

rural roads

Fall 2011 National Rural Health Association



Pedal to the mettle

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On the cover



Oregon Health and Science University students spreading the word about recruiting rural physicians take a break from their small-town bike tour across Oregon at Sharron and Dean Defrees' ranch in Sumpter Valley, Ore.

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Send your letter to editor@NRHArural.org or *Rural Roads* editor, NRHA, 521 E. 63rd St., Kansas City, Mo., 64110.



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.

Magazine inspires replication, innovation

The impact of the article Lindsey Corey wrote about Dan Shuman, DO, has already been significant.

Just after it was released (summer 2011), we received a call from a pharmacist in Craig, Alaska, telling us that it inspired him to offer his staff pharmacist paid time off for international mission work as an employment benefit, a move inspired by the *Rural Roads* cover story. He has also invited a group from Ashland to participate in a short-term service trip to his island.

Also, we just interviewed a second physician and a director of nursing who became interested in our position after reading that *Rural Roads* article. We're also sending it to mission-minded recruits for other potential positions, such as a dentist and a physical therapist.

Furthermore, we were just approved for an \$18,700 grant from our local sheriff's department to be used to bring a film crew in to assist area high school students in developing commercials with a drug/alcohol free message to be uploaded to YouTube. Pending the outcome, those commercials may be featured on the area cable television station. This was inspired by your story featuring the Montana Meth Project.

What you do is a big deal for our rural communities. Keep up the great work.

Benjamin D. Anderson
Ashland (Kan.) Health Center CEO

Lesson learned in mission-centered recruiting article applied to retention

I really enjoyed reading your "Mission Accomplished" article in the summer 2011 edition of *Rural Roads*.

Recruitment for medical providers in rural Alaska is definitely a challenge. I liked Benjamin Anderson's take on how to address that challenge for their community. It sure sounded like a win-win for both the community and the physician and his family.

My wife Sarah and I like that recruiting idea so much that we asked our employee pharmacist if she might like to take advantage of paid time off to participate in a medical mission experience. We think those kinds of experiences would help make her a better pharmacist for our little community at Whale Tail Pharmacy.

Also, many thanks to you for running the Mile Markers story on my visits to pharmacy schools and rural pharmacies (also in the summer 2011 issue). That was a nice job as well.

I appreciate your stories as well as NRHA!

Bill Altland
Whale Tail Pharmacy co-owner
Craig, Alaska

Being a strong voice for rural health



My year as the National Rural Health Association president is coming to a close.

I started the year thinking that my focus would be making health reform work in rural America. However, the environment, now with shrinking government financing and the continued unstable economy, challenges the existence of rural health care.

I think that the most important thing I can do in the time I have left as your president is help ensure NRHA has a strong voice in developing a sustainable rural health care system. I'm confident our growing and engaged membership will help with this vital mission.

Thank you for the opportunity to serve you and the communities you represent.



Kris Sparks
2011 NRHA president

pit stop

5 things I picked up in this issue:

1. Veterans in Iowa benefit from more localized community-based outreach clinics for HIV treatment. *page 12*
2. Since 2010, the President's Rural Healthcare Initiative annually reserves \$79 million to increase health care access and quality. *page 24*
3. Every EMT and hospital staff in South Dakota is training with state-of-the-art equipment brought to their communities for free. *page 18*
4. An NRHA intern changed her career focus after volunteering as a nurse in Nepal. *page 38*
5. The University of Kansas Medical Center recently introduced its inaugural class of eight students training in a small-town setting. *page 28*

While biking along the coast of Oregon, the students met a European family (with four children under the age of 5) who were on a 13-month around-the-world bike trip.



Pedal to the mettle

Med students bike across Oregon to raise awareness of physician shortage

By Angela Lutz

Second-year Oregon Health and Science University (OHSU) medical students Nathan Defrees, Weston Fuhrum and Matthew Sperry wanted to do something epic during their last free summer before returning to class. They also wanted to do something meaningful.

“We started talking about it last fall,” Sperry says. “We wanted to do something fun but that also gives back to the community, particularly to Oregon.”

So Kerry Gonzales, Oregon Academy of Family Physicians (OAFP) executive director, calls it a “happy coincidence” that around the same time the students were making plans she received a grant from the Northwest Health Foundation to engage the state’s business community and stakeholders in a conversation about rural health care.

She worked with the three medical students, all avid bicyclists, as well as veterinary student Daphne Johnson, to plan a five-week, 1,000-mile bicycle trip around the state that included 15 presentations to small business owners,

Rotary and Lions clubs and chambers of commerce on the economic benefits of recruiting a primary care physician to a community. In addition to OAFP, the trip was co-sponsored by the Oregon Office of Rural Health at OHSU and Oregon Area Health Education Centers.

“When a community adds a primary care physician, it boosts the economy, brings down the cost of health care and makes that community healthier,” Gonzales says. “Physician practices are 11 percent of the state’s labor market, plus tax revenue.”

“Things are precarious and can change for any community on a whim. Doctors retire or move, and all of a sudden you have a shortage.”

Matthew Sperry, Oregon Health and Science University second-year medical student

The students’ presentation covered: the importance of using incentive programs such as loan repayment or loan forgiveness to encourage more graduating medical students to consider rural practice; the value of retaining and supporting existing physicians and practices so the community does not have to shoulder the expense of recruiting a new provider; and county-specific data showing the economic benefits of bringing a physician into a community.

“Recruiting a physician not only improves health outcomes, it also boosts the economy,” Gonzales says. “So we felt it would resonate with the business community.”

Intimate knowledge

When their adventure began in July, the students quickly discovered that many rural communities across the state were experiencing physician shortages, and the small business owners they met were invested, active community members who understood the nature of the problem and wanted to help.

“We weren’t sure what kind of response we would get,” Sperry says. “We were afraid health care reform would cause negative responses. But that wasn’t the case at all. Most communities were very aware of the physician shortage.”

At every stop, the students heard examples of physician retention struggles and health care access woes.

“There wasn’t a town we visited where the group didn’t have some intimate knowledge of the physician shortage issue,” Fuhrum says. “Either they had felt the problem themselves or had friends or neighbors who had trouble finding or retaining a physician. They lamented that they couldn’t hold onto the doctors they liked.”

Many of the communities they visited had been without regular or local health care access for months or even years, and towns that lost a provider often spent months trying to recruit a new one.

“We heard a lot of stories where counties only have five doctors, and that’s the most they’ve had in 10 years,” Sperry says. “The community vividly remembers times when there was only one doctor for the whole county and what it felt like to have no access to health care. Things are precarious and can change for any community on a whim. Doctors retire or move, and all of a sudden you have a shortage.”

Business leaders also repeatedly told the students that physicians have left their small towns because the community wasn’t right for their spouses or families.

“We heard probably a hundred times over that physicians would be a great fit for the town, but their family might not fit with the area,” Fuhrum says. “So we also discussed the importance of recruiting families



Med students Weston Fuhrum, Matthew Sperry and Nathan Defrees give their presentation to the Baker City Democrats in Baker City, Ore.

Ride along

Learn more about the students’ trip, and view their route at medstudentscycle.blogspot.com.

And check out the video portion of the students’ presentation on the economic benefits of physician recruitment at vimeo.com/19206744.

continues



Top: Just off the Cascade Lakes Highway west of Bend, Ore., Weston Fuhrum and Nathan Defrees set up a campsite. Above: Fuhrum jumps off a rope swing on Wallowa Lake near Joseph, Ore.

and spouses so they feel integrated into the community.”

As they traveled from town to town, by day the students continued to gain a deeper understanding of rural health care in their home state, and by night they usually camped. According to Defrees, on one memorable occasion they even slept on the rodeo grounds in the unincorporated, agricultural town of Paulina. But they were hosted by many hospitable small-town doctors as well, giving them a firsthand look at the physician’s role in a rural community.

