to make timely decisions."*

Using a cost-based reimbursement model allows you to reasonably estimate Medicare settlement amounts on an interim basis. Eide Bailly's CAH Reimbursement Model is tailored to your facility's current utilization statistics and costs to run monthly calculations, project reimbursement rates, or even see the financial impact of changing certain operation costs.



Above: Franklin Memorial Hospital in Farmington, Maine. Below: Nurse Sandra Record and physician Roderick Prior answer questions during a press conference on population health success at Franklin Memorial Hospital. Speakers included U.S. Sen. Angus King and co-authors of a study on 40 years of community health outreach in the rural county.

Looking back on his own nearly 40 years of public service, Prior says he's proud to have played a role in the work of Franklin County's pioneering physicians.

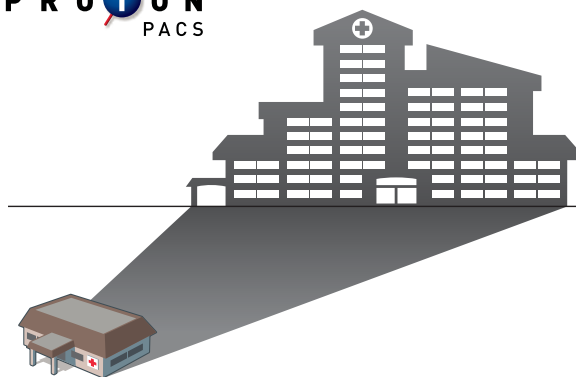
"I wanted to practice medicine and make a difference. I think we have proven to ourselves that we've made a difference," he says. "We wanted to tell our story because we think it's not a bad model for people to think about [as they think about] what they might do... in their own communities." 

John Commins is a senior editor with HealthLeaders Media, where this article originally appeared in January.

Prioritizing population health

Discover and discuss other successful population health initiatives during the National Rural Health Association's 38th Annual Rural Health Conference April 14-17 in Philadelphia.

View the full agenda and register at RuralHealthWeb.org/annual.



A PACS that helps you compete with the big boys

You don't have to be a big hospital to have a powerful PACS. With ProtonPACS, you get #1 KLAS-rated Inteleraad software plus added features without the huge capital investment, licensing fees and upgrade charges that come with other PACS. Instead, you pay a **low per-study fee**.

- Hybrid on-site server and cloud-based architecture eliminates downtime
- Access to images anywhere, on any device
- Minimized legal risk of lost studies with mirrored secure data centers
- Embedded M*Modal speech recognition eliminates transcription costs

Plus, ProtonPACS is from Radsourc, a trusted leader in imaging interpretations and PACS development.

For more information, contact your local representative at **615-376-7502**, pacs@radsourc.us, or protonpacs.com



8 Cadillac Dr, Brentwood, TN 37027

"Our long standing relationship with RWHC has been very beneficial for Crossing Rivers Health. Collaboration amongst the co-op members has given RWHC a unique opportunity to develop programs that are the right fit for rural hospitals, at an affordable price. Services such as QI reporting, leadership development & training, and financial consulting have helped us to improve our operations."

– Bill Sexton, CEO, Crossing Rivers Health



1-800-225-2531. Visit www.RWHC.com

QUALITY INDICATORS • PATIENT SATISFACTION SURVEYS • CREDENTIALING • EDUCATION

Telehealth links rural veterans with HIV to specialty care

By Angela Lutz



Michael Ohl

Roughly 25 percent of rural veterans with HIV live more than one hour away from the nearest infectious disease clinic.

For many, this can be a significant barrier. But telehealth may help shrink the distance between veterans and the care they need.

According to Michael Ohl, MD, Iowa City Veterans Affairs (VA) Health Care System and University of Iowa staff physician and infectious diseases specialist, geographic barriers coupled with lack of access to transportation can cause many veterans to rely on local primary care clinics instead of traveling to see a specialist.

“Not surprisingly, there is a very strong association between travel time to specialty care and how much specialty care people use,” Ohl says.

For individuals with HIV, choosing primary care has both pros and cons, Ohl says. One obvious benefit: Patients receive care closer to home – and for an aging population, it’s often exactly the kind of treatment they need. Conditions such as diabetes, high blood pressure

and other common and chronic ailments can best be managed at a primary care clinic.

“Individuals who are aware of their HIV infections and take medication have an essentially normal lifespan,” Ohl says. “They’re developing the common conditions that happen with aging in the United States. In fact, persons with HIV who are taking their medicine are probably more likely to die of a heart attack than of AIDS.”

“If you go to a local primary care site, they are unlikely to be doing a lot of HIV medicine. A significant limitation is receiving care at a low-volume site where there’s less experience and expertise.”


Michael Ohl, Iowa City Veterans Affairs Health Care System and University of Iowa staff physician and infectious diseases specialist

On the other hand, treating HIV can be complicated. Studies have shown that quality of care and patient outcomes for individuals with the virus are associated with the number of HIV patients seen at a particular clinic.

“If you go to a local primary care site, they are unlikely to be doing a lot of HIV medicine,” Ohl says. “They have less experience in the technical complexities of treating the virus. A significant limitation is receiving care at a low-volume site where there’s less experience and expertise.”

Due to the small number of HIV patients seen at rural clinics – as well as the myriad other demands facing primary care providers – Ohl says he doesn’t “think it’s realistic” for rural physicians to become experts on HIV care.

Instead, telehealth may provide a solution, he says. According to several VA pilot studies utilizing telehealth to treat veterans with HIV, the technology is well received by patients, maintains quality of care, and provides an opportunity for specialists to engage in shared care with local primary care sites.

“We need to be thinking about telehealth models for specialty care,” Ohl says. “As persons with HIV are aging and having health care needs that are not related to their HIV, shared care models can link distant specialists to local primary care.” 

Michael Ohl, MD, has been a National Rural Health Association member since 2014. His research on HIV care for rural veterans first appeared in the autumn 2014 issue of NRHA’s Journal of Rural Health. NRHA members can access past journal articles via NRHA Connect at connect.NRHA Rural.org.

IT'S NOT **IF** BUT **WHEN!**

don't get caught in the healthcare avalanche

personnel
turnover ICD-10
reduced reimbursement compliance
increased expenses
poor cash flow
aged receivables new regulations

Your Revenue Cycle is a complex matrix of processes, procedures, and systems. Undetected mistakes in registration, charging, coding, billing, and collections often appear only after a denial or underpayment. Add increasing complexity, rapidly changing rules, unpredictable patient flow, ICD-10 compliance, personnel turnover and the exposure to reduced reimbursements, and you quickly introduce the risk of being unable to deliver the care your community expects.

Our **proven process and technology** can improve cash flow, we will work together to uncover your strengths and the areas needing improvement. We even provide a free Benchmark Indicator Analysis you can use to compare your performance with similar hospitals.

re|solution specializes in **rural and community hospitals** and we are so confident that we can help, we offer a Revenue Improvement Program with the guarantee that the cost of the assessment will be covered by opportunities found for additional reimbursement.

For additional information call: **800-355-0410** or **info@ereso.com**

re|solution
your prescription for cash

TRAIN MORE SPEND LESS

With our comprehensive online learning solution, you will generate a quick return on investment with your valuable training dollars!



