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Fall 2013 National Rural Health Association



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When a hospital dies, where do you send the sympathy card?

On Oct. 1, Lee Regional Medical Center in Pennington Gap, Va., closed. It is dead. The jobs that were associated with that facility are dead. The money it pumped into the local economy is dead.

The cause of death listed by the Wellmont Health System is the lack of Medicaid expansion intended to offset cuts in Medicare payments from the Affordable Care Act (ACA).

ACA is a compromise. Some people wanted the U.S. government to create a universal health care system, such as those found in other First World nations. Other people thought a single-payer system would go too far; it would overreach the responsibility of the government. So a deal was struck: Hospitals would agree to lower Medicare payments, and in return more of their patients would have insurance.

In small rural hospitals the percentage of people without insurance is much higher than in urban areas. For Lee Regional Medical Center that number was 12 percent. Uninsured rates at other rural facilities range from 10 to 20 percent. Do you know of a business that could stay open if 20 percent of their customers did not pay the bill?

Which brings me back to the compromise: Medicaid

expansion was written into ACA to decrease the number of uninsured people hospitals have to treat. Yet Virginia hasn't kept up its end of the deal. More than half of the states are moving forward with Medicaid expansion, but Virginia is dragging its feet. And while our elected officials play political football with health care, a hospital has died.

In its grave lie jobs. Lee Regional Medical Center supported 190 full-time equivalent employees. These were not low-paying, entry-level jobs. These were doctors, nurses, anesthesiologists, therapists.

In its grave lies the local economy. The hospital, which was the fourth largest employer in the county, pumped \$11.5 million in labor costs into the local economy every year. At almost 24 percent, Lee County had the highest poverty rate of any county in the state before the closure.

"These political decisions clearly can have dire ramifications for small communities and the hospitals that serve them," said Denny DeNarvaez, Wellmont's president and CEO.

Patients in Lee County now have to travel to Lonesome Pine Hospital in Big Stone Gap, more than 20 miles away, and Holston Valley Medical Center in Kingsport, Tenn., some 40 miles away. Double the mileage for those living in western Lee County. People who have to travel out of their community for service will undoubtedly take their money with them. Dollars spent on gas, food and lodging will be stripped out of Pennington Gap, crippling its already fragile tax base.

If it can happen to one small community, it can happen to others. Once the dominos start to tumble, it will hurt everyone.

Last month, Virginia had 24 rural hospitals. Now it has 23. How many more will die before Virginia holds up its end of the Medicaid bargain? And where should I send that sympathy card?

Beth O'Connor

Virginia Rural Health Association executive director

See page 44 for more on threats to rural hospitals across the country.

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.



Mike and Sandra Durick and Colleen and Wayne Winter fished for Walleye in Lake Sharpe near Pierre, S.D.

Stop and take time to make your voice heard

I took time this summer to go Walleye fishing. It's a rural pastime of mine here in South Dakota. Time I spent with my husband and friends. Time I spent simply appreciating what a rural lifestyle means to me and why it's important for us to fight to preserve this wonderful rural way of life.

During my year as National Rural Health Association president, I have seen people across America fight for rural health access. Simple acts sometimes, but always with passion.

I think that passion comes from quiet summer days and from cool fall evenings. I think it comes from days when we stop our daily rush and enjoy what it truly means to be rural.


So as my term as NRHA president ends, I hope you will take the time to make a difference for rural. In big ways and in little gestures of kindness too, please take time to stop and enjoy rural America, and take time to make your voice heard.

Sandra Durick
2013 NRHA president

pit stop

5 things I picked up in this issue:

1. One social media post netted 4,000 pieces of art and inspiration for a dying father. *page 9*
2. A greater percentage of Native Americans join the Armed Forces than any other ethnic group. And native service members go into the military with the highest rate of tendency toward PTSD than any other group. *page 15*
3. A rural Tennessee hospital was so excited to have a new general surgeon that they put up signs welcoming him at every entrance to town. *page 18*
4. Non-elderly rural residents are 18 percent less likely to have insurance coverage than their urban counterparts. *page 24*
5. Incoming NRHA president Raymond Christensen gets up at 4 a.m. every day to walk for an hour or so along the north shore of Lake Superior. *page 34*



Justin Bennett, FNP
Riverside Family Medicine
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Richard S. Cooper
Chair, National Healthcare Practice
Co-Chair, National Healthcare
Restructuring Practice
216.348.5438
rcooper@mcdonaldhopkins.com

Shawn M. Riley
Co-Chair, National Healthcare
Restructuring Practice
216.348.5773
sriley@mcdonaldhopkins.com

Paul W. Linehan
Member, National Healthcare
Restructuring Practice
216.348.5413
plinehan@mcdonaldhopkins.com

Jane Pine Wood
Member, National
Healthcare Practice
508.385.5227
jwood@mcdonaldhopkins.com

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Brian Curtis is surrounded by hundreds of sunrise and sunset photos and artwork in his hospice room. Nearly 4,000 have been submitted.

A picture is worth a thousand pills

How a social media post brightened a nursing home

By Lindsey Corey



There's no such thing as "small town" on the World Wide Web.

There, acts of kindness spread faster than cancer cells.

The cancer was terminal. But legacies, those are forever.

And Brian Curtis' legacy is somehow fleeting and reoccurring, predictable yet unique, universal made personal.

Maybe that's why it caught on.

continues on page 11

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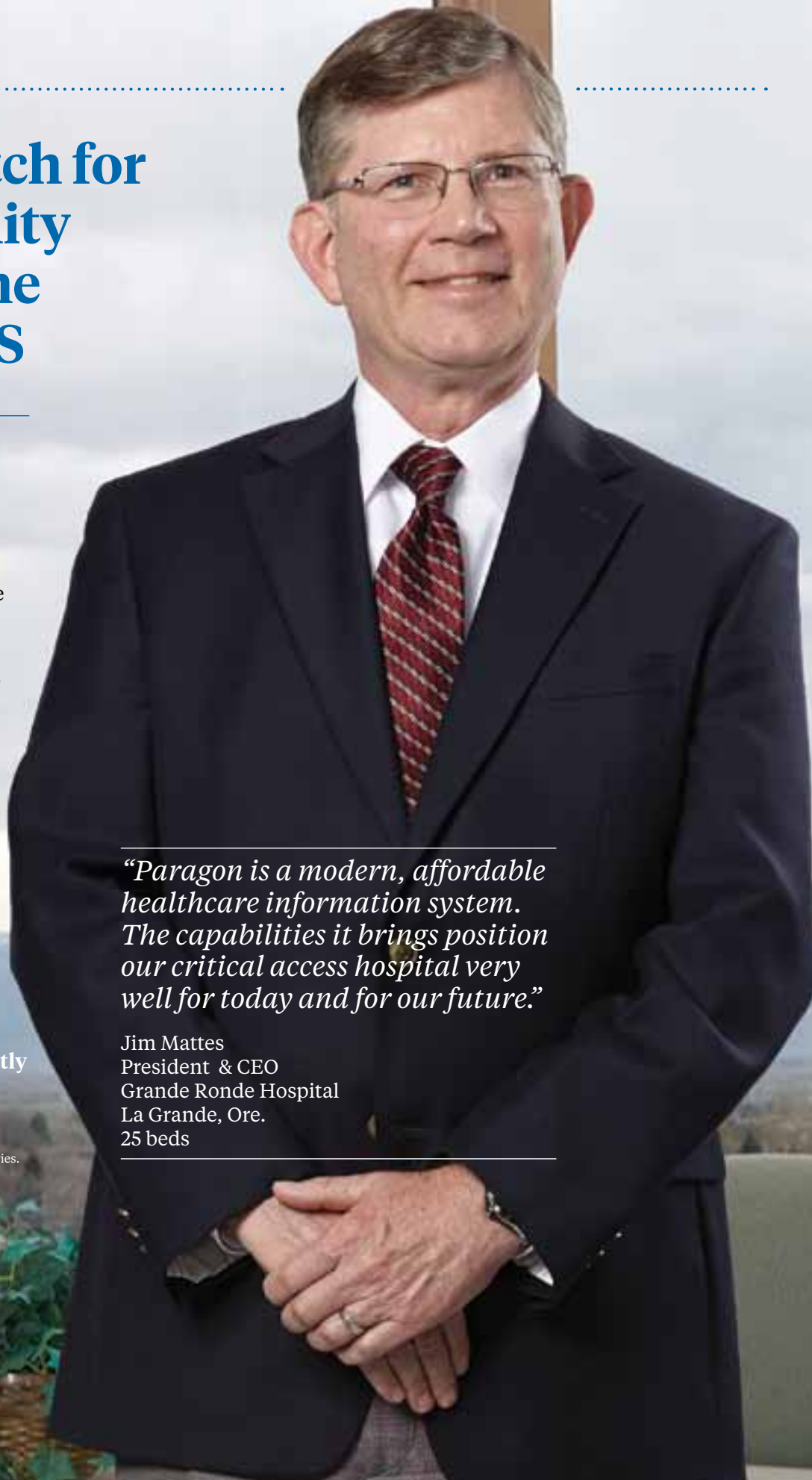
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Brian Curtis' favorite color has been sky blue pink since he was 5 years old and his mother explained it in the garden.

