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Cover photo: *Founded by two recent college graduates, Orchid Health is pioneering a new model of rural primary care delivery in Oakridge, Ore.*

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Raymond Christensen

The youngster, the elder and the future of rural America

“What’s your name?” My name is Ray, I said as I walked. “Mine is Alicia. I like funny hats,” declared the 5-year-old stranger as she continued on her bike in a small Wisconsin community, with the front brim of her hat folded up.

Later that day I had dinner at a small-town diner with Joan and my 92-year-old mother, reminding me that rural health care allows her to continue to live alone in her century-old farmhouse where I grew up.

The elder and the youngster: One has given her life to rural America, raising a large farm family and benefiting from rural care, and an engaging child represents the future of rural health and rural America.

As we bridge from the past to the future, we will continue to be battered by changing policy and acronyms, but the essence of rural health care remains clearly defined. Access to a caring health care professional and system is a rural right; let us not forget this legacy requires our mentoring and investment in the youth of rural America.

Raymond Christensen, MD
2014 NRHA president



pit stop

things I picked up in this issue:

1. Recent college graduates recruited a physician to practice in a rural area for the first time due in part to their new clinic’s unique monthly payment model that attracted 400 patients in one month. *page 7*
2. The National Rural Health Association has a plan to help stop the rural hospital closure crisis. *page 47*
3. Thanks to South Dakota’s Rural Experiences for Health Professions Students program, Redfield Community Memorial Hospital is one of the only hospitals in the state with a full-time pharmacist. *page 18*
4. Incoming NRHA president Jodi Schmidt’s mother served as a nurse with a “flying doctor” in the Australian Outback before Schmidt was born. *page 40*
5. Locals say free screenings by pharmacy students have saved lives in a rural Alabama county with a 74 percent obesity rate and the nearest hospital 25 miles away. *page 21*



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Recent grads open rural clinic, attract providers and patients with unique payment model

By Angela Lutz



Oliver Alexander and Orion Falvey founded Orchid Health, a rural primary care clinic, while they were still in college. The clinic opened in August.



While the rest of their college classmates were cramming for finals and hanging out with friends, Oliver Alexander, 22, and Orion Falvey, 24, were putting the finishing touches on Orchid Health, their new primary care clinic.

Located in rural Oakridge, Ore., Orchid opened in August and filled a vital role in the community of 3,500, which previously had 80 percent of its primary care needs unmet. Within a month, the clinic already had 400 patients.

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“We’re accepting as many patients as we can handle,” Falvey says. “We don’t have to worry about the competition. We just focus on how we can meet the needs of the patients and provide value.”

“Initially I think people thought we were dreaming – two college kids trying to create a new health care model. But definitely as we gained momentum people were impressed and ready to help and listen to us.”

Orion Falvey, Orchid Health cofounder

Orchid’s two unlikely founders met as University of Oregon business students at the school’s Social Business Challenge conference in 2013, where the prompt was to come up with a sustainable solution to a local problem.

“I’m from a small town in Alaska, about 2,500 people,” Falvey says. “Growing up there, I definitely experienced some of the challenges people face with rural health care. One of our professors told us to go for

something big – and that’s where we came up with rural health care. There’s a huge unmet need in Oregon and across the country.”

Before Orchid, which stands for Oregon Community Health Innovatively Delivered, became a brick-and-mortar clinic in Oakridge, the model

was initially conceptualized as a mobile clinic that would travel to communities lacking primary care. This idea received a lot of positive feedback from people at the business conference, as well as some startup funding. Despite this support, Falvey says starting a business while still in school was a challenge.

“Initially I think people thought we were dreaming,” Falvey says. “People were taking a backseat and seeing out this would play out – two college kids trying to

create a new health care model. But definitely as we gained momentum people were impressed and ready to help and listen to us.”

In fact, Falvey says their student status gave them unique access to hospital CEOs, insurance company executives and other health care professionals who were all eager to help. Through their discussions with industry leaders and the Oregon Office of Rural Health, Falvey and Alexander learned that many patients and providers were not happy with the current health care model, which requires physicians to see as many patients as possible each day to ensure maximum reimbursement for services.

continues on page 11



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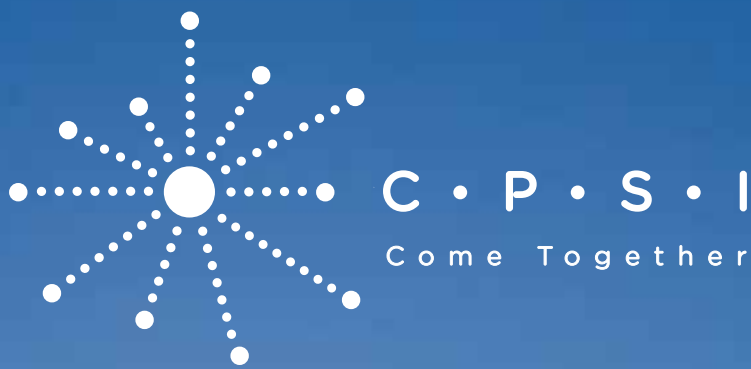
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“They weren’t able to treat their patients the way they wanted,” Falvey says. “They weren’t able to practice medicine the way they dreamed of doing when they went to medical school.”

In response to this feedback, Falvey and Alexander turned Orchid Health into a certified patient-centered primary care home, which focuses on patient health outcomes. They have also cut a lot of insurance billing out of their direct primary care model, instead allowing patients to pay a monthly membership fee starting at \$39 with no copayments or deductibles. Falvey says this model is gaining popularity across the country.

“The current system is very reactive,” Falvey explains. “We want to turn that around and have a proactive system that emphasizes primary and preventative health care. It’s no longer just about seeing a high number of patients. And that’s why we’re involved in this business: to help our patients improve their health and be there for the community.”

Allowing physicians to put care first has been a valuable recruitment and retention tool. Prior to opening, Falvey and Alexander recruited two providers: physician Mike Henderson, DO, and nurse practitioner Julie Willardson. Henderson was drawn to Orchid


Health because the model allows him to do more to help patients. This is his first time working in a rural community.

“With this clinic, there’s greater need, and to me that’s a positive because I can do more for people,” Henderson says. “That’s more satisfying to me intellectually and more helpful to the people. And because of what they’ve done with the business aspect, I can just go practice medicine and do what I’m trained to do.”