● *Serving hundreds of hospitals for over 25 years*

"While subscribing to the Swank HealthCare Program, we were able to provide more CE and CME opportunities to our staff while anticipating a 32% reduction in our education costs."

West Park Hospital, Cody, WY

● **UNLIMITED ACCESS TO OUR COMPREHENSIVE LIBRARY**

- Nearly 600 online courses in 20 different professions
- Annual training for all staff
- Patient experience training

● **CONTINUOUS ACCESS TO NEW CONTENT**

- Delivering 180 new courses each year for the past 15 years
- New courses premiering monthly

● **MORE TIME FOR PATIENT CARE**

- Our online solution will save travel expenses and time, allowing more time for patient care



Swank HealthCare
Tim Swank, Chairman



Contact us today!
1-877-227-0325

info@swankhealth.com
www.swankhealth.com

Public health campaigns for wastewater recycling may help drought-stricken areas

By Angela Lutz



An antiquated water treatment plant on the San Pedro River in Arizona. Experts say open-air facilities in the border region are ineffective ways to manage water issues.

Residents in the drought-stricken United States-Mexico border region may soon encounter a new method of water conservation.

According to Mary-Katherine Smith, PhD, A.T. Still University College of Graduate Health Studies associate professor, decades of below-average rainfall have made water quantity a growing public health issue in the Southwest.

“And it’s getting worse,” Smith says. “Temperatures are increasing with climate change; there’s less rainfall and more population growth. Everything combined is exacerbating the problem.”

In the past, public health campaigns have focused on water quality instead of quantity, but that needs to change, according to Smith. With more than 70

percent of water nationwide used for agricultural purposes, less water means fewer jobs. The socioeconomic impact of unemployment is closely linked to wellbeing, Smith says, with poor, uninsured individuals less likely to have access to quality health care.

“Water also impacts education,” Smith adds. “As the rivers are going dry, individuals are actually traveling to other locations, and that traveling keeps the children out of school.”

One possible solution is the implementation of a wastewater recycling program, also known as “toilet to tap.” The process works by purifying used water from dishwashers, washing machines, bathtubs, and, yes, toilets, making the water safe to reuse and even drink. According to David Denali, PhD, A.T. Still University College of Graduate Health Studies associate professor, people needn’t be squeamish about drinking recycled water.

“It’s a very clear message that water is contaminated that is flushed, and you don’t want to drink that water,” Denali says. “But we have the

technology to do this. We need to start reconsidering our message.”


In response to water scarcity and three years of extreme drought, Wichita Falls, Texas, began utilizing a toilet-to-tap wastewater recycling program last year. With the city’s reservoirs predicted to run dry by 2016, large-scale conservation is essential. On the whole, the public has been slow to accept the program – but Smith says a concentrated effort from public health to improve the perception of wastewater recycling could change that.

“If there’s a widespread message from public health saying we need to be reusing this water, then with that unified message we can hopefully change the mindset of the community.”

Mary-Katherine Smith, A.T. Still University associate professor

“Because of the mindset of the community, it’s hard to get buy-in,” she says. “If there’s a widespread message from public health saying we need to be reusing this water, then with that unified message we can hopefully change the mindset of the community.”

Denali adds that further water conservation efforts should focus on agricultural waste instead of domestic, noting that the amount of water saved by turning off the faucet or flushing the toilet less pales in comparison to agricultural use.

“It’s such a minimal amount of water that it’s not even worth discussing, but that’s where we put our efforts,” Denali says. “If we look at Healthy People 2020, the intent was to reduce water consumption by 10 percent. We can save .08 percent if we reduce our water consumption at home by 10 percent. If we look at the other side of the table, we’re throwing away 50 percent of our agricultural produce – and that’s 35 percent of our water consumption. We need to realize how we use water and also that we’ve gotten to the point where we can drink toilet to tap.” 

Reduce, reuse, rethink

Learn more about water scarcity as a public health issue and wastewater recycling at NRHA’s Annual Rural Health Conference April 14-17 in Philadelphia.

Visit RuralHealthWeb.org/annual for more information.

Discover more border health initiatives at NRHA’s Rural Multiracial and Multicultural Health Conference, directly preceding the Annual Conference on April 14.

Register today at RuralHealthWeb.org/mm to save.



WAPITI MEDICAL GROUP

**A COMPREHENSIVE,
PROFESSIONAL APPROACH
FOR RURAL STAFFING NEEDS.**

Wapiti Medical Group delivers a wide range of professional services, and staff, for the specific needs of your facility. We are the specialists in rural staffing.

ER, Urgent Care, Clinic, Hospitalist, Anesthesia, by PA, NP, CRNA, or MD/DO

Management Available
24/7

Hospital Credentialing
and 3rd Party Payor
Credentialing
Support

Continuing
Education for All
Staff/Quality
Assurance

Put us to work for you.

Troy Kastrup
Wapiti Medical Group
107 Flynn Drive, Suite 600
Milbank, SD 57252
troy@erstaff.com | erstaff.com

888-733-4428





Rural Health Cares

The Rural Health Foundation continues to grow, experiencing a 10 percent increase in the number of donors during 2014 and an almost 25 percent increase in the total balance of funds received to date.

FOUNDERS LEVEL

The Founders Level recognizes individuals or entities who have donated more than \$20,000 cumulative toward the Rural Health Foundation.

Dennis Berens

Tim Size

\$5,000-\$19,999

Accreditation Association
for Ambulatory Health
Care Inc.

Keith Mueller

Paul Moore

Tommy Barnhart

\$2,000-\$4,999

Tom Dean

Wayne Myers

William P. Sexton

\$1,000-\$2,000

Gail Bellamy

Rebecca Conditt

Eide Bailly LLP

Lance Keilers

George Miller Jr.

Quarles and Brady LLP

caring for the future of rural America

\$300-\$999

Denise Denton
Michael French
Richard Garza
Spencer Grover
Roxanna Jokela
Beth Landon
Rob McVay
Carol Miller
Alan Morgan
Sandra Pope
Rural Wisconsin Health
Cooperative
Saint Luke's Health System
Jodi Schmidt
James Tyler

\$100-\$299

Nicole Barbano
Larry Bedell
James G. Boulger
Patrick Branco
John Burke
Raymond Christensen
Connected Healthcare
Solutions
Gerald Doeksen
Sandra Durick
W. Suzanne Eidson-Ton
Amy Elizondo
Joseph Florence
Dale Gibbs

Michael Hagen
Hilda Heady
Michael Hedrix
Jeff Hill
Illinois Critical Access Hospital
Network
Nalo Johnson
Lisa Kilawee
Alana Knudson
Larry Lawson
Jeremy Levin
Jennifer Lundblad
Debra Phillips
Laura Redoutey
Thomas Ricketts
Rusk County Memorial
Hospital
Michael Sanders
Val Schott
Katherine Siress
Brock Slabach
David Sniff
Kris Sparks
Bill Welch
Kimber L. Wraalstad
Annie Yonemoto

\$0-\$99

Dan Bellamy
Gabriela Boscan
Andrew Coburn
Lindsey Corey

Angie Dotson
Donna Douglas
Laura Field
Andrew Fosmire
Scot Graff
Susan Green
Mark Hamed
Laura Hudson
Robert Humphrey
Sharon Hutinett
Gerald Kempthorne
Erin Kerr
Ron Kethan
Clint MacKinney
Michael Meit
Gail Nickerson
Beth O'Connor
Jamie Richgels
Robert Siebenaller
Tim Tettleton
Craig Wesley
Lise Wiese

On behalf of patients and providers, the National Rural Health Association thanks you for your continued support of rural health. To make a tax-deductible donation to the foundation, visit RuralHealthWeb.org/donate.