“Everyone talks about how physicians are leaders in the community, but I hadn’t seen that in action until I went on this trip,” Sperry says. “The physicians knew people in the community, and people looked to them to be leaders. The doctors we visited seem to have achieved a healthy balance and enjoy the medicine they are doing.”

Rural health rock stars

In addition to health care and business leaders, the members of the communities gave the students warm welcomes as well, and in many cases townspeople were anticipating their arrival.

“I think medical students should give it a shot and get out there and see rural areas.”

Nathan Defrees, Oregon Health and Science University second-year medical student

“People biked with them from one community to another, and they got a lot of local press,” Gonzales says. “It was really honest to have them talking about the challenges of coming out of medical school with so much debt and the reality of living in rural areas and what might help them and their classmates make that decision.”

As they biked through Union on their way to Le Grande, the students were surprised when Kim Montee, MD, chased them down on foot to greet them.

“He asked if we were the biking medical students,” Sperry recalls. “He was the local physician in Union, and he’d been waiting for us all day. He gave us a tour of his new mobile clinic, which was completely community operated. The community had hired him to run it after their clinic closed. It was inspiring to see a community doing so much for their health care.”

The students also received attention simply from being students at Oregon’s only medical school.

“I kind of felt like we were rock stars,” Defrees says. “The communities were excited to hear ideas about how to attract more physicians. And people were excited to meet medical students, especially because here in Oregon we only have one medical school in Portland. We’re not really seen in rural communities a lot.”

Having grown up on a cattle ranch in the rural, eastern part of the state, Defrees has already selected rural family medicine as his specialty. But he notes that a lot of the rural physicians they met on their trip weren’t originally from rural areas, and that the best way for medical students to decide if rural practice is for them is to “give it a go.”




Left: Rural physician Kim Montee talks to Nella Parks, organizer of the Oregon Rural Action Committee in La Grande. Right: The students give a presentation in La Grande, Ore.

“I think medical students should give it a shot and get out there and see rural areas,” he adds. “It gives a better understanding that rural doctors have a great quality of life, and the patient base is amazing.”

Sperry and Fuhrum grew up in metropolitan areas, but both agree that medical students considering rural practice should experience rural health care firsthand

before making a decision.

“This was a great way to expose us to the rural lifestyle,” Fuhrum says. “I’m just starting my second year of medical school, so I have a long road to go, but we are all interested in family medicine and enjoy the outdoors. Rural Oregon is a good fit for all of us, and knowing Oregon has a shortage of rural doctors makes that draw even stronger.” 

photos by Daphne Johnson

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Brian Freeman, VP, Operations
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The evolution of an epidemic

Looking back on 30 years of rural HIV/AIDS and ahead at new ways to prevent and treat rural America

By Angela Lutz



In recognition of the 30th anniversary of the first diagnosis of HIV/AIDS, *Rural Roads* asked rural providers, educators and researchers how treatment, prevention and perception of the disease have changed over three decades.

Discover how four programs work to establish effective prevention, provide treatment, and reduce stigma in rural communities.

University of Texas- Arlington College of Nursing Rural Health Outreach Program

Arlington, Texas

uta.edu/nursing/rhop



Sylvia Alonzo Rawlings

Background: The Rural Health Outreach Program (RHOP) has been involved with HIV/AIDS prevention in Texas for more than 20 years and has served a 38-county area through the North Central Texas HIV Planning Council for seven years. RHOP also provides continuing education to rural Texas nurses.

What services do you offer?

“HIV prevention provides testing, counseling and referral services,” says Jamie Schield, Texas Prevention Community Planning Group chair and Planning Council coordinator and support staffer, who has been involved in HIV prevention since the 1980s. “The Planning Council provides access to treatment services and covers the gamut from when a person is diagnosed and forward. Now that treatment is viewed more as prevention, we’re looking at expanding our treatment programs to be more along those lines. We also manage disease control.”

How have prevention efforts changed?

“In early days, we stuck around the basics: AIDS education, availability of condoms, ‘don’t share needles, don’t have unprotected sex,’” Schield says. “But every individual is surrounded by a friendship circle, that’s surrounded by a neighborhood, that’s surrounded by a community, all the way up to where the person is affected by policy, and we realized this is the area we need to be targeting for prevention.

“You need to infiltrate the different layers and circles around the person in order for prevention to be effective. You need to consider churches, friends, social networks. It’s a different model in that the plan focuses on the factors that influence behavior versus the behavior itself.”

What new challenges do you face?

“A lot of the younger population feels like it’s not that big of a deal anymore,” says Sylvia Alonzo Rawlings, RHOP director and Planning Council membership committee chair. “One young man told his family [about his infection], and his younger family member said, ‘Can’t you just take a pill for that?’ We’re trying to come back from complacency. The younger generation needs to realize this is still an issue that needs to be addressed, and it still kills people annually.”

“A lot of people think, ‘Hey, wasn’t that cured?’ or ‘Don’t we have a vaccine for that?’” Schield adds. “But there are still 56,000 new cases each year.”

University of Alabama Institute for Rural Health Research

Tuscaloosa, Ala.

cchs.ua.edu/irhr/

Background: Founded in 2001, the university’s Institute for Rural Health Research has been conducting HIV/AIDS research and prevention efforts for seven years, mainly focusing on the central Alabama “black belt” region.

What still causes stigma?

“I think it’s the characterization of the disease in the ’80s and the fact that many people feel they’re not at risk because they’re not a gay, white male,” says Pamela Payne-Foster, MD, deputy director. “Most don’t get true information about the disease, and they’re not aware of how the disease has evolved. There’s also great homophobia in the community, so it’s hard to even have a conversation about HIV because the stigma about homosexuality prevents people from opening up.

“There’s stigma in even being associated with the disease. In Alabama, none of the AIDS services organizations even have signs up. In Selma, I passed by one and couldn’t find it, because you can’t have signs out in small, rural towns because of the stigma. The disease is sort of invisible, so even if they do know someone [who is infected], they aren’t talking about it.”

continues

How have you tried to reduce stigma?

"I've been looking to church pastors to decrease stigma and provide leadership, because it's an important part of black communities, especially



Pamela Payne-Foster, MD

in the South," Payne-Foster says. "I've been able to get into the communities and get a network of pastors involved. It happens through word-of-mouth and building trust. We've been asked to do short training sessions to break the ice, usually with the whole congregation. We describe the science of the disease and the epidemic, how it's changed. We try to decrease stigma using stories and testimonials. If people can talk, it allows them to speak about their own experiences."

How has the disease evolved?

"With the advent of retrovirals, people are living longer," Payne-Foster says. "The over-50 population is increasing, which has caused AIDS to go from an acute disease to more of a chronic disease. They're also co-existing with other chronic diseases such as diabetes and heart disease. Men and women are now infected, and it's become more of a disease of color, affecting more blacks and Latinos."

"And cities over 500,000 get most of the prevention dollars, but more attention needs to be paid to the rural South. Stats show the epidemic is spreading in the rural South in particular."

Department of Veterans Affairs

Iowa City, Iowa
iowacity.va.gov

Background: The Iowa City Veterans Affairs (VA) Health Care System serves eastern Iowa and western Illinois. They have been providing HIV treatment and prevention services to rural veterans since the epidemic began.

How has technology changed HIV/AIDS care?

"The main clinic is in Iowa City and serves a large geographic area, so many veterans have to travel a great distance," says Michael Ohl, MD, investigator and VA quality scholar. "We have worked to establish co-managed care for veterans with HIV that combines primary care services in outlying community-based outpatient clinics (CBOCs) with HIV specialty care delivered via telehealth from Iowa City."