"She told me it was when the sunrise or sunset made blue and pink in the sky, and that they just forgot to label it," he said in a whisper because that's all the lung cancer would allow.

Like father, like son.

"Wanting to be like my dad in every way, when teachers would ask, 'what's your favorite color?' I always told them 'sky blue pink.' But it wasn't always accepted," Brandon Curtis remembers. "I told my dad, 'people say it's not a color.' And his response was always 'with that attitude, it's not.'"

Bright lights, bad news

The scan of Brian's chest was covered in bright white dots; Brandon and his sister Cindy Dempsey dropped their heads and watched their tears hit the floor.

"He just held our hands, looked us in the eyes, told us he loved us, and said, 'kids, it could always be worse,'" Brandon remembers from last April. "His strength and ability to find perspective at that very moment and to console us when he was the one with cancer... well, it will stick with me for the rest of my life."

The doctor gave Brian six months, plus or minus three.

"We were not going to miss the opportunity we had through forewarning of his last season of life," Brandon says. "We were going to ensure that from that moment, and through every second of every day and night, that our dad was reminded, 'we love you.'"

Sunshine and social media

So Brandon created a poster and shared it on Facebook and Twitter letting people know about the diagnosis and "inviting others to help fill Dad's life with love, support and sky blue pink."

Within seven days, the online poster had been viewed in 60 countries more than 2,000 times.

"It was an especially proud moment for my sister and me when we revealed our first set of prints to him," Brandon recalls. "He liked knowing that people heard the message of sky blue pink. As Dad's hands slid over the pink and blue pages to read the messages, he shook his head in disbelief that so many people would wish him well in such a beautiful way. And tears came from his eyes and again from ours. But this time, it was the



Brandon Curtis, Marie Curtis (Brian's mother), Cindy Dempsey and Brian Curtis gathered in Iowa shortly after Brian's cancer diagnosis and before his mother died.

good kind."

Nearly 4,000 pictures, Tweets, messages and cards have been sent Brian's way from 105 countries.

- Entire elementary schools have learned about sky blue pink, and students have thought outside of the crayon box to create cards for him and stuff envelopes headed for a town of 990 in Nebraska.
- One of Brandon's friends was taking a photo of a sunset in France, and a stranger was also capturing the colorful shot when they both realized it was for a dying man some 4,600 miles away.
- The band Good Show Great Show wrote a song about the inspiration behind the sky blue pink social media campaign.
- And Brian's favorite: a young girl, bald from chemo, standing on the beach with the sun setting behind her and a huge smile on her face. "It meant a lot to see her strength," he says.

"I wish everyone could have walls like this, walls that give love."

Brian Curtis

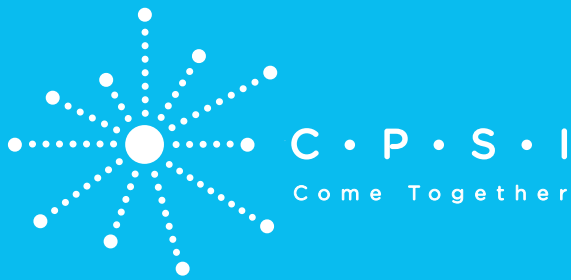
"I think it proves we want to look out for one another, even as strangers," Brandon says. "We can all relate to the message. Sure, we're all very busy, but we also want to do good. It's easy to reach into our pocket and add a hashtag, especially when you're helping to make other people's day better – or to be a part of something bigger than what we could create by ourselves."

Walls that give love

Every day, Brian gets mail at Harvard (Neb.) Rest Haven, and Brandon prints out the photos shared online. They've run out of wall space in his hospice room.

"I wake up with pride, pride in myself, pride in my family for finding a creative way to give support and bring people together, pride in all the people who have shown love to us," Brian says. "My new walls say 'I love you.' Dreary walls with nothing on them don't reinforce positive thoughts.

continues on page 13



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I wish everyone could have walls like this, walls that give love.”

His small room is now less about the end of life and more about the enrichment of it.

“I don’t think about death but about enjoying life. In so many ways, love is better than the medicine,” Brian says. “A smile or a hug is worth a thousand pills, and these photos make me smile.”

The bigger picture

They’re a comfort to others as well.

Patients and visitors stop by just to see Brian’s walls, a sort of accidental and ever-growing art project.

“We’ve never seen anything like it,” says Tina Buckhalter, director of nursing at the 37-bed facility, where the staff wore sky blue pink bandanas for awhile.

And when Cindy drives west to visit her dad after work she says she finds calm in the sunset.

“It’s definitely an emotional experience on the road, and then another in his room to think of the interconnectedness of people, all of us looking at the same sunset,” she says.

Somehow something so big can feel pretty personal too.


“My daughter is 5 so whenever she sees sky blue pink she gets so excited,” Cindy says. “She thinks it’s her sky blue pink.”

“I wake up with pride, pride in myself, pride in my family for finding a creative way to give support and bring people together, pride in all the people who have shown love to us.”

Brian Curtis

Brandon, a social media professional based in Austria, says knowing sky blue pink surrounds his dad every day and night “means everything to our family.”

And to others.

“People write to us saying ‘thank you. We now have a daily reminder to not take each other or life for granted,’” Brandon says. “It’s cool to see that it’s a wonderful gift of compassion going both ways, to see people embracing an opportunity to say ‘I love you.’” 

While Brian Curtis far exceeded his doctor’s estimates, he died – surrounded by family and sky blue pink – before this article could be published. The sky blue pink project continues.

Why I #skybluepink

By Lisa Guerra

Taking part in the sky blue pink project was not only a way to give back to the Curtis family, whom I grew up with, it was a way to encourage Brian to see how his love for his children was just a drop in the water of life, and this was a way of showing him how that one drop of love rippled into showing love and hope to a world of others, and in turn back to himself in the end. What a powerful message. What an inspiration to us all to open our eyes and our hearts to the bigger picture.

I can promise you no one who knew of this will ever look at a sky, decked out in all of its glorious colors, the same again. Instead of just seeing something “pretty,” they will see the love of a father to a son and the reflection of that love back to the father. Beyond that, if they think about the story, they will see acceptance – the lesson that there is no one right answer to everything.

Given that Brian’s initial prognosis gave him only a few months to live, there is no doubt that this outpouring of love kept him alive much longer. Physically for over a year, and spiritually for an eternity in the hearts of all who knew his story.





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Lloyd Jackson at the Flathead Reservation veterans memorial.
Photo courtesy of NBC Montana.

Tribal trust

Native American veterans help peers get benefits, health care

By Lindsey Corey

Lloyd Jackson was chief of police for Flathead Nation when soldiers were coming home from Vietnam to less-than-friendly welcomes.

“Back then, I wondered why these boys were drinking so heavy and not looking for jobs,” says the tribal elder. “Now, I realize that they needed help, but we’re talking 35 years or better down the road. They were trying to recover, but nobody understood. PTSD [post-traumatic stress disorder] wasn’t a thing then.”

Neither was the tribal veterans representative program.

A dozen years ago, Veterans Affairs (VA) reps WJ “Buck” Richardson and James Floyd called a meeting of Native American veterans in Montana after the National Guard med unit’s outreach efforts at powwows that summer netted concern that the vets didn’t know how to access their VA benefits.

“There were 150 or so veterans there, and man, they tore us up,” remembers Richardson. “When we went to chow at noon, they wouldn’t even eat with us. They actually had bets that we wouldn’t come back because it got so contentious in the morning.”

But after lunch, Richardson and Floyd moved the tables out of the way and sat in the middle of the room and listened while “they let us have it.” A couple guys stood on chairs cussing them out.

Jackson, a Korean War veteran, was at that meeting in 2001.

“Tribal members don’t quite trust non-tribal members,” he says. “Maybe it’s prejudice, but they’ve been had once and don’t want to be had again. They’ve been promised things, and those promises never came to be.”

Promises kept

Richardson and Floyd got the message loud and clear. They went to the tribal councils of seven Montana reservations and one in Wyoming and asked for their help. And in 2002, they led a training for the first nine tribal veterans representatives (TVRs), including Jackson, who had recently

continues

continued

retired and said he was “looking for a challenge – like usual.”

“I know practically everybody on the reservation, and I knew what these boys were like from my police days,” says the 78-year-old. “I figured I could help a few, which I have.”

“A few,” to Jackson is more like 600 Flathead Nation veterans “so far,” he adds.

Today, there are more than 800 TVRs across the country, most of them volunteers and vets themselves.

“It’s a huge network that will reach out to help a veteran and their family,” Richardson says.

Last month, representatives from 31 southeastern tribes gathered in North Carolina for their first training.

“If I expect American Indian veterans from a reservation to come to my four walls of brick and mortar, I’m going to be sitting by myself.”

Buck Richardson, Veterans Affairs minority veterans coordinator for Veterans Integrated Service Network 19

VA, IHS partner for Native American veterans

To improve the health status of American Indian and Alaska Native veterans, the Department of Veterans Affairs (VA) and Indian Health Service (IHS) signed a memorandum of understanding in 2010 that establishes coordination, collaboration and resource sharing between the two federal entities and leverages the strengths and expertise of each to improve care and services.