“The current system is very reactive. We want to turn that around and have a proactive system that emphasizes primary and preventative health care.”

Orion Falvey, Orchid Health cofounder

The patients in Oakridge have benefitted as well – and as Falvey and Alexander start looking toward their next Orchid Health location, they hope to support many more patients in the future.

“Every patient that comes in is very appreciative and so glad to see health care services in Oakridge,” Falvey says. “There have been patients who thought they were going to have to move from Oakridge because their parents were getting older and they needed to go someplace that had better health care facilities. They were so thankful they could stay here and have quality primary care.” 

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Missouri gets fresh crop of rural doctors

By Karen Buschmann



Rural Track Pipeline Program director Kathleen Quinn (second from right) with students Sarah Kapala, Troy Loethen and Michelle Pickens.

Angie Whitesell, MD, always knew she wanted to live her life in rural Missouri, but it wasn't until college that she realized medicine would bring her back to Lockwood, a town of fewer than 1,000 people in the southwest corner of the state.

"I grew up on a beef cattle farm in rural Lockwood," Whitesell says. "It might sound odd to someone who is not a farmer's daughter, but I have always felt a deep connection to the land and knew that I wanted to return one day to live and serve those in this area."

Her medical career began with a conversation with her adviser during her freshman year of college.

"I started out at Mizzou as a pre-vet student," she says. "My adviser told me of the shortage of physicians willing to practice in rural areas of Missouri."

That discussion led Whitesell to join the University of Missouri (MU) Rural Track Pipeline Program, which is designed to increase the supply and retention of rural

physicians statewide. The program set Whitesell on the course that eventually brought her home to work as a family practitioner at Mercy Health Clinic in her hometown.

"I sought out rural family physicians near my hometown to shadow, and I was immediately hooked," she says. "I loved watching the relationships these rural physicians developed with multiple generations of patients and how they were able to impact the communities they served."

With a critical shortage of physicians in rural Missouri, Whitesell is a success story of MU's rural track. But there is still work to be done.

Of the 114 counties in Missouri, 103 are designated as rural, meaning more than 97 percent of the geographic area of the state is home to more than a third of Missouri's population. Yet, only 18 percent of the state's primary care practices are located in rural areas. In fact, 41 counties in Missouri do not

have a hospital, and according to the U.S. Department of Health and Human Services, 28 percent of Missourians lack adequate access to health care, due in great part to where they live.

"I don't think that rural students always understand that they have the potential to become physicians."

Angie Whitesell, Mercy Health Clinic family practitioner

The MU Rural Track Pipeline Program is working to close that gap.

"When students matriculate from undergraduate school to medical school, about 3 percent say they want to practice in a rural area," says Kathleen Quinn, PhD, director of the pipeline program. "Of the students that go through one or more components of our program, 57 percent end up in rural areas in and outside of Missouri."

The MU Rural Track Pipeline Program has several components designed to introduce students to the opportunities of a career in rural health care. Through 15 area health education centers across the state, students as

young as middle school who show an interest in health care are exposed to an intense health care track of study.

"I don't think that rural students always understand that they have the potential to become physicians," Whitesell says.

Once in college, another component of the program is targeted at recruiting rural students to apply for medical school. The Rural Scholars Program is a cooperative program between the University of Missouri and six regional Missouri colleges to attract students that have rural backgrounds and an interest in practicing rural medicine by granting preadmission to medical school during a student's sophomore year of college, as long as academic and standards are met.


"Considering the University Medical School can accept less than 100 new medical students each year from the nearly 1,700 applications it receives, pre-admission is a significant incentive," Quinn says.

Other components of the MU Rural Pipeline Program are designed to give medical students experiences working with rural physicians, including a summer program for second-year medical students, a six-month rural track clerkship for third-year medical students, and a rural track elective program for fourth-year medical students.

"It is essential that programs like these help to identify, develop and support young people from rural areas who are more likely to return to those same areas someday," Whitesell says. "It is also essential that these programs expose students from all backgrounds to the benefits of rural life, so that they, too, may consider living and working in a smaller community someday."

Missouri's rural pipeline program has received national awards and recognition, but the real benefits hit closer to home.

"Although it is impossible to determine whether our actions ultimately resulted in saving someone's life, there have been multiple instances when someone was presented to our clinic with chest pain, respiratory distress or with stroke symptoms that we worked to stabilize and then transfer to the hospital for definitive care," Whitesell says. "Because we are so far, geographically, from any hospital, about half of the patients who we serve each day come in with urgent needs, such as lacerations or acute illness."

The impact that a doctor can have on a community like Lockwood is immeasurable. 

This article originally appeared in Missouri Business in May 2014.

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Community connections

Urban pre-med students gain rural experience

By Angela Lutz



Students visit the Erie Canal while participating in the Rural Immersion Project at River Hospital in Alexandria Bay, N.Y.

Pre-medical student Kyle Admire calls his first experience with rural health care “eye opening.” Before the junior at Wells College visited River Hospital in Alexandria Bay, N.Y., he had only worked at urban hospitals in Albany. He didn’t realize there was a difference between rural and urban medicine.”

“Where I’m from, there are definitely options as far as what hospitals you want to go to,” Admire says. “But in a rural setting, you have to go to one hospital or you might not make it to any hospital.”

This summer, Admire and five other students participated in the Rural Immersion Project, a weeklong program aimed at providing hands-on rural health care experience for undergraduates. The project grew out of a Central New York Area Health Education Center (AHEC) partnership with Wells College in Aurora and the Manhattan-Staten Island AHEC. Since the project began last summer, 17 students have experienced rural practice and small-town life, many for the first time.

“The students this summer from Manhattan were mostly urban dwellers and have always been,” says

Erin Hildreth, Central New York AHEC director of programs. “They kept calling it ‘vastness’ – like, ‘I can’t believe the vastness here.’ They wanted to experience rural and decide whether that might be a path for them in the future.”

This summer, pre-med students from Wells College and City College of New York went to either Alexandria Bay Hospital or Little Falls Hospital, where they shadowed physicians and other providers and were introduced to community agencies and organizations. For Admire, the connection between rural hospitals and the communities they serve was impressive. So was the rural providers’ range of skills.

“It’s important to trust yourself and your training as well as the people you’re working with, because there may only be two people in the ER at that time, and you can’t call for extra help if you need it,” he says. “The

people there need to be good at what they’re doing, and you need to trust that they can do it.”