"The goal is to create a 'one-stop shopping' experience that provides comprehensive and coordinated care for veterans with HIV who do not live near large HIV specialty clinics. Veterans were traveling to Iowa City for general routine screening and chronic care, and that wasn't convenient. Now veterans travel to these smaller CBOCs near their homes and receive primary care and HIV care via telehealth. We've done this a little over a year, and so far the response has been enthusiastic."

The changing face of HIV/AIDS

The most recent data from the Centers for Disease Control and Prevention indicate that:

- At the end of 2008, an estimated **1,178,350** people age **13** and older were living with HIV infection in the United States. Of those, **20** percent were undiagnosed.
- Approximately **56,000** people are newly infected with HIV each year in the United States.
- Of the new HIV infections in 2009, **61** percent occurred in gay and bisexual men.
- African-American men and women are estimated to have an HIV incidence rate **7** times higher than whites.
- African-Americans represent approximately **12** percent of the U.S. population but account for an estimated **50** percent of new HIV infections annually.
- Hispanics represent **13** percent of the population but account for an estimated **17** percent of new HIV infections.

How has HIV treatment changed?

“HIV infection has changed radically in the last 15 years,” Ohl says. “Therapy has transformed it into a chronic condition. Someone infected and starting therapy in their 20s is likely to live another 30 or more years and in many cases is more likely to die of a heart attack than AIDS. It’s important that people living with HIV infection have access to high-quality HIV care, but it’s increasingly important that they also have access to treatment for high blood pressure, heart disease, smoking cessation. We need to work collaboratively with primary care providers in rural areas to ensure everyone gets what they need.”

Health Horizons of East Texas Inc.

Nacogdoches, Texas
hhet.org

Background: Starting as a support group for mothers in Nacogdoches County who had lost children to AIDS, 21 years later the nonprofit agency now serves 12 counties in rural east Texas.

What services do you provide?

“We provide prevention and care services, outpatient medical care, case management, transportation, dental services, eye care, counseling, housing opportunities, HIV testing and evidence-based comprehensive risk and counseling services,” says Wilbert Brown Jr., EdD, executive director. “The most vital part is outpatient medical care. Without that the clients would continue to get sicker, and the rates for care would go down. It’s also critical to do testing, because otherwise individuals will not know their status and will continue to spread the disease.”

How has the face of the disease changed?


“When I first arrived [16 years ago], an overwhelming majority of individuals were white males,” Brown says. “Now the majority are African-American, and 43 percent of our clients are women. We didn’t provide medical services at that time – patients had to travel to Galveston or Houston. Now we have a clinic with an

infectious disease specialist here twice a week.

“We also have the Empowerment program for gay and bisexual men. Individuals come together in a small group, and we teach them how to be safe. They then bring other men to the sessions.”

What challenges remain the same?

“Stigma has been associated with HIV for a long time, especially in rural east Texas,” Brown says. “I’ve seen that change, but it’s been subtle. We’ve involved churches, and they’ve allowed us to speak to their congregations. We’ve held prayer breakfasts with 250 to 300 people that were planned by ministers, and it has affected stigma.

“And confidentiality is so important, especially in rural Texas. If a client feels his confidentiality is compromised, he won’t seek care. People can’t share sometimes even with their families. It’s important that there are clinics that deal specifically with HIV, because at the community health center, patients have the fear that someone will find out and tell their family and friends. The stigma has lessened, and we’ve done a lot to address it, but it’s still here.” 

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Darrel Brimm, nurse educator, Shaye Krcil, site coordinator, and Ben Leonard, simulation specialist, transport this 44-foot mobile learning lab to train volunteer emergency medical technicians and hospital employees throughout western South Dakota.



Mannequins that bleed

South Dakota delivers latest in emergency training to every EMT and hospital

By Lindsey V. Corey

Brent Hoffman remembers feeling helpless when he came upon an accident on a remote gravel road in western South Dakota.

"I didn't have any knowledge or even know what to do to get them out of the snow banks," the cattle rancher recalls. "These people really needed help, and all I could do was wait out there with them a long time for an ambulance."

Not long after that 2003 accident, Hoffman joined the Rural Meade County Ambulance Service, based in Enning, S.D., population 183. The all-volunteer crew of 11 covers a 1,000-square-mile area, much of it more than an hour from the nearest hospital.

"We get about 20 to 30 calls a year, not a lot of runs since we're on call at different times," he says. "So it's always a challenge to feel like our skills are as polished as they need to be."

Enter Simulation in Motion-South Dakota (SIM-SD), a statewide and state-of-the-art mobile training program for emergency health care providers.

SIM-SD gives rural hospital staffs and emergency medical technicians (EMTs), who may only encounter a critically ill or injured patient a couple times a year, the chance to practice with human-like, computerized mannequins.

The mannequins – an adult, a child and an infant –

breathe, talk, cough, sweat, blink, bleed, react to medication, cry, die and more.

Hoffman has been to EMT trainings before with inanimate mannequins that “you had to dress in different ways and imagine different wounds.”

“But this dummy can talk and respond or not respond just like a real person would,” he explains about recently working with the SIM-SD adult simulator. “It’s as close to a real patient – with vital signs you can monitor and take care of – as you can get rather than a rag doll. It was over and above anything else we’ve done by wide margin.”

“It’s always a challenge to feel like our skills are as polished as they need to be.”

**Brent Hoffman, Meade County (S.D)
Ambulance Service volunteer**

The technology can be jarring, according to Shaye Krcil, one of five SIM-SD regional site coordinators and director of trauma services at Rapid City Regional Hospital (RCRH). Most volunteer EMTs have never worked with patient simulators with microphones enabling trainers to respond.

“For the first scenario, there’s usually some wow and fear factor, like ‘I can’t believe it just blinked at me,’ and ‘whoa, he talked to me,’” she says.

“That takes away from their rhythm and flow. But it’s so realistic, that they quickly get immersed in caring for the patient together.”

Best of all, the training is free, and the educators and equipment travel to every rural care center or ambulance bay in South Dakota so the community is covered, and volunteers don’t have to leave their day jobs.

“The whole thing was designed to respect participants’ time and the commitment they’ve made to their community,” says Krcil.

Krcil’s western South Dakota region includes eight hospitals and 27 emergency medical services. Its educators – a nurse who also works in the Rapid City emergency room and a paramedic employed with the Rapid City Fire Department – and mannequins will



Top: Emergency care educators Ben Leonard and Darrel Brimm demonstrate how rural providers practice working on a child mannequin in a Simulation in Motion-South Dakota vehicle modeled after the back of an ambulance. Above: State-of-the-art mannequins are used in emergency care trainings throughout rural South Dakota.

visit 25 separate sites in one year.

SIM-SD trainers have commercial licenses to drive the 44-foot truck featuring three separate areas: one simulating the inside of an ambulance, one an emergency room and the center where instructors operate the mannequins out of view of professionals and volunteers participating in the simulations. The vehicle houses audio and visual recording equipment so educators and students may review the scenarios after their completion. Scenarios may also be conducted outside the truck to replicate EMTs arriving on a scene of an auto or farm accident.

“Everyone on our crew has at least one other job and a family life that enables us to stay in the rural area we love, so it’s not easy to get away to an annual convention for a large, all-academic training,” says Hoffman,

continues



Mannequins and video equipment are used for training rural providers in the emergency room section of the Simulation in Motion-South Dakota vehicle.

Training teamwork

Simulation in Motion-South Dakota is a collaborative effort with these partners:

- South Dakota Department of Health
- South Dakota Office of Emergency Medical Services
- South Dakota Emergency Medical Technicians' Association
- Avera Health in Sioux Falls
- Mobridge Regional Hospital in Mobridge
- Regional Health in Rapid City
- Sanford Health in Sioux Falls
- St. Mary's Healthcare Center in Pierre

who also works as a hunting and fishing guide. “That’s why this is so invaluable. They come to us with hands-on training and two or three scenarios that – if you’re serious about the training – are close enough to real that you get an adrenaline rush. That’s a valuable aspect to a crew who doesn’t get a lot of runs together because under even just a little bit of stress, the simplest things don’t always work right.”