Their mutual goals are to improve access and quality of care, promote patient-centered care, establish effective partnerships between VA, IHS and federal tribes and improve health promotion and disease prevention to these veterans.

The new TVRs learned the ins and outs of VA forms; what to do when benefits are denied; how to coordinate with Indian Health Services; and where to find veterans and their families, who often live in rural areas, transportation to VA med centers, telehealth options and other benefits.

“Some of our veterans can’t read. Some can’t write, and all that paperwork is intimidating even for those who can,” Jackson says. “But they’re comfortable coming to me because I know them. And it helps 100

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percent that I was a member of the military. A lot of them don't like to talk about the war, but I can talk to them about my experience, and then they'll open up because they can relate, and I can get the information I need to pass on their benefits."

He keeps office hours one day a week on the reservation, but Flathead Nation members and hundreds more non-tribal veterans in nearby rural communities often call him at home for help. Jackson also sets up shop in one neighboring town's Veterans of Foreign Wars trailer twice a month.

"It's unbelievable the hours our TVRs put in," Richardson says. "They do more than you can even begin to imagine, and we provide as much support and training as we possibly can."

Taking care of each other

A greater percentage of American Indians join the Armed Forces than any other ethnic group. And native service members go into the military with the highest rate of tendency toward PTSD than any other group, Richardson explains.

"I knew vets that nobody took care of," Jackson says. "When I make a benefit come through for a person, and they can start getting paid and start eating again and living with their head up, that's all the thanks I need. Quite a few of them have cried when they get the news."

Outreach, which had proven difficult for VA staff, is the easiest part for TVRs who grew up alongside the men and women they're trying to help.

"If I expect American Indian veterans from a reservation to come to my four walls of brick and mortar, I'm going to be sitting by myself," Richardson says. "Trust is a huge, huge issue. You've got to have somebody from the community that the veterans already know and already trust. I have to go where the veterans are, and in order to do that, I have to ask someone from that community to take me to where they are to be able to work with them."

"As long as you're willing to learn, they'll tell you if you show respect and ask questions," he adds. "If you don't ask, that's when you close the door in your own face."

Jackson has been impressed with how Richardson has made connections and delivered on promises.

"Buck is a person that works with anybody and


everybody," Jackson says. "He's the best person for that job because he draws no lines on nationality or nothing. He's there to help the people, all the people. He's been around long enough that he understands the culture, and every reservation has different ceremonies and stuff like that, and he's made an effort to go to every reservation and learn. He goes way above the call of duty and takes the time to explain things, which had never happened before. And when Buck says something, it usually happens. He's true to his word."

Richardson, himself a Marine Corps veteran, credits each nation's TVR for serving as a "big bridge" in establishing trust.

"A lot of the guys from that original meeting, my kids call them uncle now, and their kids call me uncle," he says. "So that's how much has changed. In fact, one of them that stood on a chair yelling at me took me as his brother. I had to bury him last October. That's how much has changed."

"I've driven from here to Texas with a bunch of those guys, flown from Montana to Maine to do honoring ceremonies with them for a plane coming back from Iraq. There are things we've done together that I can't see doing with anyone else. These traditional people have taken us in and taught us things I wouldn't trade for anything."

Richardson visits reservations in his area that extends from Canada to Arizona and Nebraska to Nevada about three times a week. He also reaches out to tribes and trains new TVRs across the country to ensure more Native American veterans and their families get the benefits they earned.

"Sometimes I sit back and ask why I'm in this role," he says. "I don't know why, but I'm having a blast and can't imagine doing anything else." 

For more information on the VA's tribal veterans representative outreach program, visit www.ruralhealth.va.gov/native/programs.asp#tvr.

Serving the underserved

The National Rural Health Association's 19th annual Rural Multiracial and Multicultural Health Conference will feature sessions on the unique needs of Native Americans and of rural veterans Dec. 4-5 in San Antonio, Texas.

Uchenna Uchendu, MD, chief officer of the newly formed Veterans Administration Office of Health Equity, will explain how the office aims to provide health care to each veteran in a way that eliminates disparate health outcomes and assures health equity.

At the nation's only conference focused on improving health for under-represented rural populations, you'll also hear from a White House official and participate in discussions on cultural attunement, health promotion and disease prevention for underserved groups.

Go to RuralHealthWeb.org/mm for event details, discounted rates, scholarship opportunities and to register today.

Matchmaker, matchmaker, make me a match

Tennessee Rural Partnership connects doctors seeking employment with communities in need

By Angela Lutz



Anjeanette Hall checks a patient in Savannah, Tenn. She found the job through the Tennessee Rural Partnership.

Anjeanette Hall, MD, provides her patients with more than just health care. She's also a support system, a family member, a friend — and a healer of broken hearts.

One of Hall's favorite patients, an Alabama transplant who struggles with obesity, hypertension, high cholesterol and diabetes, keeps monthly appointments with Hall. When the patient complained of chest pains, Hall was worried.

"I put my stethoscope on, and [my patient] said, 'Dr. Hall, I got some chest pain right here. Ever since my mama told me my baby sister died, I've had this pain right here. I know what it is — it's a broken heart. Dr. Hall, can you fix a broken heart?'"

Initially overwhelmed by her patient's request, Hall suggested medication and counseling. But a few days later, she realized her patient had come to the right place after all.

“As I was thinking about it over the next few days, it occurred to me: If she thinks I can fix her broken heart, then I can fix her broken heart,” Hall says. “So much of what we do in this community is not about sickness and health. It’s about healing members of our community, and that doesn’t always have to be with medicine.”

Hall, a graduate of East Tennessee State University Medical School, arrived in Savannah, Tenn., population 6,968, in 2009. She currently serves as medical director and practices primary care at LifeSpan Health, a federally qualified health center.

She’s been a perfect fit for the rural community. Her late grandmother’s farm is only 30 minutes away from her practice, and Hall enjoys the challenges of her job and the opportunity to make a difference in people’s lives.

“In all cases, these have been hard-to-serve places, and it’s been a lifesaver to have somebody who could help them.”

Cindy Siler, Tennessee Rural Partnership deputy director

She makes house calls to Amish communities, helps illiterate patients with insurance paperwork, and occasionally brightens regular office visits by singing Disney songs. Last year she was named primary care practitioner of the year by the Tennessee Primary Care Association.

“When you’re in a rural area, poverty has a huge impact and so does a lack of education,” Hall says. “Every day when I leave for work, my husband says, ‘Bye, have a boring day!’ And I never do. Bottom line is, I did come to the right place.”

Hall says she never would have found her calling if not for the Tennessee Rural Partnership (TRP). Since 2006, TRP has been working to match primary care providers, primarily residents in the state’s four medical schools, with open positions in underserved areas of Tennessee, where all but four counties are rural.

Cindy Siler, TRP deputy director, says the nonprofit partnership works a lot like an online dating service: Doctors, nurse practitioners and physician assistants fill out questionnaires detailing the type of employment they’re seeking and what kind of community they would like to serve.

Meanwhile, practices seeking physicians provide their vital stats. At any given time, there are hundreds of open positions, according to Siler. Then TRP staff works to match providers to communities that suit their needs, taking the time to get to know the providers and the communities. When both parties agree, TRP sets up an interview. The service is funded by state and federal dollars and is free to providers and practices, which has been a huge benefit to many communities that can’t afford recruitment firms.


Siler says that Methodist Fayette Hospital in Somerville, population 3,129, was so excited to have TRP alum Roger McGee, MD, a general surgeon, that on the day of his arrival, they put banners above every entrance to town that read, “Welcome, Dr. McGee.” Somerville hadn’t had a general surgeon in more than a year.

Since the partnership’s inception, 73 physicians have been placed, and the vast majority of them have stayed in rural areas.

“In some instances, they’re the only physician in town, so the staff has just been thrilled to death,” Siler says. “In all cases, these have been hard-to-serve places, and it’s been a lifesaver to have somebody who could help them.”

As an added incentive, TRP offers stipends to help repay student loans. In exchange for service in a rural community, physicians can receive up to \$35,000 a year for up to four years.

The stipend was a big incentive when Marc Courts, MD, joined Loudon Pediatric Clinic in Loudon, population 5,631. Overwhelmed by student debt, Courts filled out a TRP application online. He was contacted by Siler, and he received several job offers. Initially, the decision was challenging, so he and his wife prayed for a sign that would point them in the right direction. The stipend turned out to be that sign – but, he says, working in the community is the true reward. He has been in Loudon for six years and plans to stay.

“The most rewarding thing is that you really do make a difference,” he says. “The best thing about working in a rural area is these people come to rely on you and see you as part of their family. The intangibles are huge. It’s not about the money, it’s about happiness, and no matter what you do in life you’d better make sure that you wake up every day happy.” 

TRP by the numbers

Founded in 2006, the Tennessee Rural Partnership has placed more than 70 primary care providers in 50 rural and urban underserved communities in Tennessee.

Of the 95 counties in Tennessee, all but four counties are considered rural, and more than 50 have a federal health professional shortage area designation.

In exchange for service in a rural community, physicians, nurse practitioners and physician assistants may apply for funds from the TRP stipend program to repay student loans.

Visit tnrp.org to learn more.