“You can see such an impact and a transformation in the students in such a short period of time. And ultimately for the community it’s a recruitment effort. They’re able to showcase and highlight the opportunities that are available in rural life.”
Erin Hildreth, Central New York Area Health Education Center director of programs

In addition to hospital experience, students got the chance to see what life was like in a rural community. According to Hildreth, the communities “bend over backwards” to make the students feel welcome. For example, in Alexandria Bay (population 1,116), the students joined the fire department on their fireboat for a rescue simulation, and afterward they went back to the station for pizza. Meanwhile, in Little Falls (population 4,887), students attended Canal Days, a local street fair.

“You can see such an impact and a transformation in the students in such a short period of time,” Hildreth says. “And ultimately for the

community it's a recruitment effort. They're able to showcase and highlight the opportunities that are available in rural life."

The participating facilities have benefitted as well. According to Michael Ogden, Little Falls Hospital CEO, promoting health career education and training for future health care workers reflects positively on his facility.

"The unique nature of the immersion project and the fact that the students present their findings from the experience to a diverse group of community leaders as well as hospital leaders shines a light back on us as health care providers," he says. "It not only points out areas of improvement that they may see to recruit and train the next generation of health care workers, but it also reinforces many of the positive things we have to offer in rural areas from a community standpoint."


After participating in the Rural Immersion Project, Hildreth says several students are considering a rural location for their practice after they graduate. The Central New York AHEC is currently developing a "phase II" immersion project for the students who have shown the most interest.

"We want to bring them back in the wintertime and give them a different perspective and a more concentrated program," she says. "We want to keep them connected and really make this meaningful."

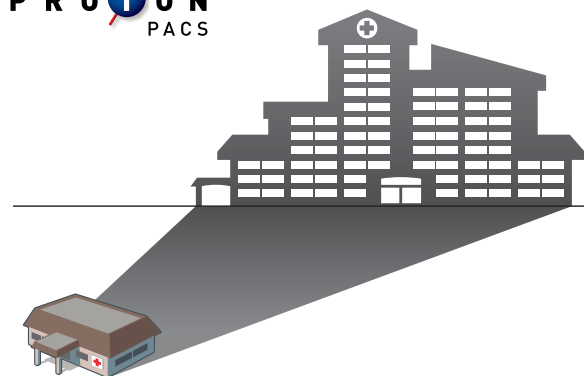
The experience was certainly meaningful for Admire. Still early in his educational journey, he is not sure where he will ultimately settle down, but the Rural Immersion Project has gotten him excited about the idea of rural community – particularly the level of trust between sole community hospitals and the patients they serve.

"The hospital staff needs to instill trust in their patients that they can provide the care that they need," Admire says. "It's a give and take between the hospital and the patients and community."

For Hildreth, allowing urban and suburban students to see the rural hospital-community connection is what the Rural Immersion Project is all about.

"I think the biggest light bulb or transformation that happens is the students have this deeper understanding of community," she says. "It's what rural health care is all about: It's access to services, but the community is intertwined with health care. I think it takes a special type of person to live and practice rural, and we've had a great pool of applicants to choose from. We're going in the right direction." 

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SD program routes students to rural health

By Angela Lutz



Pharmacist Alyssa Howard and physician Matt Owens visit with a patient at Redfield (S.D.) Community Memorial Hospital.

Before Alyssa Howard, PharmD, came to Redfield (S.D.) Community Memorial Hospital (RCMH), the 25-bed critical access hospital did not have a full-time pharmacist. A part-time pharmacist occasionally visited from a neighboring community, but Howard saw the need for more comprehensive services.

“The hospital wasn’t embracing any of the clinical or inter-collaborative services a pharmacist can offer,” she says. “There was definitely a gap.”

At the suggestion of RCMH physician Matt Owens, Howard put together a job description and presentation for the hospital board after she graduated from the South Dakota State University (SDSU) College of Pharmacy in May. By July, she was working full time at RCMH, becoming one of the only full-time pharmacists at any rural hospital in the state.

Howard’s rural career didn’t happen by accident. She first visited RCMH as a second-year pharmacy student in 2011 as part of the Rural Experiences for Health Professions Students (REHPS) program, which is when she first met and shadowed Owens. Initially funded by a three-year Health Resources and Services Administration grant and now by the South Dakota Department

of Health, the five-year-old program gives students four weeks of intensive experience living and working in rural communities across the state. REHPS has grown significantly since its inception, from three sites and six students in its first year to 11 sites and 21 students in 2014.

According to Cheri Buffington, REHPS program manager at Yankton Rural Area Health Education Center, REHPS primarily targets medical, pharmacy, nurse practitioner and physician assistant students at SDSU and the University of South Dakota, who learn about the program through in-class presentations.

“The majority of the students have some sort of rural experience,” Buffington says. “That’s what we’re looking for, because most of the research tells us students who come from rural areas are most likely to return to them. We are encouraging students who are from rural areas and interested in going into rural medicine to utilize this experience as that first touchstone.”

“They see we’re an integrated part of the rest of the health care system and we’re not out here playing cowboy. We’re not alone. We have a lot of support.”

Matt Owens, Redfield Community Memorial Hospital physician

Even students with rural backgrounds are often surprised by what it takes to provide health care in a small town. When Tia Haines, a physician assistant at Platte (S.D.) Health Center Avera, went to Winner (S.D.) Regional Hospital as part of REHPS in 2012, the range of cases she encountered surprised her.

“I was really shocked about how much variety you see,” she says. “When you specialize, you get really good at one thing, but I learned how important it is to be educated in all aspects of medicine and be on your toes, because you never know what’s walking through the door.”

In her current position, Haines says she’s in the “middle of nowhere” and manages patients with everything from rheumatoid arthritis to cancer to Parkinson’s – “stuff that normally the specialists would manage.”

Howard had a similar experience when she began working at RCMH.

“You grow up thinking that when your nose itches, you go to a doctor for that, and when your knee hurts, you go to a different doctor, but here, it’s not like that at all,” Howard says. “That was the biggest thing I was surprised to learn – and I was surprised at how well they handled it. That led me to decide that they needed a pharmacist.”

Even though rural facilities might be lacking in specialists, Owens says that technology allows physicians to provide appropriate health care for complex patients. He also notes that chances of recruitment and retention are higher when physicians feel they have a support network in place – and for students, there’s less “shock value of not having a surgeon right down the hall or a cardiologist up two floors.”