STRENGTHENING YOUR VISION FOR GROWTH

Gemino Healthcare Finance is a specialty healthcare lender focused solely on providing senior debt financing, in the form of revolving lines of credit and term loans, starting at \$2 million to healthcare providers.

Secured by accounts receivable including Medicare, Medicaid and insurance receivables, the credit facility allows your hospital to borrow money which can be used for:

- Working Capital
- Equipment Purchases
- Other Capital Needs

At **Gemino**, we understand the many ways that healthcare financing can help you achieve your goals. That's where we excel. We are Gemino, your partner in strengthening your vision for growth.

Mark O'Brien - EVP, Business
Development & Underwriting
Mark.Obrien@Gemino.com

 **Gemino**
Healthcare Finance
www.gemino.com

The numbers add up to powerful purchasing.

With 20 years of experience, Provista is a proven leader in the supply chain industry. Leveraging billions in purchasing power and over 1,500 contracts, we're connecting customers to the most sought-after suppliers.

\$13.3B

in 2013 customer
direct spend

150,000+

customers

13.7%

average customer
savings

98%

customer
retention

\$48B+

in combined
purchasing power

1,500+

contracts

Visit provistaco.com to see how our numbers add up for you.



Make it a monumental year.

38th Annual Rural Health Conference

April 14-17
Philadelphia

Rural Multiracial and Multicultural Health Conference

April 14
Philadelphia

Rural Medical Education Conference

April 14
Philadelphia

SRHA Leadership Conference

July 14-15
Minneapolis

Rural Quality and Clinical Conference

July 15-17
Minneapolis

Rural Health Clinic Conference

Sept. 29-30
Kansas City

Critical Access Hospital Conference

Sept. 30-Oct. 2
Kansas City

Rural Health Policy Institute

Feb. 2-4, 2016
Washington D.C.

Register early to save big.
RuralHealthWeb.org

Spoonbridge photo courtesy of Meet Minneapolis, Claes Oldenburg and Coosje van Bruggen, Spoonbridge and Cherry 1985–1988, aluminum, stainless steel, paint, Collection Walker Art Center, Gift of Frederick R. Weisman in honor of his parents, William and Mary Weisman, 1988.



Rural Lens

Photographers capture rural America



“Glorious Ripshin Lake” by Brenda S. Hoss

Grand prize winner

“Photographed in the fall when the brilliant colors of the maples and oaks reflected in the waters of the lake located atop Ripshin Mountain”

Brenda S. Hoss considers herself lucky to live in such a photogenic locale.

The narrow, winding roads of rural Carter County, Tenn., lead to the tops of mountains, often crowned by private lakes and vantages of the pastoral scenes below, she says.

“I love photography, and feel I live in one of the most beautiful places in the world in which to practice my hobby,” says Hoss, who has served as administrative assistant at rural Cannon Memorial Hospital in

Linville, N.C., for nearly 50 years.

Hoss says she was “absolutely delighted” to win the third annual Rural Lens photo contest, organized by the National Rural Health Association and the Rural Assistance Center. Her images won two of the three categories included in this year’s contest with a previous entry earning publication in 2013.

Hoss’ fall photograph of Ripshin Lake won the votes of NRHA Facebook fans and an iPad from the NRHA Partners Program.

Visit facebook.com/ruralhealth to view all the entries and for the latest in rural health news and events. And stay tuned for details on the next contest.

“Salute to a new star”

by Jody Gragg

Community and People winner

“Taken in tribute to my father, who passed away this year”



“The trail is calling” by Brenda S. Hoss

Rural Health winner

“Hiking has become a passion for ‘The Little Lost Hikers,’ a group of women who are or have been in the health care field.”

continues



“Battening the hatches”

by Linda Stansberry

Community and People honorable mention

“My father fixes a leak in the roof alongside the chimney of our wood-burning stove.”

“Boys laughing in barn” by Susan Veale

Community and People honorable mention

“Laughter and fun without technology at a farm in rural Tennessee”



“Eel River sunrise” by Amy Woolace

Landscape honorable mention

“The Eel River Valley on a beautiful Humboldt County (Calif.) morning”





“Moon over Pismo Preserve”
by Steve Corey
Landscape honorable mention

“A very recent addition to the California Central Coast open spaces”

“PEP volunteer”
by Kristen Rifenburg
Rural Health honorable mentions

“Kim, an X-Ray technologist, Proud Equestrian Program (PEP) volunteer, golfer and football mom”



“Fire on the mountain”
by Alfred Vitely
Rural Health honorable mention

“A rolled semi in rural Wyoming. The driver was OK.”

Fall in love with Philadelphia with NRHA member Lisa Davis

Side trip



Lisa Davis

All aboard for innovation, networking

Join experts and colleagues in Philadelphia April 14-17 for NRHA's 38th Annual Rural Health Conference, the largest gathering of rural health professionals in the country.

Choose from more than 60 innovative, practical and cost-saving sessions, along with exclusive tracks on rural community efforts, clinic and hospital management and advancements, policy, education and research, state health resources, funding and veterans' health.

Arrive early for the Rural Medical Education Conference on linking rural curricula to outcomes and the Rural Multiracial and Multicultural Health Conference, one of the only meetings focusing on this underserved and often under-represented portion of the rural population, on April 14.

Go to RuralHealthWeb.org today to save in the city that loves you back and to apply for scholarships.

Philadelphia is known as the City of Brotherly Love, and for good reason: There's no shortage of art, shops and restaurants to fall in love with while you're in town for the National Rural Health Association's 38th Annual Rural Health Conference April 14-17.

Here are a few stops you won't want to miss:

- Check out **Reading Terminal Market**. The former train station is filled with about 80 shops, markets and restaurants. It's a great way to sample local flavor.
- Find your way to **South Street**, one of Philadelphia's most famous streets. It's home to great dining, shopping and entertainment, with more than 300 (mostly) independently owned establishments.
- Philadelphia's **Chinatown** is located just a few blocks from the Philadelphia Convention Center. It's a great place to shop, eat and explore.
- All coins in the United States are made at the **U.S. Mint** in Philadelphia. Located across the street from the Region III office of the Department of Health and Human Services, a tour of the Mint provides a fascinating account of how coins are made.
- Philadelphia's **City Hall** is the largest municipal building in America, containing more than 14.5 acres of floor space. It's an architectural treasure inside and out. Sign up for a tour to the top, stand right under William Penn (the namesake of Pennsylvania), and take in the views.
- Make time for the **Philadelphia Museum of Art**, one of the largest art museums in the country. You'll want to recreate Sylvester Stallone's triumphant run from the movie "Rocky" on the stairs out front. *See page 51 for more of Rocky Balboa's favorite sites.*
- One of the best ways to see the city is to buy a pass on the hop-on hop-off bus. Be sure to sit on top of a **double-decker bus** for the best views of Philly and its landmarks. 