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After the floods, rural Colorado hospital, EMS brace for winter

Small town gets 3 million tourists a year

By Eric Whitney



In September, heavy rains fell causing the Big Thompson River to overflow its banks and begin to erode and undercut the side of the highway from Estes Park to Rocky Mountain National Park.

As snow begins falling in Rocky Mountain National Park, Estes Park, the town at its doorstep, finds itself newly isolated.

The only year-round road into or out of town now is the Peak to Peak Highway. It traverses a jumble of mountains all the way – not the kind of road an ambulance can scream along at 60 miles an hour.

“Not while I’m in the back, hopefully,” jokes ambulance driver and paramedic Erle Collum.

September floods in Colorado washed out the other two roads into town for miles at a stretch.

This is bad news for the town’s hospital, Estes Park Medical Center. Big-city medical facilities that used to be an hour away are now three or four via the single remaining road connecting the town to the rest of the world.

Collum says he’s grateful the town’s ambulances have four-wheel drive.

“In the winter time we can get some pretty good snow around here, so it’s a nice thing to have, just because of the area we work in,” he says.

It’s typical that there’s snow on the ground from

October through May. Estes Park is a town of about 12,000, and it sees 3 million national park visitors a year, but the 25-bed hospital isn’t set up to take care of critical cases for very long. Collum says at least one patient a day gets sent down the mountain to an urban hospital for more advanced care. And not everyone is stable enough for the old hour-long ambulance ride will be able to withstand four hours or more on roads Collum calls “not good.”

“They’re not the best roads anyway,” he cautions, “so I suspect it’ll complicate things when winter comes around.”

The hospital already makes pretty frequent use of helicopters for the trip to larger hospitals. There’s no place for airplanes to land, and mountain weather keeps

helicopters grounded about half the time in winter, says Bill Collins, a paramedic who flies helicopter missions into Estes Park.

“You’re basically kind of like being in the center courtyard of a castle, and the castle walls are the mountains,” Collins says.

“We’re hanging in there, and we’ll get through this flood stuff. And we’re still taking care of people. That’s what we do.”

Erie Collum, Estes Park ambulance driver and paramedic

Before, the hospital could usually count on either an ambulance or a helicopter as the failsafe. But now, a blizzard that makes air travel dangerous and closes the remaining road could cut off the town.

Martin Koschnitzke, MD, an obstetrician and the hospital’s medical director, worries about possible life and death situations, like a premature birth. Many premature babies need an intensive care unit (ICU), and there isn’t one in Estes Park.

That means doctors have to hand-pump air into the baby’s lungs constantly until it can get to an ICU with a special ventilator.

“I don’t know how long our pediatricians could manage that baby here,” he said. “I’ve seen them do it for multiple hours. I’d never want to see them do that for multiple days.”



Bobbi Swenson

Koschnitzke says there's nothing worse than not being able to get a patient to needed care.

With an uncertain winter coming, Estes Park hospital interim CEO Bobbi Swenson has to figure out a budget. She expects increased costs and is unsure whether they'll all get covered. Like whether insurance will pay for a lot more helicopter and ambulance rides.

And then there's staffing. Half the hospital's workforce lives down the mountain. Swenson


offers them temporary housing during bad weather but, she says, "There are some people that are not going to be willing to come up here for three to four days and be away from their families."

It's unclear when daily commuting on the other roads will be feasible again. And the hospital may even be busier, serving townspeople who used to drive down the mountain for everything from orthopedic surgery to chemotherapy and basic primary care.

Many small, rural hospitals like Estes Park's get special critical access payments from the federal government. But President Barack Obama says he wants to trim those payments by one percent. Swenson says full funding is essential to keep facilities like hers open.

All the uncertainty at the top for now doesn't change things at the ambulance level in Estes Park. Collom closes his up and gets ready for the next call.

"We're hanging in there, and we'll get through this flood stuff. And we're still taking care of people," he says. "That's what we do. A little more challenging to get through, but we can do it."

Engineers say they may restore more access to Estes Park by December, but that may be only a one-lane gravel road in many places. 

This article is part of a reporting partnership between National Public Radio and Kaiser Health News. Kaiser Health News is an editorially independent program of the Henry J. Kaiser Family Foundation, a nonprofit, nonpartisan health policy research and communications organization.

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Understanding the Affordable Care Act: Rural networks answer questions, outline benefits

By Angela Lutz



Joyce Hospodar (far right) distributes Affordable Care Act brochures to University of Arizona faculty. The brochures were designed to inform rural residents of their rights under the new law. Photo by Jill Bullock.

Get informed. Stay informed.

The Office of Rural Health Policy leads weekly conference calls to inform rural stakeholders – from health care providers to patients – on how the Affordable Care Act can benefit rural communities.

When: 3-4 p.m. EST every Wednesday

Number: 1-800-857-3749

Code: ORHPACA

Link: hrsa.connectsolutions.com/orh1

As 2014 approaches, there's a deluge of information on the Affordable Care Act (ACA).

It can be challenging for patients and providers to determine what aspects of their health care coverage will change, as well as what services will become available for uninsured and underinsured individuals.

To help everyone from legal immigrants and rural patients to health care providers and small business owners understand their rights under the new law, the Center for Rural Health at the University of Arizona in Tucson developed a brochure, "Know Your Healthcare Rights," which explains "12 really important things you need to know about getting insured and staying healthy." In easy-to-understand terms, the brochure clearly outlines what will change or stay the same under ACA.

"The law benefits the rural community in so many ways. Rural residents can take advantage of these services and take care of their health to ... live longer, healthier and more productive lives."

Deepti Loharikar, Office of Rural Health Policy analyst

"There's a lot of confusion," says Joyce Hospodar, health systems development manager at the Center for Rural Health. "Everything is rolling out daily here. We have about 106 different insurance providers offering something. This brochure gives the rural resident or any resident an idea what should be included, and then they can navigate."

The Center for Rural Health is part of the Southwest Rural Policy Network, which is comprised of 14 organizations in Arizona, New Mexico and southern Colorado. The brochures were printed in late 2012 using funds from the Kellogg Foundation's Rural People, Rural Policy Initiative. With versions in both English and Spanish, Hospodar estimates they will have distributed about 14,000 brochures before the end of the year.

Brochures have gone to a wide variety of recipients, from churches and libraries to hospitals, doctors' offices and economic development organizations across Arizona and New Mexico. It provides answers to several frequently asked questions, including what preventive services are covered, who is eligible for Medicaid, who can receive tax credits and how to get coverage for pre-existing conditions.

Because the law is so complex and "fast moving," Hospodar says the brochures have been in demand. Many recipients request more once all have been distributed. To help spread the word, the Center for Rural

Health has also produced a series of 13 30-second public service announcements, which are being broadcast nationwide on the radio and are also available online. Hospodar would like to secure more funding to print an updated version of the brochure, as well as to follow up on their effectiveness. In the meantime, she considers the brochures' popularity a good measure of their success.

"If I can distribute all that we've printed, it's been a success," Hospodar says. "If [the recipients] distribute them and they want more, that's the testimony."

The Office of Rural Health Policy (ORHP) is also undertaking outreach efforts to educate community stakeholders and rural residents on health reform. According to Deepti Loharikar, ORHP health policy analyst, misunderstandings and misinformation surrounding ACA are common.


"There are studies showing that many do not know that it exists or they believe that it was repealed," she says. "And for those who do know about the law, many are unsure or misinformed about new opportunities for coverage to get the care they need."

To ensure rural residents are receiving benefits, ORHP has offered each of its 71 Rural Healthcare Services Outreach grantees a one-year supplement to assist with outreach, education and enrollment in the Health Insurance Marketplace. Of the 71 grantees, 52 applied for the supplement and were able to request up to \$25,000 each. In addition to online resources, ORHP has a 24-hour call center to help grantees inform the public about the benefits of the law.

Loharikar adds that targeting places where people go, such as churches, town halls and state fairs, has been an effective way to start conversations about the law and its benefits.

"Because we know that not everyone has access to the Internet, we're also taking an old-fashioned, low-tech approach, and that's using word of mouth," she says.

According to Loharikar, the benefits of ACA are especially vital in rural communities, where more residents are elderly and chronic pre-existing conditions more common than in urban areas.

"The law benefits the rural community in so many ways," Loharikar says. "For example, since chronic conditions such as diabetes and heart disease are more prevalent in rural communities, the provision that there can be no discrimination for a preexisting condition is especially important. Additionally, now that preventive care is free under the law, rural residents can take advantage of these services and take care of their health to prevent the onset of a chronic disease and live longer, healthier and more productive lives. Having affordable health care coverage not only makes individuals and families healthier, but strengthens our health care system as a whole." 

Rural resources

These Affordable Care Act resources can help answer questions about the new law:

- To view the Center for Rural Health's ACA brochures, visit southwestruralpolicynetwork.com.
- To listen to the Center for Rural Health's public service announcements (in English or Spanish), visit acaexplained.org.
- Call 1-800-318-2596 for the government's 24-hour ACA information line.
- To get your ACA questions answered via live webchat, visit healthcare.gov. For assistance in Spanish, visit cuidadodesalud.gov.
- For a list of ACA navigators, which are hospitals, local business leaders, faith leaders, universities and community groups (among others) that are helping enroll people, visit cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/downloads/navigator-list-8-15-2013.pdf.
- Email questions to the Office of Rural Health Policy at orhp-acaquestions@hrsa.gov.