“They see we’re an integrated part of the rest of the health care system and we’re not out here playing cowboy,” Owens adds. “We’re not alone. We have a lot of support.”

In addition to shadowing physicians, pharmacists, nurses, physician assistants and other health care professionals, students are encouraged to get to know community members. Buffington says this includes everything from setting up educational booths at county fairs to going hunting and fishing. When Haines was in Winner, population 2,850, she and another student went to the pool, handed out popsicles and talked to kids about the importance of sunscreen.

“The community was great,” Haines says. “They knew how important continuing a love for rural medicine was. They were great at making us feel at home.”

Establishing this connection is important, Buffington says, because rural health care is very much a team effort – and that includes the community.

The approach has been effective. Surveys show that 95 percent of REHPS participants are more likely to consider a rural career, and 10 of 17 graduates who participated in REHPS now practice in a rural area, including seven in South Dakota.

“It definitely got me to love and appreciate the community and understand how important collaboration is between health professionals,” Howard says. “That’s the biggest thing I learned – how important it is to keep everyone involved in patient care, talking to each other, and working together as a team.” 

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Providing relief in a health care desert

Pharmacy students volunteer in Alabama's Black Belt

By Katie Stripling



Pharmacy student Whitney Williams measures blood pressure.

Plagued by unemployment, low incomes and chronic disease, Perry County, Ala., is one of the most vulnerable areas in the state.

A 2010 report from the Alabama Department of Health found that 47 percent of adults in the area have hypertension, 58 percent have high cholesterol, and 74 percent are obese. With a mere five physicians and two pharmacies in the area and the nearest hospital 25 miles away, the population of more than 10,000 faces numerous barriers to adequate health care.

In 2010, students from Samford University's

McWhorter School of Pharmacy in Birmingham, Ala., made a commitment to improving health in this rural area. Samford's chapter of the Student National Pharmaceutical Association (SNPhA) had been participating in wellness events in Perry County for years, but they wanted to do more. With Samford's American Pharmacists Association Academy of Student Pharmacists, the students launched the Alabama Rural Health Student Initiative to respond to the needs of the rural county.

Through the program, students visit the area twice a month to provide free health screenings and education. They offer blood glucose measurement, cholesterol testing, blood pressure and BMI measurement and educational programming. Programs cover a variety of topics related to wellness, health and prevention.

"People don't have access to health care here, and that's where we, as student pharmacists, can make a huge impact on the community,"

continues



Pharmacy students take a break with Perry County resident and program advocate Dorothy Hornbuckle.



Samford University pharmacy students offer free health screenings twice a month at the East Perry Volunteer Fire Department and a local church.

says Gwen Nance, fourth-year pharmacy student and program manager. “Pharmacy is so much more than what you see at your local store. We go into the community and provide services for patients that make a huge impact in their lives.”

“People don’t have access to health care here, and that’s where we, as student pharmacists, can make a huge impact on the community.”

Gwen Nance, Samford University pharmacy student

For some, the contact with the Samford students is the only access they have to health care. With 33 percent of the population living below the poverty level and a median household income of \$32,800, many individuals find themselves in situations that prevent travel or access to other health care providers. Samford’s screenings are conveniently conducted at the local Friendship Baptist Church and the East Perry Volunteer Fire Department.

Nakia Moore, Perry County resident and member of Friendship Baptist Church, says the screenings are making an impact.

“I truly believe that these screenings have saved lives,” Moore says. “We have had many success stories that have come from these clinics.”

A key component of the program’s success is the ability to support patients after the screenings. Each

month’s results are recorded to help the patients see their progress, or lack thereof. The longitudinal monitoring allows for patients in need to be referred either directly to their health care provider or to the pharmacist-run clinic affiliated with the Perry County Health Department and nonprofit organization Sowing Seeds of Hope.

As an investment in the health of the people, McWhorter School of Pharmacy provides a full-time faculty member, Pilar Murphy, PharmD, to staff the local clinic, further solidifying the university’s relationship to the area.

According to Murphy, area residents look forward to the bimonthly screenings because for many it is the first time something like this has been offered to them.

“What’s really helped all patients involved is having pharmacists and student pharmacists actually talk to the patients about their disease states. Many of them know they have diabetes or hypertension, but they are really unaware of the lifestyle changes they could implement to help control the disease states better,” she says.

Patients are also educated on the importance of compliance with their medications.

Maisha Kelly Freeman, PharmD, pharmacy professor and co-adviser for SNPhA, says the Rural Health Student Initiative has fostered relationships, increased access to care, enhanced education on health topics and supported self-efficacy.

“Perry County is somewhat of a health care desert,” she says. “To be able to come down here and see the impact that our students are having on lives and to see the trust building between pharmacist and patient is truly rewarding.”

In addition to the benefits to rural residents, the Rural Health Student Initiative provides an opportunity for students to practically apply the clinical skills and knowledge learned in the classroom. By linking the




Samford University pharmacy students with adviser Maisha Freeman.

classroom to reality, student pharmacists not only gain invaluable clinical experience, but they also develop an increased awareness of ways they can personally be involved in and lead efforts to overcome barriers to care.

“For me, pharmacy is about helping people and giving back to the community,” Nance says. “The Perry County outreach program has provided me with a way to do that.”

Student and faculty participation in the initiative has increased throughout the life of the program. Each new year brings a new group of future pharmacists who are enthusiastic about improving the health of an often disregarded patient population, Freeman says. By embracing this opportunity to serve, they are contributing to the overall health and wellness of the area and helping build awareness of the pharmacist’s role in individual health.

In recognition of the impact of the Alabama Rural Health Student Initiative, the American Association of Colleges of Pharmacy awarded the McWhorter School of Pharmacy its prestigious Student Community Engaged Service Award at its annual meeting in July.

Founded as Howard College in Perry County in 1841, Samford took root in the heart of Alabama’s Black Belt, so named for its dark, fertile soil. Although the university moved to Birmingham in 1880, Samford continues to care for the people of its hometown today. 

Katie Stripling is executive director of external relations at Samford University’s College of Health Sciences.

Watch and learn

Hear from Perry County patients and Samford University pharmacy students about the Alabama Rural Health Student Initiative by searching for “McWhorter School of Pharmacy” on YouTube.