SIM-SD focuses on the learning experience, not on evaluation. Medical personnel aren’t tested, and videos of the scenarios are deleted immediately following the debriefing portion of the on-site training.

“It has to be non-threatening; we want them to ask us to come and provide the education, so there’s no certification involved and no test,” Krcil explains. “Sometimes when you know there’s a test at the end, it becomes more about focusing on what they think we want instead of truly getting the education they need out of it. The debriefing is where a lot of the education occurs. In the real world, we don’t always get a chance to sit down and think about ways to improve, let alone



Simulation in Motion-South Dakota partners Rita Haxton, Shaye Krcil and Sandra Durick lead a press conference and educational session during the National Rural Health Association's 2011 Rural Quality and Clinical Conference in Rapid City, S.D.

SIM-SD live

Meet Simulation in Motion-South Dakota trainers and mannequins at the National Rural Health Association's 35th Annual Rural Health Conference April 17-20 in Denver.

SIM-SD partners and trainers invited attendees of NRHA's Rural Quality and Clinical Conference to tour one of five vehicles and to check the pulses of adult and infant patient simulators in July in Rapid City, S.D.

To learn more, register for the Colorado conference at RuralHealthWeb.org/ac and visit sim.sd.gov.

share that experience with other volunteers on the service. There are enough standardized courses available to be certified; this is an opportunity for something different."

The statewide collaboration is unique too, says Rita Haxton, RCRH patient care vice president.

Staff at the five partnering health care organizations – Mobridge Regional Hospital in Mobridge, St. Mary's Healthcare Center in Pierre, Regional Health in Rapid City, Avera Health and Sanford Health in Sioux Falls – determined the most frequent emergencies from rural areas and developed 13 different scenarios, each with scripted patient stories, simulator programming and evidence-based best practices. Employees at the state's Department of Health, Office of Emergency Preparedness and Emergency Medical Technicians' Association also help ensure SIM-SD reaches remote emergency care providers.

"You've got to have people who know what they're doing out in the field when you're 100 miles away from a hospital."

Rita Haxton, Rapid City Regional Hospital patient care vice president


"In South Dakota – because there are only 750,000 in the state – people really do work together," Haxton says. "When you're rural like we are, you learn to depend on each other and not to re-create the wheel. We worked hard to ensure the same level of education is provided to all EMTs across

the state because it was the right thing to do. You've got to have people who know what they're doing out in the field when you're 100 miles away from a hospital."

The SIM-SD project, currently in its second year, is funded by a \$5.6 million grant over three years. Custom trucks and simulators for each region rolled out this year based on specifications from medical personnel at the health care organizations. Funding came from the Office of Public Health Preparedness and Response and from the Leona M. and Harry B. Helmsley Charitable Trust.

"It's everyone's goal to make this sustainable once the grant period is done next December, and we're working together to make that happen," Krcil says. "The equipment is paid for so thankfully that's off the table, but there will still be maintenance, fuel and staff costs."

Hoffman says he hopes his crew is able to participate in another training.

"We built a better camaraderie and working relationships that day," he says. "It's the best government program I've ever been involved with in the way the money was spent and its effectiveness. I can't emphasize enough how important it is for us to practice those skills in such a life-like situation." 

photos by Barbara Downen

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Grants help new programs attract students to rural health careers

By Lindsey V. Corey



University of Nebraska Medical Center students practice stitches under the guidance of a Butler County Health Care Center provider.

When people in David City, Neb., heard med students were coming for a visit, the whole community got involved.

“Even the local butcher was excited to donate pig ears and feet for them to practice stitches,” says Joleen Huneke, executive director of southeast Nebraska’s Rural Comprehensive Care Network (RCCN).

Twelve University of Nebraska Medical Center (UNMC) students in the Omaha campus’ Family Medicine Interest Group hopped in a van for David City, population 2,648, with the promise of no-cost, hands-on skills building.

“As first- and second-year students, we don’t get much clinical practice, so that drew me in,” says UNMC student Alisha O’Malley.

But beyond putting casts on the hospital CEO and inserting IVs into local volunteers rather than mannequins in school, O’Malley says she appreciated that the day away from the city wasn’t solely intensive training.

“It was nice that they showed us more than just the medicine. I expected to do suturing and IVs, but I got more out of the experience,” she says. “It was eye-opening to hear that doctors there do a lot of procedures and get more involved in patient care than some do in cities. We left with a positive impression of what rural practice – and rural life in general – was like.”

Mission accomplished, according to Huneke, who helped create the Rural Road Trip events with funding from a \$600,000, three-year Office of Rural Health Policy (ORHP) workforce development grant.

“We brought in young community leaders who choose to live in David City,” Huneke says. “The students could talk candidly over lunch with people they can

relate to so they can imagine their career in a rural area and understand better the quality of life they would have.”

The concept came out of RCCN’s annual physician meeting. RCCN serves 19 critical access hospitals and 78 rural doctors.

“We look around and see that a lot of our doctors in that circle are getting older, and they want to make sure they have a high quality person coming in to take care of their patients,” Huneke says. “They recognized that we need to get medical students more in touch with our rural areas and get them out of the urban metro for awhile. This grant provided the mechanism to make that a reality, and we were thrilled ORHP has their finger on the pulse of rural and saw this huge workforce need.”

Huneke was also thrilled to have a waiting list of UNMC students for upcoming Rural Road Trips and plenty of small towns eager to welcome them.

“This project points to the importance of partnerships all the way from ORHP to us to UNMC and rural hospitals,” Huneke says.

She insists partnerships are the only way to address the rural health workforce crisis.

“It’s a huge issue that young students are choosing careers that are more lucrative than family practice, which is what we desperately need in

rural Nebraska,” she says. “But in the medical community, family practice is not thought of as the glorious career like neurosurgeon and cardiologist. But in family practice, you need to know about every system in the body from ‘you seem depressed’ to ‘is your big toe hurting?’ and everything in between from birth to death. A specialist knows about the heart, but you have to see a good family practice doctor to get to a cardiologist. We wanted to help elevate the status and open these students’ eyes.”

Renee Bauer, RCCN workforce development director, recalls the students being impressed with Butler County Health Care Center’s facility and staff at the 20-bed David City hospital.

“We left with a positive impression of what rural practice – and rural life in general – was like.”

Alisha O’Malley, University of Nebraska Medical Center student

“Even if not all 12 of these students come back to rural practice, we’ve erased some of those negative perceptions and created goodwill, so that if they become a specialist, they’ll know their rural patients come from a high quality provider,” she says.

RCCN was awarded one of 20 grants as part of a three-year pilot program, developed by ORHP in 2010 when President Barack Obama named workforce a priority in his Rural Health Initiative.

“This is an exciting time for rural communities and the rural health field because we have this initiative looking at workforce and the White House Rural Council and the Health and Human Services secretary’s Rural Health Information Technology Task Force all working together to help build on an infrastructure already in place to make collaboration stronger so everybody is interested on how rural residents fare in health care,” says Heather Dimeris, ORHP senior adviser.

And this rural health focus, including the Rural Training Track Technical Assistance Program in cooperation with the National Rural Health Association, didn’t require additional government funds, says Nisha Patel, ORHP community-based division director.

“ORHP didn’t have any new appropriations to do this, but because it was addressed as a priority, we were able to create this opportunity geared specifically to a huge challenge and do it quickly using existing appropriations from the rural health care services outreach program,” she explains.

The workforce grant projects total \$12 million over three years and represent all disciplines from mental health to physical therapy.