Rural relevance

A greater proportion of rural residents stand to benefit from the Affordable Care Act than their urban counterparts.

Demographic characteristics:

- The eligible uninsured in rural areas are older than their metro counterparts. The non-metro eligible are more likely to be between 35 and 64 and less likely to be younger than 35.
- The eligible uninsured in rural America are more likely to receive food stamps than their urban counterparts.

Distribution:

- Non-elderly U.S. citizens and legal residents in rural areas are 18 percent less likely to have insurance coverage than their urban counterparts. In all, more than 7.8 million non-elderly U.S. citizens and legal residents that live in rural areas are uninsured.
- More rural residents than urban dwellers (10.7 percent versus 9.6 percent) can receive tax subsidies under ACA to purchase private insurance, and more uninsured are eligible for an expanded Medicaid program (9.9 percent versus 8.5 percent).
- In rural parts of the southern census region, 21.5 percent of U.S. citizens and legal residents are uninsured, the highest rate in the country.

NRHA's foundation fosters connections



Give back, move forward

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

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

Or send your tax-deductible donations to NRHA Rural Health Foundation, 4501 College Blvd. #225, Leawood, KS 66211.

To explore giving opportunities and for more information, contact Alan Morgan at morgan@NRHArural.org or 202-639-0550.

All 2013 contributors will be recognized in the next issue of *Rural Roads* magazine.

October marked the one-year anniversary of the Rural Health Foundation.

With more than \$110,000 pledged in the first year, plans are well underway to begin supporting future rural leaders in 2014.

The National Rural Health Association's foundation was created to establish a permanent endowment for rural leadership. The foundation board is discussing providing educational conference scholarships next year and is considering creating a yearlong leadership program.

"I have no doubt that we have a hometown advantage in that rural communities want rural providers to succeed and to keep local care local."

Tim Size, Rural Health Foundation co-chair

The White House Rural Council and the Office of Rural Health Policy, in partnership with Grantmakers in Health and NRHA, hosted a White House meeting of rural philanthropy stakeholders in July.

"The meeting was useful with a focus on potential opportunities to advance rural health through new partnerships between the private and public sectors, in particular the role of private foundations," says Tim Size, Rural Health Foundation co-chair. "I have no doubt that we have a hometown advantage in that rural communities want rural providers to succeed and to keep local care local."

The meeting provided an opportunity for the participants to learn about each organization and to discuss some of the key issues facing rural health and research findings on those topics and to identify areas of potential collaboration.

"Throughout the meeting, many foundations emphasized the need for an overarching vision for rural health care in the future and the importance of thinking proactively about rural health care systems rather than reacting to changes in the landscape," says Amy Elizondo, NRHA program services vice president.




Doug McKalip, White House Domestic Policy Council rural affairs senior policy advisor; Bill Corr, Health and Human Services deputy secretary; Faith Mitchell, Grantmakers in Health CEO; and Alan Morgan, NRHA CEO, participate in a meeting of rural philanthropy stakeholders at the White House.

Participants wanted to build upon the meeting's momentum, and NRHA offered to host a second meeting in 2014.

The White House Rural Council also expressed interest in hearing about joint activities and common areas of investment between the public and private sector participants. As a result of the meeting, multiple federal agencies have offered to conduct webinars to provide additional information about key rural-focused programs and resources for the philanthropic participants.

"The goal of the enhanced collaboration is to highlight resources, programs and tools that focus on rural health. Those programs and resources may also align well with new and ongoing philanthropic initiatives to better serve rural communities," Elizondo says.

As rural health care continues to change, the Rural Health Foundation will provide a stable base for future rural leadership and a resource for ongoing education in the coming years.

With your help, NRHA can identify current and emerging leaders and provide them with training and resources to help ensure access to quality health care in their rural communities. 

Supporter spotlight



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

George N. Miller Jr., CommUnity Care Health Center CEO



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

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


Jodi Schmidt, Labette Health president and CEO



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

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

Dennis Berens, Nebraska Times president



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Use the internet on a cell phone, tablet or other mobile handheld device



Have a cell phone



Have a smartphone



Say yes, they look for health or medical information online



Receive text updates or alerts about health or medical issues



Have apps that help track or manage their health

Source: Pew Internet/California HealthCare Foundation's Mobile Health 2012 report

MARYANNE, 62

Feels lightheaded and isn't sure if it's related to her new blood pressure medication. She also has diabetes. What could be the cause of her symptoms? After reading about her medication on iTriage, she calls her doctor. Maryanne uses iTriage to make an appointment with her doctor for the next day.



HENRY, 35

Fell from his tractor and has a swollen and sore arm. Does he have to drive 45 minutes to the closest urban ER? No. Using the iTriage app from his smartphone, he sees that his local community hospital has the ability to do xrays on his arm. He can even alert the ER that he is on the way with ER Check-In.



ALICE, 30

A stay-at-home mom of 3 young children. How can she keep up with all of their pediatricians and medications? From her iPad, she can quickly add their information to MyiTriage, a secure place to store personal health information and retrieve it on the go.



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NRHA interns put classroom theory to practice



NRHA interns Swaha Pattanaik, Bryant Conkling and Jeslin Jose with NRHA CEO Alan Morgan in front of the White House.

“These four exceptional students represented their universities and NRHA well,” says Amy Elizondo, NRHA program services vice president. “From the day-to-day activities, to policy paper updates, to helping coordinate national meetings and trainings, they were a part of it all.”

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.

“I would recommend interning with NRHA to anyone interested in the field of public health. NRHA provides great opportunities for its interns to truly learn the ropes of how a nonprofit organization functions, encourages us to get involved with the ongoing projects and conferences affiliated with the organization and also provides a great medium to network with officials from various health organizations,” Jose says.


Jeslin Jose says her National Rural Health Association 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.”

NRHA hosted three other summer interns in its D.C. office:

- Alexis Brana, University of Virginia undergraduate student in foreign affairs
- Bryant Conkling, University of Iowa master of public health in policy and administration student
- Swaha Pattanaik, North Dakota State University master of public health student

She and the other public health student assisted in planning community health worker trainings and identifying curriculum and updating the HIV-Aids policy paper to be submitted to NRHA’s Rural Health Congress. The foreign affairs student worked directly with NRHA’s new International Rural Health Task Force, and the health policy student worked with the association’s government affairs staff on emerging issues and served as the recorder for a rural philanthropy meeting at the White House. The interns also attended numerous briefings on Capitol Hill and around D.C.

NRHA offers internships every semester in D.C. and works with students to meet their internship requirements. To apply for an internship or for more information, contact Laura Hudson at hudson@NRHArural.org. 

Connecting with constituency groups



Gail Nickerson

National Rural Health Association members represent a variety of professions, and this diverse group of individuals and organizations brings their own interests and agendas to the organization's common goal of ensuring access to quality health care for rural Americans.

Through its constituency groups (CGs), NRHA is structured to represent individual concerns as well as the more encompassing interests of thousands of members.

Each CG elects a chair to serve on NRHA's Board of Trustees and Rural Health Policy Board to guarantee individual interests and agendas are given a voice in the leadership of NRHA, helping to determine the association's policies and direction.

Rural Roads recently asked Gail Nickerson, Rural Health Clinic CG chair and longtime NRHA member, about CGs.

What is a CG?

CGs are constituency groups, providing networking opportunities for NRHA's members with folks from all over the country who do similar work.

Getting together, we can learn from each other, share best practices, and help NRHA see rural health from our perspective.

Tell us a little about your CG.

We work with NRHA to ensure our needs are included in rural health advocacy efforts and planning educational content for conferences and webinars.

We have a volunteer leadership group for our CG that meets by phone as well as in person with other CG members at NRHA events. We also interface with the national association for our type of clinics and the federal Office of Rural Health Policy.

NRHA's 10 constituency groups

Clinical Services
Diverse Underserved Populations
Federally Qualified Health Centers
Frontier
Hospitals and Community Health Systems
Public Health
Research and Education
Rural Health Clinics
Statewide Health Resources
Students
Learn more at RuralHealthWeb.org/go/cg.

Connect to the connected.

**Join NRHA Connect,
a free, online networking
community for members.**

Visit connect.NRHArural.org.

Click on the directory tab.

Enter your email address as the username.

**And begin accessing key legislation, rural-
relevant research and member-driven
information exchanges.**



You'll find colleagues close to
home and across the country
who share your interests.

Call 816-756-3140 or email
membership@NRHArural.org
for more information.

Why does NRHA have CGs?

NRHA is a broad umbrella that covers all aspects of rural health.

Having CGs means that our national organization can focus on each specific group's needs as well as the big picture, which provides great value to members.

We are all part of the unified group and also get to deal with the specifics of our constituency group.

How do I become a CG member?

When you sign up for membership, you can – and should – enroll in a CG. NRHA staff is happy to help new members in finding the best fit for their needs and interests. Email them at membership@NRHArural.org.

May I choose more than one CG affiliation?

You can enroll in more than one CG, depending upon your membership type. This allows you to get specific information from each CG you're enrolled in and make connections with your multiple areas of interest.


What are the benefits of being active in a CG?