Lisa Davis is Pennsylvania Office of Rural Health director and outreach associate professor of health policy and administration. She has been an NRHA member since 2007.

Become a Healthcare Leader.

Online Rural Healthcare MBA



Our Rural Healthcare MBA is focused on the skills and knowledge necessary to meet the unique challenges faced by hospitals and clinics in rural communities. All of our courses are taught online by faculty who are leaders in the industry.

The program follows a part-time schedule, with accelerated 8-week terms, allowing students to earn their degree in less than two and half years.

Apply by August 15 and start this fall.

go.css.edu/rural
(877) 287-8734



The College of
St. Scholastica

Beginnings & Passages



Erin Gregg
Photo by Britni Rutledge

“What I quickly
learned... is how
much I didn’t
know.”

New job gives fellow ‘quite the education’

By Erin Gregg

There’s nothing quite like a West Texas sunset.

That painted sky seems as if it were made for the wide-open spaces of this part of the state. Cattle graze peacefully under the shadows of wind turbines and pump jacks. Wheat and corn stalks sway in the swirling wind.

The scenery is one of the many things I love about living in this place, a place that’s always been my home and one I thought I knew everything about.

What I quickly learned when I began working for the West Texas Area Health Education Center (AHEC) last summer is how much I didn’t know.

I didn’t know what a health professional shortage area was, or that they surrounded us. I didn’t know how dire the need for mental health professionals is becoming. I had never heard of a critical access hospital. There was plenty I didn’t know, but it was easy to see the needs are great, and the opportunities are overwhelming.

Covering a 13-county area the size of Maryland has also been quite the education. Out of the group, 12 are considered to be frontier counties, with less than seven people per square mile. The elderly and Hispanic populations are each growing more rapidly in West Texas than elsewhere. Socioeconomic indicators such as income, poverty and educational attainment place the region behind the rest of the state and nation. Nearly all the small towns and settlements are medically underserved, and the most vulnerable people suffer from an array of health disparities.

The appeal of AHEC work is simple: making our communities a healthier place to live. No matter what we’re doing, we’re using a collaborative approach, whether it’s how to engage youth in health careers or how to address specific regional health needs.

I’m thrilled to have been selected as one of the National Rural Health Association’s Rural Health Fellows this year, and my hope is to gain experience that will further enhance my ability to facilitate building the community relationships foundational to affecting change in rural health care delivery.

There is still plenty I don’t know. But what I do know is a rural resident deserves a life of health and happiness, and I’m one of them.

Erin Gregg is a program coordinator for the West Texas Area Health Education Center in San Angelo, Texas. She joined NRHA in 2014 and is a 2015 NRHA Rural Health Fellow.

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

Innovative rookies and seasoned professionals share their experiences.

“It would be difficult to find a more committed, generous and supportive group of people.”



John Gale

The great joy of rural health care

By John Gale

I believe strongly in serendipity – those unexpected events that connect different parts of your life’s experiences and set you off in a different direction. This has happened twice in my career.

In school, my career interest was in public administration and intergovernmental relations. When the intergovernmental relations course didn’t fit my schedule, a professor recommended an alternate course in inter-organizational relations in health care. I never looked back and pursued a health care career that led me to senior management positions in large primary care and behavioral health physician practices.

Sixteen years later, I entered the University of Southern Maine Muskie School of Public Service’s health policy and management program, as I wanted to think differently about health care apart from my day-to-day responsibilities. I had not expected the decision to change my career trajectory.

To my surprise, it did. At Muskie, I found a group of colleagues, Andy Coburn, David Lambert and Dave Hartley, who influenced my thinking and career direction. When I had an opportunity to join the rural health research team at the Muskie School, I jumped at the chance.

The extent to which my work in rural health has connected different parts of my life and career interests is fascinating. Growing up in a rural southern Maine community has provided

insight into the sociological context of rural living and health care delivery.

My research portfolio in primary care, behavioral health, and rural systems of care draws on my experience in managing the delivery of primary care, mental health, and substance abuse services. My approach to research was influenced by my experience in practice management; I focus on practical research topics relevant to providers, administrators and policymakers that can be used to make a difference in the performance of rural systems of care.

One of the great joys of working in rural health has been the opportunity to work with a wide range of people from across the country. It would be difficult to find a more committed, generous and supportive group of people. I am pleased to call many of these people colleagues, and more importantly, friends. The other great joy is the ability to make a difference in the lives of rural people through research that builds on the strengths and assets of rural communities.

John Gale is a population health and health policy research associate at the Muskie School of Public Service. He has been an NRHA member since 2001 and is a frequent presenter at NRHA conferences. Hear him at NRHA’s 38th Annual Rural Health Conference April 14-17 in Philadelphia.

It's time.

Center for Healthcare Innovation



- Your source for online ICD-10 training
- Training created for providers by providers
- Coder training provided by HIM professionals



go.css.edu/icd10
(877) 287-8755



The College of
St. Scholastica
ARIZONA • MINNESOTA • ONLINE

Analyze.

Control.

Save.



- ✓ Significant Savings
- ✓ Reduce Cost for Service on Mature Equipment
- ✓ Extended Equipment Life
- ✓ Choice of Service Provider

Contact your Rural
Hospital Representative
today for a
no-cost quotation!

www.theremigroup.com

Types of Equipment Covered:
X-Ray, MRI, CT, Laboratory, Surgery, Office Automation,
Information Technology, Security, Communication, & much more!

Contact a Rural Hospital Representative Today!
888.451.8916 Option #1 | info@theremigroup.com



Mobile. Intelligent. Connected.
PeriOperative Analytics – Pen & Paper Simplicity

“Graphium Health's platform allows our doctors to be at the patient's bedside – taking information & then being able to put that information into our system so I can use it to make decisions about start times, staffing & patient safety needs...”

Chris Shoup, CEO | Methodist Hospital for Surgery - Addison, TX

Shouldn't having more information
make you smarter?

We were promised a world where medical records were digitized, simple, & intuitive.

The Electronic Health Record solutions that have emerged have room for improvement – especially in acute care, high mobility settings like anesthesia where they are distracting and cumbersome. For administrators, EHRs are expensive and most neglect their ultimate value: *to provide the analytics needed to improve operations and the overall patient experience.*

Graphium Health's AnesthesiaEMR™ solution will show you [there's a better way.](#)

AnesthesiaEMR™



PHONE: 972.532.6094
www.GraphiumHealth.com

Benefits of vaccinations outweigh risks

By Wayne Myers, MD



Wayne Myers talks with HRSA Administrator Mary Wakefield at NRHA's Rural Health Policy Institute.

I started working on the wards as a medical student 50 years ago. The polio vaccination was new and marvelous. All kids caught measles. Only about one in 400 was permanently damaged or died, but measles was so common that the total number killed or injured was greater than those paralyzed by polio in its heyday.