President’s Rural Health Initiative

From fiscal year 2010 through 2013, \$79 million has been set aside annually to improve access to and the quality of rural health with funds targeting:


1. Health workforce recruitment and retention
2. Building a programmatic “evidence base”
3. Telehealth and health information coordination
4. Cross-governmental collaboration

“We have asked all the grantees to really engage students in community activities to expose them to different rural opportunities and help them understand why providers do want to practice in rural areas and want to be part of a community to help make sure these people get health care,” Patel says. “We’re just beginning to evaluate the program to get an understanding of why they want to live and work in rural areas and why they’re hesitant to practice there. At the end of three years, we’ll have qualitative and quantitative data to really tell the story and share with our partners.”

She hopes many of the models will be replicable and become self-sustaining.

“We get questions all the time from communities struggling to bring on providers, and we want to be able to offer solutions,” Patel says. “We want to see the creative ways they’re collaborating to recruit students to rural areas.”

Bauer is confident RCCN’s Rural Road Trip could work anywhere.

“As long as you have university support like we do, you can start creating this important pipeline to rural communities,” she says. “The value of the skills is what hooks the students first, but the true value is once they get out there and they see what they can do in rural medicine.” 



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Small-town med school trains small-town doctors

By Angela Lutz



The inaugural class of students at the University of Kansas Medical Center's Salina campus started this fall with a rural focus.

It's the smallest medical school campus in the country, and also one of the few dedicated specifically to training rural physicians.

Located in the agricultural community of Salina, Kan., population 46,006, the new University of Kansas Medical Center campus will be one of the first schools in the country to train future rural physicians in a rural setting. The inaugural class of eight students kicked off their first semester in August.

"Many of the students have selected this campus because they're interested in returning to rural areas to practice as family physicians," says William Cathcart-Rake, MD, Salina campus director. "We're giving the continued opportunity to see what life is like

in smaller communities. Life can be good, and practice can be challenging and rewarding."

Training a new generation of rural physicians to practice in Kansas is vital, especially as demand increases. Rural communities are poorer, older and more likely to be uninsured than the general population, and five Kansas counties have no doctors at all. Additionally, nearly 25 percent of doctors in Kansas are 60 years of age or older and nearing retirement. According to Cathcart-Rake, the need to fill these gaps in the rural health care delivery system was the No. 1 factor that led to the creation of the Salina campus.

In order to keep the costs of opening and operating the new campus down, each morning students attend basic science courses broadcast via interactive television from the main medical center campus in Kansas City, Kan. More specific courses such as labs, clinical skills and anatomy are

taught by local faculty in Salina, many of whom are volunteers from the neighboring Salina Medical Center, where the students will receive much of their training and clinical experience.

“We’re not hiring a whole new basic science faculty,” Cathcart-Rake says. “A lot of faculty members are volunteers who realize part of their obligation as physicians is to teach the next generation of physicians.”

Of the eight students, seven are native Kansans, and most of them selected the Salina campus as their first choice over the larger Wichita or Kansas City locations. Though Cathcart-Rake says the faculty’s primary goal is to train the students to be good physicians and support them whether their practice is urban or rural, six of the students have already accepted scholarships with a commitment to practice in a rural area.

“The students are smart enough to see for themselves what the challenges are facing small-town physicians, but they’re also smart enough to see what the rewards are.”


William Cathcart-Rake, MD, University of Kansas Medical Center-Salina director

“The students are smart enough to see for themselves what challenges are facing small-town physicians, but they’re also smart enough to see what the rewards are,” he says. “As they continue to grow in their education, those ties with small communities will remain strong, and they’ll want to return.”

Students who study in small towns are also more likely to meet spouses from rural areas, which is an important factor in a physician’s ability to settle into small-town life, Cathcart-Rake says.

“Part of the problem with training in metro areas is that [students] get comfortable there, and they meet their spouses there,” he explains. “We’ve had the problem with spouses not wanting to move to rural areas – the wife or husband says no, even when the physician wants to return. Recruiting the spouse or family is just as important. If the spouse is unhappy, it’s unlikely we’ll keep the physician.”

Ultimately, the goal is for the Salina campus to serve as an example for other universities considering developing similar satellite programs across the country, he says.

“We think that if this works, it could be a model for other medical schools to follow,” Cathcart-Rake says. “It’s trying to address the crisis in rural health care by encouraging more physicians to practice in rural communities, and it’s also relatively cheap. And the students are excited about getting down to studying, because it’s a grueling process. But they also realize they’re part of something innovative and new.” 

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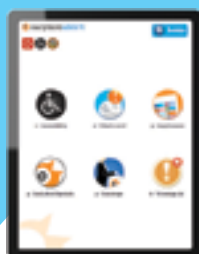
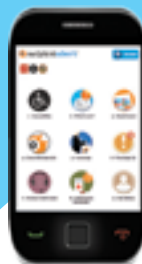
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Rural public health programs hit hard by budget cuts

By Angela Lutz

Between 2008 and 2010, rural public health departments lost approximately 30 percent of their workforce due to budget cuts and staff attrition.

According to Michael Meit, National Opinion Research Center Walsh Center for Rural Health Analysis co-director and National Rural Health Association Community Health Status Constituency Group chairman, public health departments that serve less than 25,000 people have taken a heavier hit than urban departments.

“They have fewer resources, fewer staff – it’s already a fragile system, so these cuts can drastically affect rural communities that are already struggling to maintain their public health systems,” he says. “It can disproportionately affect rural more so than urban.”

A lack of funding can limit the capacity of rural public health departments to provide essential services, such as disease tracking and monitoring, health promotion, and safety net care, including immunizations and in some cases comprehensive primary care. Maternal and child health programs, chronic disease management programs, emergency preparedness activities and environmental services have also been reduced. According to the National Association of County and City Health Officials, 59 percent of the U.S. population lives in an affected jurisdiction.

Meit says that the loss of these public health programs that ensure a population stays healthy will lead to potentially serious consequences.

“When public health functions well, you don’t know it’s there, because it’s operating behind the scenes,” he says. “That has been a lot of the success that public health has accrued over the last century. But when these services are lost, restaurants aren’t being inspected, children aren’t being vaccinated, and communicable diseases may spread. It won’t happen overnight, but many people won’t know [public health programs] are gone until these things start happening.”

At the Coconino County Public Health Services District in Flagstaff, Ariz., Barbara Worgess, chief health officer, has been struggling to continue serving her 18,600-mile service area in the same capacity she did before the budget cuts. The largely rural county, population 130,000, is roughly the size of New Jersey and Delaware combined and includes tribal reservations and Grand Canyon National Park, which presents geographic challenges to providing care.

“We’re basically a frontier county, and given the size, it’s very difficult to



Michael Meit

serve,” Worgess says. “Not only is it geographically a lot of area, there’s a canyon cutting through the middle, and you can’t just cross that. You have to go around it.”

In Coconino County budget cuts have totaled more than \$11 million, and Worgess has lost one seventh of her staff as a result, going from 141 full-time equivalent employees in 2008 to 119 employees today. She says they’ve had to make difficult decisions regarding services that may need to be reduced or eliminated, as well as when to cut back on visits to remote communities.

“We have to consider how we’ll effectively serve remote areas when we’re two to four hours away,” Worgess says. “You often see health disparities based on where people live, and these cuts have only made that worse. It’s only increased the disparity between people who live in and around Flagstaff and those who don’t.”

In order to address the challenge of limited funding and prevent further cuts, Meit says public health departments need to increase their day-to-day visibility and not just take center stage during a crisis.


“Just over a year ago we were dealing with H1N1, and a lot of public health resources were utilized to immunize and educate people, and it was a public

health success,” he explains. “But as soon as the crisis abates, the issue seems to fall away. We need to learn how to gain sustained attention by showing that investments in public health improve people’s lives every day, not just during crises.”

Worgess has managed to gain some attention and avoid more staff layoffs by making Coconino County a public health tax district last December, which created a specific tax that will create a reserve to protect against future cuts. She is also trying to remain optimistic.