Being active in your CG means that you will make good contacts, learn new things and be able to get support from the CG to advocate for what matters most to you.

I feel very lucky to be involved with my CG. It has expanded the value of membership in NRHA for me.

How can I connect with colleagues between conferences and CG meetings?

We use NRHA Connect to update our CG members on issues specific to our interests. Anyone can post a question that goes out to their entire CG. This members-only networking resource allows for problem-solving and sharing best practices without our questions and comments being available to the general public.

To find members in your region or with similar interests and to join the conversation, visit connect.NRHArural.org. 

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Here's how it works:

1. Submit your anonymous question to consult@NRHASC.com.
2. NRHA Services Corporation will distribute your question – with the utmost discretion – to corporate partners and will send you their responses.

Partners will not know who submitted the question and will not contact you directly.

The Ask our Partners program is designed to provide current information for National Rural Health Association members. Partner responses will provide general information rather than specific legal or financial advice. Answers will not be intended to create, and receipt of them does not constitute, an attorney-client relationship. Because it is necessary to apply legal and financial principles to specific facts, always consult an adviser before using the information as a basis for a specific action.

Get to know NRHA's incoming president



Raymond Christensen at Lake Superior

Raymond Christensen, MD, will lead the National Rural Health Association in 2014. He's been a family physician in Moose Lake, Minn., population 2,753, since 1972 and also serves as the University of Minnesota Medical School associate dean for rural health.

Christensen joined NRHA in 1987 and received the association's Louis Gorin Award for Outstanding Achievement in Rural Health Care in 1989.

Tell us about your most memorable day as a doctor.

While on call at the hospital, I learned that the ambulance was at a trench collapse where a worker was trapped six to eight feet down. After waiting for some time, I took my radio and drove to the site.

A backhoe was used to remove some of the sides, but the concern was possible further collapse. When I arrived, he was still buried to his waist and did not have feeling in his lower extremities. They continued to dig getting down to his knees with the continued worry of the sides caving more.

Finally, he and I discussed the situation and decided to lift him out taking the risk that he may have more severe injuries to his legs. We also knew that further collapse would leave him trapped and at serious risk of injury or death. Fortunately, he got out without any injuries to the lower extremities and was able to go home the next day.

What don't most NRHA members know about you?

I believe strongly in the balance of body, mind and spirit. I have run many marathons and lesser distances as well as completed a few bike races. I no longer run but do get up at about 4 a.m. daily and walk for over an hour.

It's a very spiritual and natural outdoor time as I walk on the north shore of Lake Superior. The night sky, comets, occasional Northern Lights, wind and waves and Lake Superior ore boats and others makes this ritual a time of nature and reflection.

How does an ag major wind up in med school?

I am the oldest of six children from a small dairy in northwest Wisconsin. At 16, I left home to work on another farm. As you can imagine, study time on the farm did not exist, only chores. I learned to work long hours and also that the value of the farm dollar was significantly different than working for construction and town jobs.

I was very aware of the medical needs of our neighbors and communities and the stories of poor health care. Medicine had crossed my mind in high school, but it was obviously out of reach financially. I knew I wanted to attend college and with a loan was able to start.

Not knowing how to study caused me to look carefully at my major. I needed to draw on my experience so I chose agricultural chemicals. As I overcame my "rural retardation," I realized that I was interested in doctoral work or veterinary medicine. My ag school dean was instrumental in guiding me back to that unreachable goal of medicine. I was accepted at the University of Wisconsin Medical School before the vet schools accepted me, and the goal was mine to achieve. Farming and agriculture provided a great community foundation for medicine.

Why did you go into teaching?

It was not something that I ever planned and frankly felt that I was good at, yet we teach patients all day long.

A new medical school in Duluth with a rural focus and rural required experiences involved me the first year of practice. A few short years later we were asked to become a Rural Physician Associate Program site for the University of Minnesota-Twin Cities. Over the years, we have had students from many different health care professions in our practice and hospital. My decision to accept a position at the university in Duluth was largely based on my hopes that my rural background and personal mission would be helpful in the continued success of the program in training rural physicians.

You're a busy guy. Why do you continue to see patients?

Clinical medicine is part of me.

I have been so fortunate and blessed with a wonderful practice and supportive community. And seeing patients is a prerequisite for speaking for and representing the profession.


What's the biggest challenge facing rural health? And what can we do about it?

Rural practice and advocacy always focus me back to demographics and geography and the necessity of providing access to high quality health care. Local community health care must assure appropriate and timely access allowing maximization of the golden hour for all rural citizens and visitors.

As a family physician, I am held to the same standard wherever I practice. As a rural physician, our rural health systems have the same obligation.

Unfortunately the standards set by regulations, mandates and community priorities generally cannot be financed locally by small communities and require greater societal support.

NRHA has a complex but wonderful rural reflecting construct. We are dedicated to rural health care for America's rural citizens and visitors.

With our diverse membership and leadership base wedded to excellent NRHA staff, we are prepared to continue our efforts to maintain access, evaluate and improve rural health, interpret new laws and mandates, and advocate for appropriate governmental and health plan recognition and support of rural health care. We will continue to be a formative force in the health care debate. 

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Annual Rural Health Conference

April 22-25
Las Vegas, Nev.

Rural Quality and Clinical Conference

July 16-18
Atlanta, Ga.

Rural Health Clinic Conference

Sept. 30-Oct. 1
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Critical Access Hospital Conference

Oct. 1-3
Kansas City, Mo.

Register early to save big.



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Beginnings & Passages



Nick Box on the Main Salmon River in Idaho.

“The exposure and experience from working in such a challenging setting is second to none.”

From an island to Idaho, PA enjoys rural work

By Nick Box

When I graduated Idaho State University's physician assistant program in August 2010, I was frequently asked what my plans were for a job. Despite being in consideration for a couple of positions in more specialized fields close to home, the fact of the matter was I didn't know.

As chance might have had it, those positions fell through, and I was faced with the task of starting my search all over again. This time I decided to think out of the box and begin applying for positions that qualified for loan repayment through the National Health Service Corps. That decision completely changed the course of my career.

In a span of six months, I sold a house, two cars and consolidated everything I own into a 10-by-24 foot storage unit. I packed two suitcases and moved halfway across the world to the tiny tropical island of Saipan. Most people haven't heard of the island, but it's a protectorate of the United States.

“Where are you moving,” people would ask, “Taipei?”

“Close,” I would answer, which was technically incorrect but saved a great deal of time.

There I worked in a hospital, the *only* hospital on an island with about 50,000 inhabitants. It has one of the highest percentages of non-communicable diseases, like diabetes, obesity and hypertension, in the world. I saw everything from sea urchin and jellyfish stings to strokes and heart attacks.

I now find myself working at a critical access hospital in the northern Idaho panhandle. Closer to home I suppose, however some residents in this region view southern Idaho as a completely different state. I spend half of my time at the hospital and half of my time 45 minutes up the Clearwater River in a satellite clinic. Interestingly enough, I can't say that practicing medicine here is any less exciting than in Saipan.

If I could offer advice to those gearing up for graduation it would be this: Don't assume that you would be selling yourself short when considering a position in a rural or medically underserved area. My experience has been quite different from this. The exposure and experience from working in such a challenging setting is second to none.

Nick Box serves as a physician assistant for Clearwater Valley Hospital and Clinics in rural Idaho. He found the position through the National Health Service Corps.



A closer look

See Nick Box at work in rural Idaho and why he says he's got the best commute in the world via a short National Health Service Corps video at <http://bit.ly/NickNHSC>.

Innovative rookies and seasoned professionals share their experiences.

“I am able to draw from the skills I have developed over the years and put them to use for such a great cause.”



Margaret Vaughn with sons Frank and Robert at Chicago's Navy Pier.

Love of politics catapults suburban girl into rural advocate

By Margaret Vaughn

Growing up in the tiny suburb of Summit which bordered Chicago, I was not familiar with the challenges rural communities face, although we did have a volunteer fire department.

My father cultivated my love of politics, and I have childhood memories of us eating leftover Halloween candy together as we anxiously watched the November election results.

It was during a college internship with a local state representative, whose district covered a large rural area, that I was able to gain a better understanding of rural life.

After college, I served on the House and Senate staff and then started my own lobbying firm at the age of 25. The Illinois Rural Health Association (IRHA) was one of my first clients back in 1995, and I worked to garner \$5 million from the state to fully fund the Illinois Rural Downstate Health Initiative, which provided scholarships and funding to medical schools providing residency programs in rural areas, as well as scholarships for nurses who would agree to practice in rural areas. Shortly after that time, I went on to adopt two babies from Eastern Europe and referred IRHA to another colleague.

Since then my lobbying business has grown to include a variety of clients (firefighters, county fairs, roofing contractors), and I have worked for the successful passage of more than 90 laws. Some of my highlights related to public health include the passage of legislation to license surgical first assistants, surgical

technologists, genetic counselors, body art establishments and pyrotechnic operators. I also founded the Illinois Coalition of Community Blood Centers and passed legislation so that both private and public sector workers in Illinois would not be docked pay for donating blood.

In 2012, I was once again hired by IRHA to not only lobby on their behalf but to serve as executive director. In addition to our Annual Educational Conference, my focus has been holding ongoing legislative forums and educational workshops throughout the state to make it more convenient for more members to participate, while at the same time gaining a better understanding of local needs.