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Rural partnerships achieve sustainable outcomes by leveraging federal funds

By Ann Ferrero, Marcia Green and Christina Villalobos



Susan Foster, nurse, and Rori Schreiman, nurse practitioner, discuss a patient's medical record at Live Well Community Health Center in Concordia, Mo.

For more than 20 years, the Office of Rural Health Policy (ORHP) has been providing grants to small, rural community-based organizations.

And many rural networks have leveraged the federal funding by using ORHP grants to catapult their goals.

“These grants serve as seed money for helping rural communities test out new ways to address local health care challenges,” says Tom Morris, ORHP associate administrator. “What’s been amazing over the years is to also watch how so many grantees are then able to garner additional funds and resources – often local and foundation dollars – to keep those projects going long after federal funding has ended. They serve as examples that others can learn from as they end up producing outcomes and benefits beyond the original intent of

their funding requests.”

ORHP’s Rural Health Information Technology Network Development (RHITND) Program is a three-year, one-time initiative. The program seeks to improve health care and support the adoption of health information technology (HIT) in rural America by providing targeted HIT support to rural health networks.

“The ability to secure the necessary capital for expanding a network’s organizational capacity and obtaining the initial investment in essential hardware and software is a challenge for many rural providers, so the intent of the RHITND Program is to improve health care and support the adoption of HIT among rural health networks located in the most disadvantaged areas,” says Nisha Patel, ORHP community-based division director.

Health Care Collaborative of Rural Missouri

The Health Care Collaborative of Rural Missouri (HCC) is one of 41 RHITND Program grantees. HCC’s focus is to develop and implement programs that are responsive to documented health needs of rural patients in West Central Missouri with specific health status indicators as benchmarks for progress on addressing those needs.

“These grants serve as seed money for helping rural communities test out new ways to address local health care challenges.”

Tom Morris, Office of Rural Health Policy associate administrator

HCC implements and supports region-wide programs that help create access to education, awareness, prevention and treatment of health care conditions. HCC works directly with service providers such as rural hospitals (I-70 Community Hospital, Carroll County Memorial Hospital, Fitzgibbon Hospital and Lafayette Regional Health Center), federally qualified health centers (Rodgers-Lafayette Dental and Health Clinic and Live Well Community Health Center), a community mental health center (Pathways Community Behavioral Healthcare Inc.) and county health departments.

“When you bring people together who are passionate about health care and equally passionate about looking out for the underserved, you can move the needle,” says Toniann Richard, HCC executive director.

The network is supported by leveraging funds from federal agencies and the private sector. Since 2008, HCC has successfully implemented a number of ORHP grants through its various programs, including Rural Health Network Development Planning Program, Rural Health HIT Network Program, Rural Health Network Development Program and Rural Health Care Services Outreach Grant Program. HCC has also leveraged other federal funding such as Health Resources and Services Administration grants and a U.S. Department of Agriculture grant.

Each ORHP grant opportunity is carefully matched with another funding or revenue stream, which aligns with HCC's strategic plan, Richard explains.

HCC has secured more than \$5 million over the past six years to address access to care needs. Most recently, HCC was awarded a Health Center Cluster 330 Grant and federally qualified health center status for its two rural clinics in Lafayette County, Mo.; it is the first rural health network in the country to achieve this status.

Chautauqua County Health Network

Chautauqua County Health Network (CCHN), in western New York, is another example of multiple organizations coming together to leverage funds.

In 2010, CCHN received the Small Healthcare Provider Quality Improvement (SHPQI) grant, its first federal grant. The purpose of ORHP's quality program is to provide funding and other support to improve the quality of health care services in the rural primary care setting. Grantees focus on improved health outcomes and enhanced chronic disease management by using a team approach and providing more patient-centered care. Funding recipients are required to collect and report data on clinical quality measures and use the data to drive quality improvement efforts.

"CCHN and other grantees have used the grant announcement as a catalyst to seek additional funds through the building and strengthening of partnerships," says Ann Abdella, CCHN executive director.

The network comprises more than 100 local health care providers and community-based organizations. Its mission is to strengthen the economic viability of hospitals and other health care providers, promote access to quality health care related services, facilitate partnerships to address community needs, plan for the efficient delivery of care and develop appropriate health resources.

"In 2010, a diverse collection of clinicians and organizations was providing health care in Chautauqua County, with little or no coordination among them," Abdella explains. "So CCHN engaged 10 primary care practices to build an integrated network with the support of the quality grant. As the practices began by sharing data and ideas, their confidence




Health Care Collaborative of Rural Missouri staff

in working together increased and led them to begin thinking about more effective and efficient ways to coordinate patient care across multiple settings, which is especially important for patients with chronic conditions or multiple illnesses. These efforts not only have led to better health outcomes for CCHN patients, but also facilitated the formation of an accountable care organization (ACO)."

The ACO, known as Chautauqua Region Associated Medical Partners, is a group of doctors, hospitals and other health care providers who have come together to voluntarily provide coordinated care to Medicare patients.

"This effort has resulted in improved outcomes for patients with diabetes and hypertension," Abdella says. "Every practice showed an improvement in blood pressure, with a 4.6 percent improvement overall."

CCHN staff also plan to analyze claims data to demonstrate they have improved health care quality at lower cost and use it to negotiate future pay-for-performance contracts with insurers, contributing to the sustainability of the providers. 

Ann Ferrero, Marcia Green and Christina Villalobos are public health analysts for the Office of Rural Health Policy's community-based division.

More money

Learn about current and former Office of Rural Health Policy grantees that have leveraged federal dollars to expand health care programs and services by visiting the Rural Assistance Center's Rural Health Models and Innovations Hub at raconline.org.

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Beginnings & Passages



Alex Spencer

“I found medicine trying to attain some sense of utility for a community that could do almost everything for themselves.”



Fixing what's broken: Rural student chooses general surgery

By Alex Spencer

I grew up just outside the Mount Saint Helens National Monument and spent most of my free time riding motorcycles on the mud flats left over from the eruption, exploring old logging camps and crawling over half-buried equipment. Among other things out in the woods, I discovered old log bridges made by men with no formal education using whip saws and elbow grease.

This “can do” attitude was evident in most of the people I grew up with. Everyone could hunt, can foods, build homes and fix almost anything that could break.

I idolize the skill of my community to the extent that I found medicine trying to attain some sense of utility for a community that could do almost everything for itself.