“When public health functions well, you don’t know it’s there, because it’s operating behind the scenes.”

Michael Meit, National Opinion Research Center Walsh Center for Rural Health Analysis co-director

“This is a very difficult time, because people who work in public health are so passionate about making a difference in people’s lives, and it’s hard for them to be unable to do what they did before,” she explains. “But in this challenge, the opportunity is to step back and focus. We have to realize we can’t do it all, so we’ll focus on what we can do best. It gives us the incentive to look very carefully at what we do and consider if it’s the best way to spend our money.” 

Public health’s big 10

The National Public Health Performance Standards Program has identified the following 10 essential public health services to provide a working definition of public health and a guiding framework for the responsibilities of local public health systems:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.



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Beginnings & Passages



Elizabeth Zimmerman in Nepal

“I cannot stop asking myself the question of privilege.”

Nepali patient inspires nurse to fight for health care equity

By Elizabeth Zimmerman

Snip, snip, snip.

Violently cutting through a young girl's white dress was not my ideal Saturday afternoon and neither was hearing shrill Nepali screams of the girl's mother who was several feet from the medical gurney. There had been a major bus and taxi accident in the Kathmandu valley of Nepal, and many severely wounded patients were flooding into our three-bed emergency department of the only charity hospital in the Valley that provided free health care for the surrounding farming and rural community.

My primary patient was a 6-year-old unconscious girl named Sangita*. Cutting through her dress revealed extensive wounds, and I immediately began work to revive the little girl who was clinging to life.

In hindsight, Sangita would turn out to be both the worst and best patient I would ever encounter during my nearly decade-long career in emergency nursing. Sangita made me think of the haves and the have-nots.

That eye-opening experience was nearly seven years ago, and I cannot stop asking myself the question of privilege: Is it possible to create policies that promote healthy living and assist in appropriately allocate funding to facilities and health care systems that serve the impoverished and underserved, like Sangita?

With that question and many others, I resigned from my position as charge nurse at an urban hospital and enrolled in a health policy graduate program. Between my first and second year of school, I was required to complete an internship. I chose the National Rural Health Association's Washington, D.C., office.

During my first week, NRHA was visited by a North African health professional delegation whose experiences reminded me of my own in rural Nepal. These delegates who serve in their rural communities and what I learned as an NRHA intern brought about a common thread: rural health care providers and their rural communities, regardless of limited resources, personnel or other barriers, are hard-working, resilient and have the biggest hearts.

As my NRHA internship progressed, it is evident how true this is in rural America and of those who advocate for equity and equality of rural health care.

**name changed*

Elizabeth Zimmerman is working on her master's in public health policy at Saint Louis University School of Public Health. She was an NRHA intern in 2011.

Innovative rookies and seasoned professionals share their experiences.

“If you are a good collaborator,
you are a great negotiator.”



Sandra Pope

Collaboration key to career in rural health

By Sandra Pope

Working with rural communities really is my life.

During summer breaks in high school, I worked at the West Virginia Department of Mental Health in Charleston. I enjoyed the programs and the people and always wanted to return to work in state government. After college graduation, I began working as a temporary employee and was eventually hired in the Office of Community Health Services. I never dreamt I would spend the next 20 years working there in various capacities.

I am most proud of my work with rural communities and health care providers and my role in helping to establish critical access hospital (CAH) designation. These towns were struggling, and yet many were reluctant to learn about this program that could maintain needed services in their communities. To them, I was a meddling outsider, but I was driven because this was good business for them and I felt that if I stuck with it long enough they would come to accept me and the program, which became very successful.

I entered one rural hospital through the emergency room to talk to staff about CAHs, and the treatment room gurney was loaded with food for a holiday party. Talk about rural!

Today, I am most challenged by collaborating. It sounds so simple, but I have found it to be one of the most difficult things to actually accomplish. If you are a good collaborator, you are a great negotiator. I think this is truly one of my strengths, and because of it, I am able to work with just about any group of people.

In recent years, I think my major accomplishment has been my ability to promote and support rural projects and initiatives, many of which have been targeted to minority populations. I am proud of the successes of the National Rural Health Association's Multiracial and Multicultural Council. This is a group of extremely knowledgeable and competent leaders who embody true personal commitments to reduce health disparities among minority populations.

There is so much to do. It seems like the projects are endless, but I just try to stay committed to doing my part, and providing leadership or support wherever I can.

Sandra Pope is the West Virginia Area Health Education Center program director and serves as NRHA's Multiracial and Multicultural Council chair.

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

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Lance Keilers

5 questions: Get to know 2012 NRHA president Lance Keilers

1. What led you to choose a career in rural health?

I was already in health care when the Ballinger Memorial Hospital District administrator position came open. The hospital board took a chance on a young guy with not much experience in rural health, and they have been by my side ever since that day 14 years ago. It has been a great partnership.

Our small critical access hospital (CAH) and a rural health clinic are staffed with two physicians and two mid-level practitioners. The hospital was on the brink of closure when I accepted the position, and the main thing that kept it open was the federal CAH designation. Our hospital, guided by a great board and wonderful physicians and staff, has fought back to become financially stable. Our hospital is in a taxing district, and without the tax revenue – even with the CAH designation – we would not be open. The taxpayers believe in the hospital and continue to support it, so our goal is to provide quality, affordable care locally.

2. What are the main challenges facing rural health care in the next year?

I am concerned that on a state and national level, rural health does not have the representation it once had. With population shifts and political

redistricting, rural has lost many of its champions.

NRHA members have to be more involved and more engaged than ever before. Every time rural health is discussed, NRHA and its members need to be in the room. Our membership is very diverse, and the impact of 20,000 rural advocates engaged on every issue that pertains to rural health is limitless. The involvement of our members will also have a direct impact on the long-term success of NRHA.

This is a critical time for health care in our country, and there are many challenges ahead.

3. Why have you continued to work in rural America despite the challenges?

I believe rural health needs a voice. People in rural communities have challenges that their urban counterparts do not, and the key to long-term survival is involvement. It is no longer enough for the local hospital CEO to be the voice for the facility. In today's environment, everyone has to be involved from the board of directors and staff to community members.

4. What are your favorite parts of working for rural America?

Without a doubt, it's the people. I have been blessed to meet and work with the brightest and most insightful people in health care.

The hospital staff is a constant encouragement to me and has shown me what dedication is. We have employees that went years without a pay raise just to keep the doors open.

They come to work every day because they love what they do. When you are surrounded by that, it's contagious. I look forward to going to work every day.

5. What are your favorite ways to relax?

The way that I relax is to spend time with my family. Living in west Texas, obviously hunting and fishing are abundant, and I enjoy both.

I have also been fortunate to travel and have seen some beautiful places from D.C. to Colorado to Costa Rica.

Lance joined NRHA in 1999.

accelerating advocacy

NRHA advocates to save rural facilities

The National Rural Health Association fought hard to ensure rural hospitals and practitioners were protected in the Budget Control Act (BCA) of 2011.

Passed by Congress in August, the bill allowed for an increase in the amount of debt the U. S. government may incur while reducing total federal government expenditures. Nine hundred billion dollars in cuts to federal spending and an additional \$900 billion of borrowing authority have already gone into effect.

In this unprecedented advocacy effort, NRHA staff wrote letters to President Barack Obama, House Speaker John Boehner, Senate Majority Leader Harry Reid, Health and Human Services Secretary Kathleen Sebelius and Health Resources and Services Administrator Mary Wakefield. NRHA staff and members visited with staffers from the Senate Finance and House Energy and Commerce committees and met with numerous senators and representatives.

While NRHA was successful in protecting rural facilities in round one of deficit reductions, continued advocacy remains vital.

The BCA also calls for an additional \$1.2 to \$1.5 trillion in federal expenditure reductions over the next 10 years. The Joint Select Committee on Deficit Reduction - or "super committee" - was created and tasked with developing policies that will produce these reductions. And rural health has been targeted in various proposals to this committee and to Congress as a whole.