Newborns damaged during pregnancy by rubella, or “German measles,” were common. There were usually three or four kids in the hospital with bacterial meningitis, an infection of the brain. Most would survive but with some brain damage. A really scary problem was called “epiglottitis.” It’s an infection of the flap that keeps food and saliva out of the windpipe. All these common childhood illnesses are, or should be, gone now, prevented by immunizations. I’ve not mentioned others that were pretty rare by then: tetanus, whooping cough (pertussis), diphtheria.

The Centers for Disease Control & Prevention estimates immunization will prevent 732,000 early deaths among people born in the U.S. between 1994 and 2013. So why are some parents deciding not to get their kids immunized?

I think there are several reasons. Most people have never seen a really sick kid and deep down can’t picture their child being deathly ill. Second, we humans don’t know how to think about risk very well. Third, we are suckers for the flaw in logic that says if an outcome follows something we did, our action must have caused it. And there’s a considerable list of reasons specific to individuals, groups and particular vaccines, including a wish to exert more control over what’s happening to our children.

Considering risk, we like to think of things as “safe” or “not safe.” But nothing is completely safe. Every action simply has more risk or less risk. The risk of catching whooping cough for an infant may be one

in several thousand – but the risk of serious injury from the immunization, one in several hundred thousand.

According to the CDC, immunization lowers the risk of catching whooping cough about 26 fold. The risk analysis strongly favors the immunization. But that sort of thinking is hard for people. There were over 9,000 cases of whooping cough in California in 2010 with 10 infant deaths. All the deaths were in infants under two months – too young for shots. They caught it from mothers or older kids. Pertussis is the Ebola of very young babies, but it kills quicker.

The flaw in logic I mentioned earlier has a Latin

description: “Post hoc, ergo propter hoc” or “after it, therefore because of it.” If an event follows an action, the action must have caused it. For example, “I wore my lucky sweater to the game, so my team won.”

Here’s where it gets complicated. About 3 or 4 percent of normal little kids will have a convulsion when they have a fever. The first one happens between two and eight months of age. They’re called “febrile convulsions,” and they scare parents terribly. They look exactly like any other full-blown seizure. They run in families, but for some reason grandparents don’t tell young parents to expect them. They are harmless unless the child is in a dangerous place like a bathtub.


But there are some brain problems that only show up as a child develops. Some of the brain problems include seizures. Most kinds of seizures are more likely to occur with fever.

“Immunizations, like car seats for children, aren’t absolutely safe, but they are ever so much safer for the children – and those around them – than going without.”

One of the major “baby shots” is “DTaP,” the one for diphtheria, tetanus and pertussis. It starts early because whooping cough is really bad for young babies. Three doses are given in the first six months. Until a few years ago, it was a much stronger vaccine, far more likely to cause fever. If a child developed fever, had a convulsion and was then recognized as having a significant developmental problem, it was likely to be blamed on the vaccine – “post hoc, ergo propter hoc.”

Finally there’s the important concept of “herd immunity;” for example, “if everyone else is immune, there will be no one to carry the infection to my child.” It’s good, but not perfect. Ours is a mobile society. People – and infections – move. People with similar ideas about politics, religion and immunization are likely to congregate for, say, play days and home-school

outings, creating clusters of vulnerable youngsters. Amish barn builders brought measles home from the Philippines to their kids. It’s a small world.

Immunizations, like car seats for children, aren’t absolutely safe, but they are ever so much safer for the children – and those around them – than going without. 

Wayne Myers, MD, was the National Rural Health Association’s president in 2003. He is a retired rural physician, directed the Office of Rural Health Policy and is a board member of the Maine Health Access Foundation and NRHA’s Rural Health Foundation.

A shot of information

With the recent swell of opinions on vaccinations it may be difficult to tell fact from myth. Here are a few facts from the Centers for Disease Control to share with patients:

- The United States currently has the safest, most effective vaccine supply in its history.
- Numerous scientists and researchers continue to study these vaccines reaching the same conclusion: There is no link between vaccination and autism.
- Vaccine-preventable diseases have a costly impact, resulting in doctor’s visits, hospitalizations and premature deaths.
- When everyone in a community who can get vaccinated does get vaccinated, it helps to prevent the spread of disease and can slow or stop an outbreak.
- Newborn babies are immune to many diseases due to antibodies received from their mothers. However, this immunity goes away during the first year of life.
- If an unvaccinated child is exposed to a disease germ, the child’s body may not be strong enough to fight the disease.
- Immunizing individual children also helps to protect children who are too young to be vaccinated and those who can’t receive certain vaccines for medical reasons.
- To be fully immunized, children need all doses of the vaccines according to the recommended schedule.
- Reducing and eliminating the diseases that vaccines prevent is considered one of the top achievements in the history of public health.

Source: Centers for Disease Control

Rural advocates set record, campaign to save rural hospitals

The National Rural Health Association's 26th annual Rural Health Policy Institute brought a record 441 rural health advocates together in D.C. in February.

Sen. Al Franken (D-Minn.), new co-chair of the Senate Rural Health Caucus, presented at the event for the first time.

"Not only do we have a provider shortage in rural America, but our current providers aren't getting any younger. I see a lot of doctors that look like me, and by that I don't mean they're Jewish, although some are – usually the psychiatrists," Franken joked. "What I mean by that is they're my age; I'm 63. And rural communities tend to have a high percentage of providers nearing retirement age. That's why we need to step up our efforts to recruit the next generation of health care workers."

The "Saturday Night Live" alumnus got lots of laughs, but he was serious about rural health issues too.

"We face unique challenges in providing access to health care in rural communities, and we need to make sure that solutions are tailored to those communities – I'd like you to think of me as a partner in that effort to develop solutions," he told attendees from across the country.

Rep. Adrian Smith (R-Neb.), who received one of NRHA's 2015 Legislative Awards, also thanked attendees for their efforts.

"I speak to you today as a grateful member of Congress for what you do at home and how you're engaging here because it helps me get the job

done," he said. "I could spend all day, 365 days a year telling my colleagues about rural issues, but it doesn't have the same impact as you being here."

Sens. Chuck Grassley (R-Iowa) and Chuck Schumer (D-N.Y.) introduced a bill to permanently extend a key rural Medicare payment program in conjunction with NRHA's annual Washington event.

"I believe in America when enough people find out the injustice that's going on, they'll do something about it," Belhaven, N.C., Mayor Adam O'Neal said about NRHA's campaign to #SaveRural hospitals and patients.

The Rural Health Foundation enhanced the NRHA Rural Health Fellows leadership program by providing direct financial support to bring the results of one of its yearlong projects to NRHA's Policy Institute agenda.

NRHA's 2016 Policy Institute will be Feb. 2-4 in D.C.



Left: Sen. Pat Roberts (R-Kan.) told these University of Kansas med students, "You're the future, and I'm going to keep fighting for you." Above: Sen. Al Franken (D-Minn.) signed one of his books for NRHA member Keri Robbins. Roberts and Franken co-chair the Senate Rural Health Caucus.