Health care is different, however. It's something that rural America is struggling to fix. Part of the problem is that with medicine it is not as simple as just “knowing how.”

The intricacies of the business of medicine drove me to get a master's in business administration degree so I could really help solve some core issues of rural medicine. After that, I found a perfect fit at the University of Washington School of Medicine in the Targeted and Rural Underserved Track.

I got involved in the National Rural Health Association during my first year of med school in order to learn how to speak up for rural communities on the national stage. I am consistently amazed at the passion and energy NRHA members bring every day to make sure that rural communities are not forgotten.

As a senior medical student, I recently had the honor of choosing my specialty. I chose general surgery for two reasons. The first is because I love the operating room and the tools, and I can see the “fix” in real-time. The second reason is that the shortage of rural general surgeons is truly profound, making it impossible for some rural medical communities to stay viable. No matter where I will have the privilege to complete my surgical training, I will continue to proudly support rural communities, eagerly awaiting the days when I can call one home again.

Alex Spencer is a student at the University of Washington School of Medicine and is chair of the National Rural Health Association's Student Constituency Group. He joined NRHA in 2013.

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“Every time I see that someone, some family or some community needs a hand up, I feel lucky if I can possibly help a little.”



Jim Boulger

Improving rural health care one smile at a time

By Jim Boulger

What have you done with your life?

I would have been more surprised than anyone else if I could have seen my career path 50 years ago. But what a great ride it has been. I grew up in an economically poor neighborhood, but one that was full of family, love and great friends.

I chose the academic life for the same reasons that we all choose our careers – I wanted to make a positive difference in the world. I wanted to do research, to teach the next generations, to measure and alter the world so life will be improved. I have been gifted with a family of origin – as well as by marriage – that supports and enables me to continue on the weird and winding path I have taken.

As a new medical school faculty member in 1969, I discovered a new specialty had just been established: family medicine. I was part of a newly created medical school (actually two newly established schools as I moved to Duluth four years later) that was formed out of the turmoil of the '60s and the recognition that many in our nation were being left by the wayside as medicine changed.

The attempts to improve care for our sisters and brothers who had been long underserved because of race, gender, rurality or economic disparities pushed, grabbed and changed many of us to make the “right” things happen as we tried to create a new generation of physicians.

Reviewing the nation now, I see much progress in eliminating some disparities, but many problems persist. While there has been a great deal of progress for some of us, we still

need to work hard to achieve better health for all of us. Every time I see that someone, some family or some community needs a hand up, I feel lucky if I can possibly help a little.

The rewards have been great – I have seen generations of bright, young, passionate, inquisitive and caring students assume the mantle of medical responsibilities, caring and competence. They are great colleagues in making the world a better place a person at a time, a discovery at a time, a smile at a time.

I have been privileged to count myself as a friend and colleague to hundreds of rural physicians and health care providers, and I have seen the tremendous quality with which they care for their patients and communities. I have been blessed with many colleagues in the training of rural physicians at the local, regional and national level, and all share the desire to create equality in health care.

I am thankful that I have been a passenger on this journey.

I always try to remember that life is good – it may not be fair, but it sure has been good.

I am blessed.

Jim Boulger, PhD, is a charter faculty member at the University of Minnesota Medical School in Duluth and director of the Center for Rural Mental Health Studies. He recently received the Minnesota Department of Health and Minnesota Rural Health Association's Rural Health Hero Award. He has been an active National Rural Health Association member since 1986 and received NRHA's Outstanding Educator Award in 2003.

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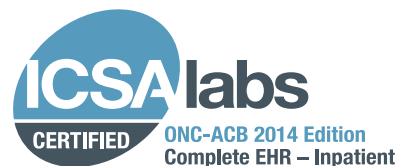
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Rural hospital closure crisis: Can we stop the bleeding?

By Herb B. Kuhn



Herb B. Kuhn

Last fall's edition of *Rural Roads* included commentary from Virginia Rural Health Association executive director Beth O'Connor about a rural hospital closure. The headline read, "When a hospital dies, where do you send the sympathy card?"

At the time, I thought the question was appropriately provocative. Missouri hospitals were facing grim times too – reduced Medicare and Medicaid reimbursement to pay for expanded coverage that had not materialized through Medicaid. I wondered about the sympathy card idea.

In August, Sac-Osage Hospital in Osceola, Mo., announced it would close. A public forum was scheduled in the town of 900; approximately 200 residents attended. The community was grappling with what the hospital closure meant, and I was asked to speak about the climate for hospitals in Missouri.

I came prepared with the facts. Hospitals are facing significant economic headwinds. It is difficult for all hospitals, but particularly for smaller, rural hospitals. Although closure is the extreme outcome of these headwinds, many hospitals across Missouri are eliminating important services and quietly shedding jobs.

The analogy I used was that "just because you can't see the blood doesn't mean there isn't serious internal bleeding." I laid out additional concerns, including workforce issues, the opportunities and challenges of consolidation for independent hospitals, the demand for more performance information and increased financial risk from payment reductions, the uninsured and charity care.

I also spoke about the lack of Medicaid expansion. Several states bordering Missouri have expanded Medicaid. Missouri lawmakers' decision not to expand is reducing the opportunity to stimulate the health care sector and economy.

I cited recent action by Ozarks

Community Hospital to eliminate hospital and clinic jobs in Springfield, Mo., and grow new jobs at its hospital and clinics in Arkansas, a state that has expanded Medicaid.

These issues were all relevant. However, there was little to be done. The hospital was closing. There was no way to stop the bleeding.

"When a community loses a hospital, it loses a part of what it means to be a community."

Herb B. Kuhn, Missouri Hospital Association president and CEO

Rural hospitals greatly matter to the communities they serve. They provide a strong economic boost and serve as an economic and social anchor for the community.

A hospital, like a high school, is a community-defining institution. When a community loses a hospital, it loses a

part of what it means to be a community.

Losing a rural hospital transforms the face of health care access in a community as well. Rural residents select care close to home when it is available. When a rural hospital closes, distance to care expands while the golden hour for lifesaving care erodes. The comfort of knowing that a physician is available locally 24/7 disappears.

Rural residents are older, poorer and more likely to be uninsured than other segments of the population. Rural health status generally lags behind urban and suburban areas. And rural work – including farming – has a higher percentage of crush-related injuries than urban and suburban professions.

In a rural community, the hospital is the center of the medical community. It's very difficult to recruit physicians to a community without a hospital.