The bi-partisan committee must make recommendations for continued spending cuts by Nov. 23.

"Your action is critical in making sure your elected leaders know how important rural facilities are to rural patients and the rural community," says Alan Morgan, NRHA CEO.

The specific payment reductions advocated by each proposal vary, and a number of groups have put forward suggestions. Proposals include:

- **The Congressional Budget Office**

This plan to eliminate critical access hospital (CAH), sole community hospital and Medicare dependent hospital designations would reduce hospital payments by \$3.8 billion in fiscal year (FY) 2012 increasing to \$9.5 billion in reduced payments in FY 2021.

Total cut from rural facilities over 10 years: \$62.2 billion

- **President Barack Obama:**

Starting in FY 2013, the President's plan would end add-on payments for physicians and hospitals in frontier states, reduce CAH reimbursement to 100 percent of reasonable cost, and end CAH reimbursement for facilities located 10 miles or less from another hospital.

Total cut from rural facilities over 10 years: \$6 billion

- **House Republican leadership**

While specifics of the proposal were not released, House Republican leadership sought to cut \$2 billion from frontier state add-on payments and \$14 billion from rural hospital reimbursement structures.

Total cut from rural facilities over 10 years: \$16 billion

- **Ways and Means Democratic staff**

The Democratic staff from the House Ways and Means Committee embraced the Congressional Budget Office recommendation.

Total cut from rural facilities over 10 years: \$62.2 billion

- **Sequestration**

If the super committee fails to produce sufficient savings, Medicare reimbursements will be sequestered. An automatic cut of 2 percent will be instituted on all providers.

Total cut from rural facilities over 10 years: \$5.9 billion

"These proposals erroneously claim that they eliminate 'higher than necessary reimbursement' to rural facilities," Morgan says. "However, CAHs account for only 5.3 percent of all hospital spending while providing care for 8.7 percent of Medicare adjusted patient days. Proposed cuts will exacerbate significant funding shortfalls for rural hospitals that are providing efficient services to the most vulnerable beneficiaries."

Currently 41 percent of all CAHs operate at financial loss. If these proposals to cut billions in Medicare reimbursements go into effect, many more small hospitals will lose money. Morgan predicts that some will have to close their doors, further jeopardizing access to inpatient and emergency care.

Congress created the CAH designation in 1997 to prevent hospital closures, like those that occurred in the 1980s and 1990s. In those two decades, 360 rural facilities closed.

"From 2000 to 2009, only 43 CAHs closed proving that the CAH program is a safety net program that is working," Morgan argues. "CAHs are vital access points for rural seniors who are, per capita, older, poorer and sicker than their urban counterparts."

Recent reports show that Medicare contributes more than 40 percent of all revenue to CAHs, compared to 32 percent for urban facilities. Medicare cuts to rural hospitals will disproportionately harm these vital safety net facilities, Morgan cautions.

For tips and resources to effectively advocate for rural communities, access NRHA's Congressional Action Kit at RuralHealthWeb.org.

Esta Willman, ATP
President
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Rural Multiracial and Multicultural Health Conference

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Rural Health Policy Institute

Jan. 30-Feb. 1

Washington, D.C.

Rural Medical Educators Conference

April 17

Denver

Annual Rural Health Conference

April 17-20

Denver

Rural Quality and Clinical Conference

July 18-20

Seattle



www.RuralHealthWeb.org

Regulatory Rundown

In 2011, the National Rural Health Association has read more than 3,200 pages of the Federal Register and submitted eight comment letters of more than 50 pages to the Administration regarding newly released regulations:

1. Centers for Medicare and Medicaid Services (CMS) value-based purchasing rule
2. Office of the National Coordinator for Health IT 5-year strategic plan
3. CMS Medicare shared savings program and accountable care organizations
4. CMS inpatient prospective payment system updates for fiscal year 2012
5. CMS proposed methods for assuring access to covered medicaid services rule
6. Health Resources and Services Administration clarification of orphan drug exclusion for 340B entities
7. CMS outpatient prospective payment system updates for calendar year 2012
8. CMS implementation of health insurance exchanges

For more information and rural health updates from Capitol Hill, follow NRHA's Rural Health Voices blog at blog.RuralHealthWeb.org.

Send your career updates to editor@NRHArural.org.

Members on the move

Feltner leads rural health center in Kentucky

National Rural Health Association member Frances J. Feltner is the new director of the University of Kentucky (UK) Center for Excellence in Rural Health in Hazard.



Frances J. Feltner

In this role, Feltner oversees all aspects of the center, including the Kentucky Office of Rural Health, Kentucky Homeplace program, and the center's other rural health initiatives in education, research, service and community engagement.

Feltner, a former nurse and health worker administrator, has worked in rural health for 35 years.

"Over the years I have seen firsthand how health disparities affect the rural communities we live in," she says. "The programs here are set up to help communities identify problems and then work together to find solutions. The center's team consists of dedicated employees full of knowledge, talent and a willingness to move our mission forward."

Feltner is also pursuing a doctorate in nursing practice from UK.

Conditt moves to West Texas AHEC

Long-time National Rural Health Association member Becky Conditt recently became director of the West Texas Area Health Education Center (AHEC).

Conditt most recently was director of the Capital Regional Operation of East Texas AHEC also serving as executive director of the Texas Rural Health Association. She has 18 years experience in the East Texas AHEC program.

As director of the West Texas AHEC, an outreach of the Texas Tech University Health Sciences Center, Conditt will oversee five regional offices. The AHEC's work focuses on community health needs assessment and health workforce pipeline development, Conditt says.

"I know I will continue to stay involved with the National Rural Health Association for education, advocacy and friendship in my new role in Lubbock, Texas," Conditt says.

News briefs

Conference to focus on changing demographics

Former U.S. Census Bureau Director Steve Murdock, PhD, will give the keynote address during the 17th annual Rural Multiracial and Multicultural Conference Dec. 7 and 8 in Daytona Beach, Fla.

"Dr. Murdock knows rural. He knows the Census. And, more than most, he can help us understand just what this all means for the current decade," says Gail Bellamy, PhD, Blue Cross and Blue Shield of Florida Center for Rural Health Research and Policy director and Florida State University College of Medicine professor. "I'm excited that he accepted our invitation to be a keynote speaker at this year's Multiracial and Multicultural Conference; we could not have a better guide."

The National Rural Health Association event is the nation's only conference focusing on improving health for under-represented rural populations.

As details from the 2010 census are unveiled, Murdock, now a Rice University sociology professor, will help attendees put them in perspective and discover how to adapt health care initiatives to rural America's changing demographics, Bellamy says.

"What does rural look like today?" she asks. "The census has enormous implications for rural America. What is the proportion of racial/ethnic minorities? What industries dominate? Are we still older? More than just the demographics, the census plays a key role in determining how many Congressional seats a state has and how those seats are divided up. What are the implications politically for rural for the next decade?"

Participants will learn how to develop policy and implement programs to improve health access and

outcomes in rural multiracial and multicultural communities and will gain creative approaches to delivering health services in rural and frontier areas.

Visit RuralHealthWeb.org/mm for the full agenda, scholarship opportunities and event details.

Medical students have new resource for rural residency options

Medical students evaluating residency training options can utilize a new website that provides information about various aspects of rural residency.

The website, www.traindocsrural.org, is the first online resource solely dedicated to offering medical students in-depth information on rural residency programs.

The site includes residency training options, an overview of rural residency and practice, the ability to contact physicians and residents practicing in rural areas, and links to financial support and incentive programs.

"Medical students have been requesting a resource like this for some time, with a focus on their needs," said Rural Training Track Technical Assistance Program (RTT-TAP) Project Director Randall Longenecker, MD. "For them, it helps take some of the mystery and stress out of finding a rural residency."