I love my role at IRHA because I am able to draw from the skills I have developed over the years in advocacy, association management, fundraising, meeting planning, marketing, membership development and public relations and put them to use for such a great cause.

Margaret Vaughn is the executive director of the Illinois Rural Health Association and president of Margaret Vaughn Consulting Inc., a lobbying, public relations and association management firm. She was recently named the Chicago Tribune's Remarkable Woman, and her career was highlighted on the front page.

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.

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Members who gathered in Chicago left inspired, informed

The National Rural Health Association's 9th annual Rural Quality and Clinical Conference brought more than 100 members together in Chicago.

Attendees from 30 states heard from national experts on telehealth research and practice, coding implementation, quality measurement and more. Tom Morris, Office of Rural Health Policy (ORHP) administrator, and Paul Moore, DPh, ORHP senior health policy advisor, discussed why quality is a critical rural health policy issue, how the rural health landscape is changing and how rural health professionals can successfully prepare for changes ahead.

"All the NRHA staff and conference speakers are very knowledgeable and approachable," one attendee wrote. "I always leave NRHA events more inspired and excited about rural America."

Another noted in their evaluation that they'd never been to NRHA's annual clinical event but would "absolutely be back" for the 2014 Rural Quality and Clinical Conference July 16-18 in Atlanta.

State rural health association (SRHA) leaders gathered prior to the clinical conference to hear from ORHP, share best practices and network.

With a focus on building and sustaining SRHAs, 47 participants received tools to immediately impact their nonprofit associations. Presentations ranged from board and membership development to improving communications and starting student chapters.

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

SRHA representatives' next leadership conference will be July 15-16 in Atlanta.



Clockwise: State rural health association leaders from across the country gathered in Chicago in July. Tom Morris, Office of Rural Health Policy administrator, presented at both NRHA's Rural Quality and Clinical Conference and State Rural Health Association Skill Building Workshop. NRHA CEO Alan Morgan, David K. Mineta, Office of National Drug Control Policy deputy director, and Dave Schmitz, NRHA Clinical Constituency Group chair, talked after Mineta's presentation at NRHA's Rural Quality and Clinical Conference.

Explore San Antonio sites with NRHA member Denise Adame

Side trip



Denise Adame and the Tower of the Americas, where visitors can get a revolving view of San Antonio.



San Antonio's River Walk will be draped with lights during NRHA's Rural Multiracial and Multicultural Health Conference.

My beautiful hometown is nestled in south-central Texas. Though it's been several years since I've lived in San Antonio, it is where my family, my home and my heart remain so I visit as often as I can.

Here are some of my favorite places in the city:

1. The **River Walk** lines the San Antonio River with about five miles of shops, restaurants and bars and connects to several other downtown attractions, including the Alamo, Rivercenter Mall and La Villita.

You can also catch a boat ride via Rio San Antonio Cruises, and learn about city landmarks as you cruise down the river.

Enjoy delicious Texas barbecue at The County Line.
2. **Hemisfair Park** is one of my all-time favorite places downtown. Here you can enjoy a nice quiet walk through the park, relax by the waterfalls and fountains, and visit historic places and museums.

The park is also home to the **Tower of the Americas**, the tallest building in the city. Take an elevator ride up to the observation deck or dine at the Eyes Over Texas revolving restaurant.
3. One of my favorite things about San Antonio is that it is rich in culture. At the **Market Square** you can experience the beauty of the Mexican culture through its authentic restaurants, shops and live entertainment.

Connect and collaborate

Join rural health colleagues and national experts for the National Rural Health Association's 19th annual Rural Multiracial and Multicultural Health Conference Dec. 4-5 in San Antonio, Texas.


Hear from a White House official and participate in discussions on cultural attunement, health promotion, disease prevention and more at the nation's only conference focused on improving health for under-represented rural populations.

Visit RuralHealthWeb.org/mm for event details and discounts.

If you're still in San Antonio on Dec. 7 and 8, make sure to catch Primer Sabado in Market Square, a free event with local entertainment, arts and crafts, and food.

4. No matter where you are or what you decide to do while visiting San Antonio, don't miss the beautiful music of **mariachis singing traditional music** from Mexico. Mariachis can be found playing their melodies in restaurants (especially along the River Walk), events and pretty much everywhere in the city.

I highly recommend Mi Tierra Café y Panaderia, a fun and lively restaurant and bakery that never sleeps. You can always find mariachis and great food here.

5. Take some time to visit the historic **Alamo** and walk on the battlegrounds as you learn about the settlement of the city. Admission is free. Get a glimpse of life in early Texas, including a firing demonstration on Dec. 7.
6. **Rivercenter Mall:** Four levels of shops, restaurants and entertainment, including a comedy club. What more could you ask for? 

Denise Adame is the student representative on NRHA's Multiracial and Multicultural Council. She is in the doctor of public health program at the University of North Texas and completed an internship with NRHA in 2012.



Denise Adame and a friend stroll along the River Walk.

All lit up

San Antonio is especially amazing during the holiday season, when Christmas lights sparkle in the streets at night, and the weather is just right (usually mid 70s during the day and upper 40s at night) for an adventure or a simple stroll downtown.

Check out these events while you're in town for the National Rural Health Association's Rural Multiracial and Multicultural Health Conference Dec. 4-5:

Holiday Boat Caroling

6:30-9:30 p.m. Dec. 4

Caroling will fill the evening air along the River Walk as more than 185 school, church, company and civic choral groups ring in the holidays by singing traditional carols on cruising boats.

Caroling Nights with Santa

6-9 p.m. Dec. 5-8

Enjoy a magical evening on the River Walk with luminarias, lights and carolers. Get your picture with Santa on a decorated river barge.

Fiesta de las Luminarias

7-10 p.m. Dec. 6-8

Experience the holiday serenity of the River Walk as you stroll along the lush banks of the San Antonio River guided by more than 6,000 luminarias. This century's old tradition begins at dusk Fridays, Saturdays and Sundays in December.

Seaworld San Antonio's Christmas Celebration

Seaworld San Antonio is decking the halls for its annual holiday celebration. Enjoy live shows in this wintry, watery wonderland.

Members on the move

Kansas hospital gains new CEO



Roger Barnhart

Roger Barnhart recently became CEO of Ashland (Kan.) Health Center.

Prior to leading the critical access hospital, the rural Kansas native spent 15 years working in home health, women's health, pediatrics, skilled nursing rehabilitation and long-term care in the Kansas City area.

A licensed skilled nursing administrator, Barnhart served as a continuum of care administrator aligning community services, hospitals, physician groups,

sub-acute rehabilitation facilities, assisted living, home health and providers to address care gaps and develop transition of care services to prevent avoidable hospital readmissions for the past five years.

"Within the emerging and ever-changing health care market, the only constant is an ongoing commitment of caring for our community," Barnhart says. "The challenges facing us require a new model of collaboration and support that is available through NRHA so that together, we may all provide innovations on how and where patient care is provided."

Ashland Health Center joined the National Rural Health Association in 2012.

Fellows graduate finds university program



Patrick Cross

National Rural Health Association member Patrick Cross, DPT, recently founded Briar Cliff University's doctor of physical therapy (DPT) program for which the Sioux City, Iowa, college is seeking accreditation.

"I have been blessed with a wonderful opportunity to be able to design an entry-level DPT curriculum. Due to the fact that Catholic Franciscan traditions are ingrained in the university's mission and values, service to the

underserved, including rural Northwest Iowa, Northeast Nebraska and Southeast South Dakota, will be an integral part of this new program," he says. "I believe interprofessional and service-learning experiences will help

provide the tools necessary for future DPT graduates to be highly competent, confident and successful in providing quality, holistic health care services to individuals in rural and underserved environments."

Before joining the Briar Cliff faculty where he also serves as a professor, Cross worked at the University of South Dakota for seven years and became a tenured associate professor of physical therapy and director of the transitional DPT program.

He is also the first and only physical therapist to complete NRHA's Rural Health Fellows program.

"My involvement in NRHA, specifically as a fellow, has enhanced my leadership skills, helped me to develop fantastic contacts, made me more aware of various factors that contribute to rural health disparities, assisted me with my scholarship and strengthened my relationships and level of perceived expertise with federal officials and their legislative assistants," Cross says. "My experiences with NRHA have played a positive role in my career advancement and the position I have today, a position that will allow me to fulfill my personal and professional goals of serving and preparing students to serve underserved populations."

Cross joined NRHA in 2008 and was a Rural Health Fellow in 2010.

Member leads two Wisconsin hospitals



Jason Douglas

National Rural Health Association member Jason Douglas recently became CEO of two critical access hospitals in Wisconsin: Memorial Medical Center

in Ashland and Hayward Area Memorial Hospital in Hayward.

He replaced Dan Hymans, who retired after 20 years.

Prior to leading the rural Wisconsin hospitals, Douglas served as CEO of Mercy Hospital and Healthcare Center in Moose Lake, Minn., for eight years. While at Mercy, he was successful in securing U.S. Department of Agriculture grant funding for much of a \$38 million addition and renovation.