At the community meeting, Sac-Osage Hospital CEO Chris Smiley focused on her employees, referring to them many times as family. Community members spoke about their connection to the hospital, including a woman who was born at the hospital and delivered her two children there. She also spoke of how her mother passed away at the hospital. The closure was personal.


Citizens Memorial Healthcare, from the neighboring community of Bolivar, Mo., will be opening a seven-day-a-week clinic in Osceola. Residents still will have a local ambulance service. But they won't have a hospital. And they remain concerned about their future.

At the meeting they expressed concern about the loss of jobs and services. Community members wanted information about what will happen when there are emergencies. They wondered what to do when the clinic was closed, about how the closure would affect the football team and law enforcement. The question was asked, "Will the community unravel if we lose the hospital?"

I was reminded of Elizabeth Kubler-Ross' five stages of death and dying. Most of the attendees had moved through the denial, anger, bargaining and depression stages. They were – reluctantly – moving on to acceptance.

It's clear to me that no sympathy card can assuage a community's pain from such a significant loss. And too

few policymakers – those with the tools to make a difference – understand that they hold the keys to the front door of hospitals throughout rural Missouri and rural America.

The trip to Osceola was my first public meeting about a hospital closure. I hope it is my last. I'm afraid it won't be. 

Herb B. Kuhn is the Missouri Hospital Association's president and CEO. He joined NRHA in 2014.

Crisis plan

The National Rural Health Association has a plan to help stop the rural hospital closure crisis. Learn about it in Accelerating Advocacy on page 47.

And plan now to advocate for rural patients and providers at NRHA's 26th annual Rural Health Policy Institute Feb. 3-5 in D.C. Register at RuralHealthWeb.org/pi.

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Rural clinic, hospital leaders convene in KC

More than 500 clinic and hospital colleagues joined the National Rural Health Association Sept. 30-Oct. 3 in Kansas City for the 13th annual Rural Health Clinic and Critical Access Hospital Conferences, NRHA's fastest-growing events.

NRHA CEO Alan Morgan and Hamilton County (Kan.) Health CEO Bryan Coffey were interviewed on-site for a national radio show about the rural hospital closure crisis and the work being done to reverse this trend.

"There are 283 hospitals now that have the potential to shut their doors in the coming year," Morgan told the Agritalk host and listeners. "We've got to do a better job of having our champions carry our water at the state and federal level in keeping rural health available, and more importantly, making sure that the rural lifestyle is one that we can continue to enjoy.

Until such time that Congress and the Administration put a commitment behind ensuring that we have rural hospitals and rural doctors out there, this crisis is going to continue to expand."

NRHA also partnered with Safety Net Hospitals for Pharmaceutical Access to host a free post-conference forum on the federal 340B drug discount program.

Plan now to join colleagues from across the country for next year's rural clinic and hospital conferences Sept. 29-Oct. 2 back in K.C. Presentation submissions will be accepted at RuralHealthWeb.org for the 2015 events beginning in March.



Clockwise: Sarah Young, John Gale, Gail Nickerson and Paul Moore chat at the conference reception. Kayur Patel presents on health reform's impact on rural health clinics, patients and providers. Attendees visit with partners during the conference reception.



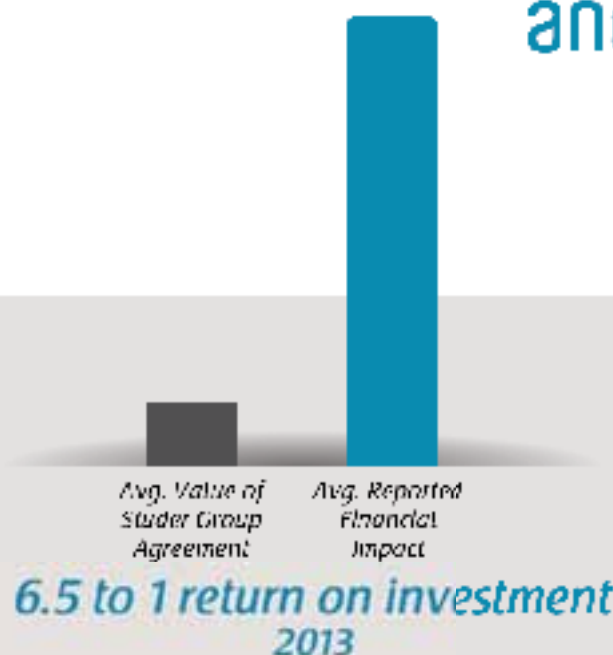
Clockwise: NRHA president Raymond Christensen gets a demo from an exhibitor. Conference attendees take advantage of a photo booth at the reception. Dan Collard gives the Critical Access Hospital Conference keynote address. Kristi Martinsen presents on the future of the Medicare Rural Hospital Flexibility Grant Program.

More friendly faces

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



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— Mike Schafer, CFO, Spooner Health System (Spooner, WI)



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Leslie Corbett, winner of "I love American Sentinel" student Facebook photo contest.

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Get to know incoming NRHA president Jodi Schmidt



Jodi Schmidt

In 2015, Jodi Schmidt will become the National Rural Health Association's 10th female president. She has been an NRHA member for 23 years and has worked for Labette Health since 2010, serving as administrator of the 99-bed sole community hospital in Parsons, Kan., and three rural health clinics.

What is your most memorable moment in rural health?

My entire health care career has been with rural providers, joining Hays (Kan.) Medical Center in 1987 and becoming executive director of the Northwest Kansas Health Alliance in 1991, the same year I joined NRHA.

My most memorable day on the job came that same year, when Sen. Bob Dole was on-site to recognize ours as the first essential access community hospital/rural primary care hospital network in the country. I'd inherited

administrative responsibility for the network three days prior to our first survey under this new six-state demonstration program, making it especially gratifying to know we'd been successful.

There were many more challenging days to come, including some spirited town hall meetings as communities contemplated conversion to this predecessor of the critical access hospital program. But as we grew from three members to 12, and ultimately 24 rural hospitals, the network's focus on clinical quality made it clear any bumps in the road were worthwhile.

I keep a picture from that day on my desk as a reminder of what can be accomplished when we come together for a common purpose.

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

My mother was Australian, serving as a nurse with a "flying doctor" service in the Outback before I was born. Growing up an Air Force brat, we did return to her home country for a year, where I attended kindergarten and spent a month in an Australian hospital after a ruptured appendix.