Clockwise: Policy Institute presenters Adam O'Neal and Dee Davis talk with NRHA CEO Alan Morgan. Rural health advocates from across the country network at the Policy Institute reception at the U.S. Botanic Garden. Rep. Adrian Smith (R-Neb.) talks with NRHA members from Nebraska following his presentation. NRHA member and rural hospital CEO Neal Gold is interviewed for NBC Nightly News on the rural hospital closure crisis during NRHA's Rural Health Policy Institute. U.S News and World Report, Politico and others covered the event and corresponding campaign to save rural hospitals and patients. NRHA member John Eich talks with Paul Moore, Office of Rural Health Policy senior healthy policy advisor and 2008 NRHA president.

More friendly faces

Continue your trip down Memory Lane or see what you missed with more photos from the Rural Health Policy Institute and other NRHA events at flickr.com/nrha.

Learn more about and become involved in NRHA's advocacy efforts on pages 47 and 48.

Members on the move



Becky Conditt

Member says NRHA conference connection led to new job

After 22 years serving area health education centers (AHEC), including three years as program director of the West Texas AHEC, National Rural Health Association member Becky Conditt became director of clinical training at CommUnityCare Health Centers in Austin, Texas, in January. CommUnityCare has 29 clinics in Travis County, including two rural sites.

Conditt credits connections made at an NRHA conference with helping her gain the job.

“NRHA is the best place to network with people who have a passion to serve the rural and underserved,” Conditt says. “I am thrilled to be working with past NRHA president George Miller and his dedicated team at CommUnityCare. I will continue to count on the friends and colleagues I know from NRHA to give me wise counsel in my new position.”

Conditt joined NRHA in 2004 and has served on the association’s board of trustees.

NRHA president-elect focuses on recruitment, retention

Longtime National Rural Health Association member Lisa Kilawee began working as a provider employment consultant with Ministry Health, a health system in Wisconsin, in December. In her new role, Kilawee helps Ministry Health recruit and retain clinicians at their hospitals and clinics, many of which are rural.

Previously, Kilawee served as director of rural health services at Avera Health for 12 years. She has also worked at the South Dakota Office of Rural Health.

“Recruiting and retaining physicians and other health professionals to work and live in rural communities is essential to preserving access to services and reducing health disparities,” Kilawee says. “It’s related to a complex series of issues and policy challenges that I’m able to keep up on through NRHA. Additionally, I’ve had the opportunity to work with the best and brightest minds working in rural health care today who I’ve met through NRHA, such as Hilda Heady and Bill Sexton.”

Kilawee joined NRHA in 1996 and was recently elected to be NRHA’s 2016 president.



Lisa Kilawee

Send your career updates
to editor@NRHArural.org.

NRHA members, staff appointed to rural quality task force

National Rural Health Association members John Gale, Ira Moscovice, PhD, and Tim Size, along with NRHA staff member Brock Slabach, were recently appointed to the National Quality Forum's (NQF) new Rural Health Committee.

"CMS recently announced that by 2018 half of Medicare spending outside of managed care will be tied to incentives to manage quality and costs," says Slabach, NRHA's membership services senior vice president. "This newly formed NQF task force may be the only vehicle for rural providers to be fairly treated in this value-based reality at CMS. It is refreshing that NQF selected highly regarded NRHA members to assist in this important work."

NQF is a nonprofit, nonpartisan organization that works to catalyze improvements in health care. Its Rural Health Committee will provide recommendations to the Department of Health and Human Services regarding performance measurement issues for rural and low-volume providers, such as critical access hospitals, rural health clinics, community health centers and the clinicians who serve in these facilities.

Gale joined NRHA in 2001, Moscovice in 2007 and Size in 1996.

List of notable rural hospital leaders includes 13 NRHA members



Jeff Hill

Becker's Hospital Review recently compiled its second annual list of "50 rural hospital CEOs to know" from facilities nationwide that included 13 National Rural Health Association members.

"It is an honor to be recognized by *Becker's* and in the company of so many accomplished rural CEOs," says Jeff Hill, Steele Memorial Medical Center CEO. "Successful rural health care leaders realize the importance of leveraging resources to overcome the many challenges

of providing quality care in a rural environment. NRHA is one such essential resource. By providing leadership on rural issues through advocacy, communications, education and research, NRHA plays a vital role in supporting hospitals and health care organizations like ours."

These NRHA members made the industry magazine's list:

Eric Barber, Mary Lanning Healthcare, Hastings, Neb.

Nicole Clapp, Grant Regional Health Center, Lancaster, Wisc.

Margot Hartmann, MD, PhD, Nantucket (Mass.) Cottage Hospital

Jeff Hill, Steele Memorial Medical Center, Salmon, Idaho



**Let
NRHA
help.**

The NRHA Career Center offers employers and job seekers:

- alerts when résumés and jobs meeting your criteria are posted.
- easy ways to save and manage your favorite postings.
- a variety of affordable packages.
- exposure to the National Healthcare Career Network, a group of more than 265 health care associations reaching out to professionals nationwide.

careers.RuralHealthWeb.org



**National Healthcare
Career Network**

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

Laura Lambeth, Ashe Memorial Hospital, Jefferson, N.C.

Steve Massey, Westfields Hospital and Clinic, New Richmond, Wisc.

Mary Ellen Pratt, St. James Parish Hospital, Litcher, La.

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

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

Philip Stuart, Tomah (Wis.) Memorial Hospital

Paul Taylor, JD, Ozark Community Hospital, Springfield, Mo.

Larry Veitz, Spearfish (S.D.) Regional Hospital

Gibson Area Hospital and Health Services won NRHA's Rural Health Quality Award in 2013. Susan Starling is currently NRHA's Hospital and Community Health Systems Constituency Group chair.

NRHA news

NRHA announces new leadership

Leadership for the National Rural Health Association is secure for 2015 and beyond, thanks to recent elections for its Board of Trustees positions.

NRHA members selected Lisa Kilawee as president-elect. Tommy Barnhart, Patrick J. Branco and David Schmitz, MD, also ran. Kilawee will assume the duties of NRHA president in 2016, and Jodi Schmidt will serve as president in 2015.

"I am passionate about the work that NRHA does to help ensure access to health care services for everyone living in rural America," Kilawee says. "I believe that people should have adequate access to quality health services whether they live in a busy city or a rural community."

Kilawee has been an active NRHA member for more than 15 years. She is a provider recruitment consultant at Ministry Health in Steven's Point, Wis.

Dave Pearson, Texas Organization of Rural and Community Hospitals president and CEO, was elected to serve as NRHA's board treasurer in 2015 and 2016. He joined the association in 2004.

Visit NRHA's blog at blog.RuralHealthWeb.org for the full list of newly elected constituency group chairs and Rural Health Congress representatives.

NRHA congratulates Rural Health Fellows graduates



2014 Rural Health Fellows

The National Rural Health Association congratulates the following 2014 Rural Health Fellows for completing the intensive program aimed at developing leaders who can articulate a clear and compelling vision for rural America.

The 2014 fellows presented the results of a year of research and collaboration during their graduation ceremony at this year's NRHA Rural Health Policy Institute in Washington, D.C.

These NRHA members are now alumni of the competitive program:

Mary Atkinson Smith, DNP, Starkville Orthopedic Clinic nurse practitioner, Starkville, Miss.