“NRHA has always been a great wealth of information over my career. It has served as one of my go-to spots in keeping up with rural health and wellness issues,” he says. “I look forward to many years of connection to the health needs of rural people and the resources provided by NRHA.”

Douglas joined NRHA in 2004.

NRHA president leaves state job, starts consulting



Sandra Durick

2013 National Rural Health Association president and longtime member Sandra Durick retired from the South Dakota Office of Rural Health in October.

She has more than 35 years in health care administration, including 14 years at the state office, which she led since 2007.

Durick was a member of NRHA's first Rural Health Fellows class and served as board treasurer from 2007 to 2011.

“Thanks to my active involvement in NRHA, I gained leadership skills, insights and information and most importantly colleagues from across the country, who quickly became dear friends and advisers,” she says. “As a leader in NRHA and the state office, I feel it's been my job to mentor future rural health leaders, and it's truly been an honor to do so as part of these important organizations.”

Durick recently started a consulting firm focusing on health care, workforce, policy and leadership development.

“I look forward to continuing my work on behalf of

rural Americans to help build and sustain the rural health infrastructure,” she says.

Durick joined NRHA in 1986 and will be honored at NRHA's Rural Health Policy Institute Feb. 4-6 in D.C.

NRHA news



2012 Rural Lens finalist

NRHA, RAC kick off photo contest

Based on the success of the National Rural Health Association's first photo contest in 2012, NRHA's Communications Committee has partnered

with the Rural Assistance Center for this year's Rural Lens competition.

Photos will be accepted through Jan. 6 in three categories: community outreach, people and landscape.

“We all know that rural America is the most beautiful place on earth with the most dedicated and hardworking people in America,” says Matt Caseman, committee chair. “There's nothing like sharing rural health pictures across the nation from scenery, community outreach and the wonderful people that serve our rural communities.”

NRHA Facebook fans will select their favorite photos in early 2014. The grand prize winner will receive an iPad from Patient Focus. The winner in each category will have their image featured in *Rural Roads*.

Visit RuralHealthWeb.org for contest rules.

ORHP awards NRHA Rural Training Track grant

The Office of Rural Health Policy recently awarded the National Rural Health Association grant funding for a rural medical education project.

The “sustaining and multiplying rural training tracks (RTTs) as a strategy in rural medical education” grant was renewed for a second three-year cycle.

Led by NRHA and anchored by project advisers and field offices, the program will continue to connect RTT program directors, faculty and staff with state offices of rural health, a rural assistance center, and a rural research center – all in an effort to bolster existing RTTs and foster the growth of new programs.

“NRHA is looking forward to continuing the groundwork established

continues

continued

during the first three years of this project alongside the RTT consortium partners and expanding it further in the next three years to ultimately work to address workforce issues in rural America,” says Amy Elizondo, NRHA program services vice president.

The Rural Assistance Center, the National Organization of State Offices of Rural Health, the Washington-Wyoming-Alaska-Idaho Rural Health Research Center and the Robert Graham Center are partnering with NRHA in the consortium. Randall Longenecker, MD, Dave Schmitz, MD, and David Squire will serve as project advisers.

The project’s purpose is to tap into the expertise of individuals and programs distributed across the nation in an effort to sustain the 1-2 RTT model, which requires one year of residency in an urban environment and two years of residency in a rural area, as a national strategy for producing well-qualified physicians who will practice in rural communities.

The efforts of the current consortium will continue to be shaped by four aims:

- Support existing RTTs
- Assist in the development of new RTTs
- Increase the number of students matching to RTTs for residency

- Expand the evidence base of knowledge of these programs and their outcomes

NRHA and its partners will further advance these goals by promoting and developing osteopathic 1-2 RTTs as none to this date have existed and more deeply exploring the financial challenges and successes in RTT education.

NRHA to accept award nominations

The National Rural Health Association will accept nominations for its 2014 Rural Health Awards at RuralHealthWeb.org Dec. 2 through Feb. 11.

Winners will be selected by a committee of NRHA members and honored during the 37th Annual Rural Health Conference April 22-25 in Las Vegas.

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

accelerating advocacy

The hits just keep coming

The Department of Health and Human Services Office of Inspector General (OIG) released a report in August that, if fully implemented, could close 846 rural critical access hospitals across the country.

And hundreds more rural prospective payment system (PPS) hospitals are in jeopardy as Congress debates whether certain rural hospital funding is warranted or not.

“Rural health care delivery dangles precariously in the hands of a bitterly divided Congress as never before in history,” says Maggie Elehwany, National Rural Health Association government affairs and policy vice president. “Quite simply, this report seeks to kill rural health care by shutting down as many as 70 percent of a state’s rural hospitals.”

If Congress acts on the 34-page OIG report, it would eradicate individual state determinations on which small hospitals are critical “necessary providers” in a state, by overriding state decisions with federal authority.

The fate of rural PPS hospitals who receive either a Medicare-dependent hospital or a low-volume hospital payment is equally concerning.

“As it debates ways to cut Medicare spending, Congress is not eager to continue payments to rural providers likely because most members of Congress and staff don’t remember the reason Congress created these critical payments to rural providers in the first place: to stop the massive closures of rural hospitals that occurred in the 1980s and 1990s as a direct result of the switch to the prospective payment system,” Elehwany warns. “The irony in both the OIG report and in current congressional attempts to save Medicare dollars is that rural providers are cost effective and efficient.”

In fact, in comparing identical Medicare services in a rural setting to an urban setting, the cost of care in a rural setting is on average 3.7 percent less. This rural focus on primary care, as opposed to specialty care, saves the Medicare program approximately \$2.2 billion each year.

Members’ continued advocacy efforts are needed now more than ever, Elehwany says.

Join policymakers, experts and colleagues from across the country for the largest rural advocacy event of the year, NRHA’s Rural Health Policy Institute, Feb. 4-6 in Washington, D.C. Visit RuralHealthWeb.org/pi to register today and save.

Next conference to focus on serving underserved

The National Rural Health Association's Rural Multiracial and Multicultural Health Conference will be Dec. 4-5 in San Antonio, Texas.

This will be the 19th year for nation's only conference focused 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 and past NRHA Multiracial and Multicultural Council chair. "This conference is the perfect venue for learning about and sharing successful projects and initiatives that can be replicated in your community."

This year, multiple sessions will highlight issues and

solutions relating to rural women's health, community health workers, U.S.-Mexico border health and cultural attunement.

Presenters include Uchenna S. Uchendu, MD, the chief officer of the newly formed Veterans Affairs Office of Health Equity, as well as a White House official.

Visit RuralHealthWeb.org for the full agenda and to register, and see page 40 for a member's advice on turning your trip to San Antonio into a warm-weather vacation.

NRHA is offering a discounted road trip rate for attendees from Texas, Arkansas, Louisiana, New Mexico and Oklahoma. Scholarships are also available.

Send your career updates to editor@NRHArural.org.

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Gratitude is the best medicine

How writing yourself a prescription for gratefulness can positively impact your overall health

Most of us take a few moments around the holidays to think about – and sometimes share – those things for which we are most thankful. However, studies have demonstrated that being intentionally grateful all year long, as a lifestyle choice, can have a *great* impact on your health.

According to *Healthline* and a study by Robert Emmons, this attitude of gratitude has been shown to:

- lower risk for heart attacks
- enhance immune systems
- decrease depression and anxiety
- inspire healthier eating and increased exercise

For Emmons, “gratitude is defined by your attitude

toward both the outside world and yourself.” His research suggests that the happiest people look outward but are also very aware of how full their own lives are.

To find this balance, try these strategies: Keep a daily journal and hold yourself accountable by sharing your plan to look at things differently with a friend. Are you a visual person? Use pictures or notes throughout your home and office to remind you of all that you have.

And this Thanksgiving, make gratefulness a habit that goes beyond the holidays.

shifting gears

Green giving



Get creative with reusable and eco-friendly gift wrap that will stand out this holiday season.

Why not try newspaper, grocery bags with rubber stamps or even a map?

Break out the art supplies, and have your kids personalize the paper. Reuse bows and yarn for the finishing touches.

Off the beaten path

Totally tubular: American history through a kaleidoscope



World's Largest Kaleidoscope. Photo via roadsideamerica.com.

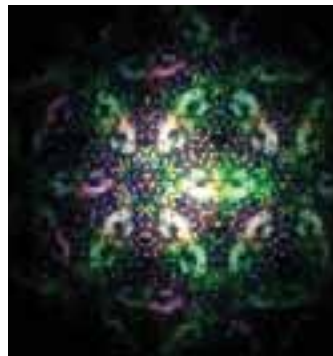


Photo via gobigorgohomeblog.com.

Nestled near the Catskill Mountains, just north of New York's Route **212**, a traveler may happen upon the World's Largest Kaleidoscope.

And while New York law protects the Catskills from industry – going so far as mandating the land must be kept “forever wild” – just down the road in Mount Tremper, N.Y., population **1,050**, a father-son **duo** went for another kind of wild. Their impressive feat of engineering was once a farming silo and stands nearly **60** feet tall.

This attraction – which promises to “assault all the senses” – opened in **1996**. The presentation “loosely” chronicles the history of America, and Isaac and Raphael Abrams dubbed their creation “the **first** cathedral of the **third** millennium.”



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