Created through a cooperative agreement between the National Rural Health Association and the federal Office of Rural Health Policy, RTT-TAP is a consortium of 25 rural residency programs tapping rural expertise to help sustain and grow RTT programs as a national strategy in training physicians for rural practice.

RTT-TAP and the Rural Assistance Center at the University of North Dakota School of Medicine and Health Sciences collaborated to develop the site.

UK Center for Excellence in Rural Health celebrates 20 years

The University of Kentucky Center for Excellence in Rural Health (UK CERH) recently celebrated its 20th anniversary with a ceremony honoring current and former faculty, staff, students and community partners.

The Nov. 10 event's keynote speaker was U.S. Rep. Harold "Hal" Rogers, a long-time advocate for the improved health status of Kentucky's 5th Congressional District. Among those in attendance was Wayne Myers, MD, the UK CERH's first director and a former National Rural Health Association president.

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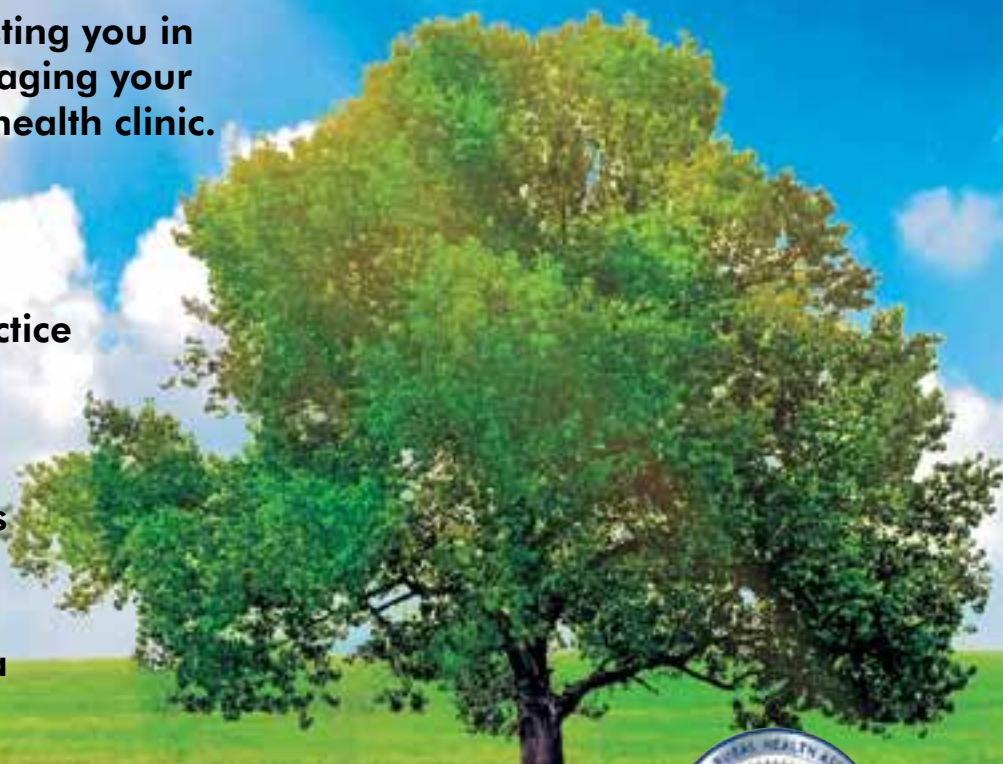


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continued from page 47

The UK CERH, located in Hazard, was created by mandate of the Kentucky General Assembly. Its mission is to improve rural health care systems – and the health of rural Kentuckians – through education, research, service and community engagement.

More than 550 students have graduated from the UK CERH's academic programs, with the majority still practicing in rural areas. The UK CERH also includes Kentucky Homeplace, a nationally recognized community health worker initiative; the Kentucky Office of Rural Health; and the East Kentucky Family Medicine Residency Program.

The UK CERH, its programs and its staff have won five NRHA Rural Health Awards.

NRHA represented on *Modern Healthcare's* top 100 list

National Rural Health Association CEO Alan Morgan and member Nick Wolter, MD, made *Modern Healthcare* magazine's 2011 list of the 100 Most Influential People in Healthcare.

Morgan has worked for NRHA for nearly 11 years, and Wolter is CEO of the Billings Clinic in Montana.

This is the first time each man has made the annual list. Readers nominated American health care professionals and voted on the top 300 candidates, representing 50 percent of the final outcome. The magazine's senior editors determined the other 50 percent.

More than 2.2 million votes were cast.



Ty Borders, PhD

Journal of Rural Health impact grows

More authors are citing the National Rural Health Association's *Journal of Rural Health*.

The peer-reviewed journal's citation impact factor increased 28 percent from 2009 to 2010. The impact factor rose from 1.105 to 1.410, which means a larger number of authors are citing original articles published in NRHA's academic publication, explains Ty Borders, PhD, *Journal of Rural Health* editor and University of Arkansas health policy and management professor.

"Boosting the impact factor has been one of my key goals as editor," he says. "The impact factor not only reflects the journal's reputation among professors but also elevates its credibility and value among health policy leaders, health care managers, clinicians and other rural health decision makers."

The international journal is devoted to advancing professional practice, research, theory development and public policy related to rural health.

NRHA members have free access to *Journal of Rural Health* articles by logging in to NRHA Connect at connect.NRHArural.org.

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Are you an NRHA fan on Facebook? Check it out for the latest health reform news, special discount offers and the chance to expand your rural health network.

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5 reasons to attend the Rural Multiracial and Multicultural Health Conference Dec. 7 and 8 in Daytona Beach:

RuralHealthWeb.org/mm

- 1 Why not spend some of your snowy December in the Sunshine State?
- 2 The Plaza Resort and Spa is beach-front and ocean-side. Think toes in sand, cocktail in hand.
- 3 You'll hobnob with and learn from national experts and fellow rural health pros.
- 4 It's an excuse to dust off your golf clubs, driving gloves and dancing shoes.
- 5 You'll be faced with difficult decisions, such as which fresh seafood to order, whether you'd prefer to swim with dolphins or manatees, and if you take your fresh orange juice with or without pulp. Don't say we didn't warn you.

shifting gears

From décor to the dinner table

While your Halloween pumpkin won't turn into a horse-drawn carriage, its multiple uses may surprise you. Here are some fun, delicious ways to celebrate and go green this Thanksgiving.

- If pumpkins aren't part of your own garden, try supporting area farmers by purchasing locally. In addition to being a healthier, often-organic alternative, it will cut down on packaging waste and transportation.
- Pumpkins and squash can be used as fall decorations and table centerpieces. Write on tiny pumpkins for eco-friendly place settings instead of paper name cards.
- When making pumpkin pie, always save the seeds. Plant them in the spring, or bake them. Roasted pumpkin seeds are packed with minerals and antioxidants.

Off the beaten path



Col. Jonathn Buck's tomb

Bewitched Buck: Cursed for the Centuries

Just **40 miles** from the popular tourist destination of Bar Harbor, Bucksport, Maine — population **4,908** — proudly displays the tomb of its founder, Col. Jonathan Buck.

Though celebrated as a “Revolutionary War hero,” most of Buck's modern-day notoriety stems from the legend of a witch and the curse she placed on his monument. Part of her leg is said to have rolled out of the flames the day Buck burned her at the stake for alleged sorcery.

This tombstone has been scrubbed, cleaned and even replaced twice throughout its witch history. But locals and passersby alike still see the eerie and unmistakable outline of a foot, some **200 years** later.

To learn more, visit bucksportchamber.org.



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- creative approaches and lessons learned in delivered health services in rural and frontier communities
- how to develop policy and implement programs to improve health access and outcomes
- how to adapt health care initiatives to changes demographics
- how to improve health care equity and foster wellness