Angela Bangs, Montana Office of Rural Health/Area Health Education Center project coordinator, Bozeman, Mont.

Mitchell Berenson, Community Infusion Solutions CEO, Rockwall, Texas

Maritza Bond, Eastern Connecticut Area Health Education Center executive director, Willimantic, Conn.

Kelly Cheek, West Texas Area Health Education Center director, Abilene, Texas

Alison Davis, PhD, University of Kentucky Community and Economic Development Initiative of Kentucky director and professor, Lexington, Ky.

Kevin Driesen, PhD, Arizona Rural Hospital Flex Program director, Tucson, Ariz.

Tammy Hatting, Avera business development manager, Sioux Falls, S.D.

Gretchen Holmes, PhD, University of Kentucky College of Medicine Center of Excellence in Rural Health assistant research director, Hazard, Ky.

Cody Mullen, Indiana University Fairbanks School of Public Health associate instructor and doctoral student, West Lafayette, Ind.

Ken Reid, Capella University doctoral student, Bosque Farms, N.M.

Dayle Sharp, PhD, University of Texas School of Nursing clinical assistant professor, El Paso, Texas

Will Wilson, Minnesota Department of Health supervisor, St. Paul, Minn.

Holly Wolff, University of North Carolina Gillings School of Global Public Health research assistant, Chapel Hill, N.C.

"Being an NRHA Fellow has allowed me to interact with an extremely dynamic and forward-thinking group of people that I would have never had the opportunity to meet otherwise," Holmes says. "Learning about health policy from numerous experts and being able to have conversations about important policy issues have made this experience invaluable. I look forward to continuing my work in health policy and feel much better prepared and informed to make a difference."

As part of the yearlong program, the fellows developed six projects examining how quality of life impacts rural recruitment and retention, the future of behavioral health, telemedicine capacity in critical access hospitals, Native American Medicaid financing, rural quality improvement and economic development policy.

For more information, visit RuralHealthWeb.org.

NRHA welcomes new fellows



2015 Rural Health Fellows

Following a competitive review process, 16 fellows were selected to participate in the National Rural Health Association's yearlong, intensive program aimed at developing leaders who can articulate a clear and compelling vision for rural America.

"Once again, this class represents various levels of rural health expertise," NRHA CEO Alan Morgan said. "With the successes achieved by the previous classes, we look forward to continuing the tradition of building rural health care leaders through this valuable program."

The 2015 Rural Health Fellows first met during NRHA's Rural Health Policy Institute in February in Washington, D.C.

The new fellows are:

Brandon Baumbach, Rural Assistance Center rural health policy specialist, Grand Forks, N.D.

Roxana Cruz, MD, Hunt Regional Medical Partners primary care medical director, Greenville, Texas

Sue Deitz, Critical Access Hospital Network executive director, Newport, Wash.

Christine Eisenhauer, PhD, University of Nebraska Medical Center College of Nursing assistant professor, Norfolk, Neb.

Erin Gregg, West Texas Area Health Education Center program coordinator, San Angelo, Texas

Robert Hines, PhD, University of Kansas School of Medicine-Wichita assistant professor, Wichita, Kan.

Carla McKelvey, MD, North Bend Medical Center general pediatrician, Coos Bay, Ore.

Julie Middleton, University of Washington School of Medicine student, Seattle, Wash.

Robert Monical, McPherson Hospital CEO, McPherson, Kan.

Gary Nelson, PhD, Healthcare Georgia Foundation CEO, Atlanta, Ga.

James Parrish, Humboldt General Hospital CEO, Winnemucca, Nev.

Maria Sallie Poepsel, PhD, Scotland County Hospital chief anesthetist, Memphis, Mo.

Justin Stokes, U.S. Rep. Richard Hanna chief of staff, Washington, D.C.

Ann Turner, Dartmouth-Hitchcock Center for Rural Emergency Services and Trauma program manager, Lebanon, N.H.

Margaret Woeppel, Bryan Health regional services consultant and critical access hospital coordinator, Lincoln, Neb.

Mary Zelazny, Finger Lakes Community Health CEO, Penn Yan, N.Y.

continues

accelerating advocacy

Curing the closure crisis

A hospital closure crisis is gripping rural America.

And the National Rural Health Association's staff and grassroots activists continue to work with members of Congress, encouraging them to take steps to prevent more rural hospitals from closing their doors.

The rate of rural hospital closures has accelerated over the past two years, stripping many rural residents of access to needed emergency, acute and primary care services close to home. A recent report showed that 283 rural hospitals throughout the nation are currently at such financial risk that closure could be their fate.

"Without immediate engagement at every level of government, this relatively small trickle of closures will turn into a tsunami, leaving hundreds of thousands of rural Americans without local access to important health care services," warns Maggie Elehwany, NRHA vice

president of government affairs and policy.

NRHA continues to advocate for multiple solutions that would help end the closure crisis. From stopping current funding cuts to rural hospitals to providing needed regulatory relief from CMS and establishing new reimbursements and delivery forms, NRHA will continue to fight until the health care delivery system in rural America is on solid footing.

Participate in the Grassroots Advocacy Forum on NRHA Connect (connect.NRHArural.org) and use #SaveRural on Twitter to join the fight to save rural hospitals and patients.

For more information on the Rural Health Fellows, visit RuralHealthWeb.org. Application materials to join the 2016 class will be available online in May.

NRHA launches Grassroots Advocacy Forum

The National Rural Health Association launched the Grassroots Advocacy Forum via NRHA Connect in the fall to allow members to collaborate with a group of their peers as a valued voice in NRHA's advocacy efforts.

In addition to setting the record straight on the latest from Capitol Hill, this enhanced forum will focus on what you can do to educate, advocate and coordinate on behalf of your community and colleagues.

"We look forward to you joining the conversation and sharing your ideas on how best to fight for rural and make your voice louder," says Maggie Elehwany, NRHA government affairs and policy vice president.

Replacing the former Grassroots Listserv as an important member benefit, NRHA invited members to join the forum to facilitate discussion and campaign locally and nationally for rural patients and providers.

Log on at connect.NRHArural.org to participate in this enhanced member benefit. For assistance accessing NRHA Connect, email membership@NRHArural.org.

Scholarships, discounts available for NRHA conferences

The National Rural Health Association's Rural Multiracial and Multicultural Health Conference will precede the 38th Annual Rural Health Conference April 14-17 in Philadelphia, the largest gathering of rural health professionals in the country.

Scholarships are available for these events as well as the Rural Medical Education Conference on April 14.

This will be the 19th year for the nation's only conference focusing on eliminating health disparities and improving access to quality health care services for rural underserved populations.

"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. "This conference is the perfect venue for learning about and sharing successful projects and initiatives that can be replicated in your community."

Register for all three conferences by March 23 to save up to \$260.

NRHA internships open students to future possibilities

Did you know the National Rural Health Association offers internships? Former intern Jeslin Jose says her NRHA internship was invaluable.

"There unfortunately exists a dichotomy when it comes to sitting in a classroom and learning about theories versus being out in the field and putting them to practice," says the Texas A&M University master of public health student. "However, interning with NRHA proved to be that perfect platform where the two merged into a perfect unison to truly showcase how public health performs on a grandiose level to help rural America."

Because of NRHA's range of activities and programs, since 2005, its internships have allowed students to pursue a project in an area of interest to them while participating in the overall NRHA experience.

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

Alyssa Mavi is currently working with NRHA's program services team on a rural training track project, as she has an interest in rural primary care. She is a master of public health student at George Mason University with a graduate certificate in biostatistics. Mavi also has a bachelor's degree in neuroscience from the College of William and Mary.

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

NRHA presents during CMS webinar on insuring rural children

National Rural Health Association staff members Gabriela Boscan and Laura Hudson presented during the Connecting Kids to Coverage National Campaign webinar in October, providing tips, techniques and campaign resources to use in enrollment efforts.

Reaching rural communities presents unique challenges, but they discussed effective strategies being used in rural areas to successfully find and enroll eligible families in Medicaid and the Children's Health Insurance Program.

NRHA also participated in the Champions of Change event at the White House in the fall, which highlighted the Affordable Care Act (ACA) and organizations working to assist with enrollment efforts.

Learn about ACA's implications on rural patients and providers during NRHA's 38th Annual Rural Health Conference April 14-17 in Philadelphia.

NRHA hosts DC premiere of documentary on free rural clinic



Jeff Reichert and Alan Morgan answer audience questions at the premiere of "Remote Area Medical."

"Remote Area Medical," a documentary on the annual two-day "pop-up" medical clinic in Tennessee, opened nationwide in December.

The film follows the plight of rural Americans who have gone without vision or dental care for most of their lives.

The National Rural Health Association hosted the D.C. opening of the film at the West End Cinema with a post-screening discussion with NRHA CEO Alan Morgan and one of the directors, Jeff Reichert.

"This film is a glimpse into the lives of everyday rural Americans who struggle to access care," Morgan said. "Rural Americans, on average, are poorer, sicker and older than their urban counterparts. 'Remote Area Medical' is a compelling story of those desperate for medical care."

NRHA recognizes congressional rural health champions



Rep. Adrian Smith receives an NRHA Legislative Award from NRHA member Roger Wells.

The National Rural Health Association recently presented its 2015 Legislative Awards, which recognize outstanding leadership in rural health issues by U.S. congressional members and staff.

This year's member recipients are Sen.

Michael Bennet (D-Colo.), Sen. Charles Grassley (R-Iowa), Rep. Ron Kind (D-Wis.) and Rep. Adrian Smith (R-Neb.).

Staff awards were given to Brian Perkins of the Office of Sen. Jerry Moran and Colin Brainard of the Office of Rep. Lynn Jenkins.

"The winners embody hard work, commitment and a true devotion to rural America," says Maggie Elehwany, NRHA government affairs and advocacy vice president. "Their efforts to guarantee quality, accessible health care in rural areas are appreciated, and NRHA and all rural advocates are fortunate to have such stalwart champions."

Award winners were honored during NRHA's 26th Rural Health Policy Institute, which brought more than 440 rural health advocates to D.C. for education and advocacy in February. (See page 42 for more on the event.)

The 2016 Policy Institute will be Feb. 2-4 in Washington, D.C.

Speak up: Present at NRHA conferences

The National Rural Health Association is accepting presentation submission proposals for its upcoming educational events.

Submissions for this year's Rural Health Clinic and Critical Access Hospital Conferences will be accepted through May 18. The events will be Sept. 29-Oct. 2 in Kansas City, Mo.

Go to RuralHealthWeb.org to submit proposals for review by NRHA members.

Your Partners. Your Resources.

Some say “buy local,” but at NRHA we say “buy rural” — buy from organizations dedicated to the success of rural health care. This is possible when you choose the specially designed products and services the NRHA Partners offer our members.

All of our Partners know rural health, and they are pre-screened and vetted by rural health experts based on their knowledge and experience in the rural health care industry. So they can start working for you right away — saving time and money.

Visit our NEW Partners website — www.nrhapartners.com.



Visit nrhapartners.com



By Kacie Fodness

Get your ringside seat



Philadelphia Museum of Art

The Philadelphia skyline as seen from the steps of the Philadelphia Museum of Art.
Photo by Jeffrey M. Vinocur

Flying to Philly for the National Rural Health Association's Annual Rural Health Conference? If so, you won't want to miss all the heavyweight attractions the City of Brotherly Love has to offer, especially to fans of the "Rocky" franchise.

Just outside of the Philadelphia Museum of Art, movie aficionados and sports enthusiasts alike will recognize this iconic 72-step scene and its skyline.

In one corner is the bronze statue of Rocky Balboa himself, and in the other, a breathtaking view of the Philadelphia skyline that includes Benjamin Franklin Parkway and City Hall. In addition to "the Rocky steps," you can tour many other sites from the four on-location films, including Rocky's apartment and gym.

So while you're in town this April, go a few rounds with these cinematic steps and the many more attractions Philadelphia has to offer.

Off the beaten path

Reinventing the wee'l



In **1982**, the owner of Dale's Thrifty Barn in Dunseith, N.D., population **773**, decided to hire an artist to weld his extra **2,000** wheel rims into the shape of a turtle.

The result was North Dakota's Wee'l Turtle, an **18-foot** high, **1-ton** sculpture in the Turtle Mountains along the Canadian border. Some **30** years later, George Gottbreht's metal monument

can be seen from Highway 3 or from the parking lot of the architect's local convenience store.

From giant walleyes to massive buffalo, this tortoise is one of many larger-than-life statues that flank North Dakota's roads.

Even if "slow and steady" isn't your traveling motto, if you find yourself passing by North Dakota's Turtle Mountains, stop by this far-from-*tired* attraction.

shifting gears

There's an app for that

NRHA will introduce a new conference agenda app during its 38th Annual Rural Health Conference April 14-17 in Philadelphia.

This digital app will provide a resource for attendees to enjoy one-stop access to everything important to your event experience.

You can invite other conference attendees to join from within the app or share via social media. And best of all, it's an ecofriendly upgrade from the formerly printed programs and evaluations.



National Rural Health Association

4501 College Blvd. #225
Leawood, KS 66211

“A penny saved is a penny earned.”

— Benjamin Franklin



Sign up today to save 10,000 pennies on your trip to Philly, home of the U.S. Mint.

NRHA's 38th Annual Rural Health Conference, the nation's largest gathering of rural health professionals, will be **April 14-17 in Philadelphia.**

You can bank on this event with more than 60 innovative, practical and cost-saving sessions on:

- effective rural-centric solutions
- ACA, federal policy, programs and grants
- public health and telehealth trends
- forming community partnerships and leveraging funds
- proven recruitment and retention strategies
- paramedicine, mental health and veterans initiatives
- primary care collaborations and integrated delivery systems
- hospital and clinic management
- disease prevention and treatment
- plus much more

Arrive early for the Rural Medical Education Conference or Rural Multicultural and Multiracial Health Conference on April 14.

Turn your trip to the conferences into a vacation. Visit the Liberty Bell, “Rocky” steps, historic sites, art museums and more.

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