Later we lived in an old home in Sacramento, Calif., above the doctor's office where my mother worked, which became my after-school playground.

She later became director of nursing in a local hospital, which I visited often enough to decide I did not have what it took to be a nurse and would never work in health care. Yet somehow, that's exactly where I landed, years after her death. And I am certain she's up there smiling about that.

It's interesting to read the letters my mother wrote during her years in the Outback, underscoring the challenges of distance, access and workforce. Her descriptions of their transportation and telemedicine applications – tiny rotor-wing planes and ham radios – are also fascinating.

In so many ways, those challenges are the same we

face in rural health care today, although a world away in both geography and technology. And how we manage those challenges, through collaboration, hard work and determination, remains the same as well.

I suppose her letters and example are why I've chosen to work in rural health care rather than urban, knowing it provides an opportunity to truly make a difference in people's lives.

Over the years, NRHA has provided the foundation for individuals like me to come together and make a difference in the broader health care landscape. The NRHA team analyzes industry changes and their impact in a way that those of us working to keep our organizations operating just don't have the time to do on our own, which allows me to do a better job for our organization, day in and day out. Staff also takes input from the Government Affairs Committee, Policy Congress and members around the country to the decision makers in D.C., making certain our voices are heard throughout the year.

What are some of rural health care's biggest strengths?

Rural care offers exactly what health reform is about: strong primary care, coordination between local and regional providers and dedication to improving the health of the people we serve. And in rural communities, implementing evidence-based practice is not akin to turning a battleship, as with large organizations.

We are nimble, thoughtful and dedicated providers, literally caring for our friends and neighbors.

With the right financial support for the rural safety net and concentrated strategies to communicate everything we bring to the table in this new environment, our ability to thrive under these new models of care is our greatest asset.

Tell us about your family.

My husband, Dave, sold his real estate company when I accepted the Labette Health position and now works with a physician recruitment firm in Kansas City. Our oldest, Christopher, manages on-site implementations




Jodi Schmidt's mother Shirley Johnston returns an infant to its Aboriginal tribe in the Outback of Australia after treatment in 1959. Johnston was a nurse with the country's Flying Doctor Service. Schmidt says her mother's career inspired her to work in rural health.

for a health IT vendor, traveling across the country and internationally. With a degree in business, T.J. is a wellness coach and certified personal trainer, leading an unbelievably healthy lifestyle he did not inherit from his mother. And my daughter, Taylor, is a recent graduate of the University of Kansas managing a partner store for a fashion design company.

We remain a close family and take off for one week every year on a cruise ship, unplugging from all the myriad electronic devices and just enjoying ourselves.

What is your favorite way to relax?

My three grown and ornery children recently bought me a sparkly red Snow White headband in an attempt to mock my efforts to feed the wildlife in our backyard. But watching the deer, fox, squirrels and birds, often with a glass of wine in my hand, has become my preferred way to relieve stress. 

Members on the move

Longtime rural health pro celebrates retirement



Lynda Bergsma

After a 27-year career working to improve rural health, former National Rural Health Association Rural Health Fellow Lynda Bergsma, PhD, retired earlier this year.

She most recently worked as director of the State Office of Rural Health Program at the University of Arizona Center for Rural Health in the Med and Enid Zuckerman College of Public Health. She was also an assistant professor at the university.

In retirement, Bergsma is looking forward to traveling – a cruise through the Panama Canal is next on her list. She also plans to spend time with family and friends.

“One of the best things NRHA did for me was select me as a 2009 Rural Health Fellow,” Bergsma says. “The training I received and the people I got to know through this fellowship opened up so many opportunities for me to serve NRHA and rural health on a national basis, as well as attend more to policy issues in Arizona.”

Bergsma joined NRHA in 1981.

NRHA member becomes hospital association vice president



Andy Fosmire

Andy Fosmire recently became vice president for rural health at the Oklahoma Hospital Association (OHA).

Previously, Fosmire worked as executive director of Rural Health Projects Inc. and the Northwest Oklahoma Area Health Education Center for 14 years, as well as managing director of the Rural Health Association of Oklahoma for nine years.

In his new role, Fosmire will serve as a liaison to rural members of the association and work to strengthen health care services and outcomes in rural Oklahoma.

“The National Rural Health Association has been invaluable in filling

my knowledge gaps over the years and helped prepare me for this new challenge with the Oklahoma Hospital Association,” Fosmire says. “It’s the great combination of everything NRHA has given me access to: attending workshops and conferences, being a member of the State Association Council, learning to be an effective policy advocate. One of my first tasks at OHA will be a new membership in NRHA.”

Fosmire joined NRHA in 2008.

New state association leader aims to address hospital closure crisis



Sandy Hayes

Longtime public and rural health worker Sandy Hayes recently became executive director of the Rural Health Association of Tennessee.

In her new role, Hayes plans to address the rural hospital closure crisis

and study options to keep small hospitals open.

“I have joined a solid membership who desires to help assure rural considerations are given when there are discussions of improving both access and quality health care,” Hayes says. “There is no better time than now to be a part of the Rural Health Association of Tennessee.”

As a former National Rural Health Association Rural Health Fellow, Hayes has utilized NRHA’s resources to address legislative matters and better understand the legislative process.

“I count one of my most trusted resources for rural health information to be the National Rural Health Association,” she says. “It is understood that the 21,000-plus members of the association are a major voice for rural populations.”

Hayes joined NRHA in 2011.

Rural Health RoundTable gains new leader



Kim Mohan

NRHA member Kim Mohan was recently appointed as executive director of the New England Rural Health RoundTable, a collaborative organization that serves six states. Mohan previously served on the RoundTable's

board of directors and worked at the Northeast Telehealth Resource Center.

In her new position, Mohan plans to help RoundTable members build relationships with each other and with state, regional and national entities. She also plans to address challenges and organizational barriers created by the organization's regional nature.

"NRHA continues to serve as a valuable resource for me professionally," Mohan says. "The high-quality educational opportunities are complimented by valuable networking opportunities."

Mohan joined NRHA in 2010.

Rural health researcher earns promotion



Davis Patterson

After becoming deputy director of the WWAMI Rural Health Research Center last November, Davis Patterson was promoted to research assistant professor in the University of Washington Department of Family Medicine in May.

Patterson previously worked as a research scientist at the university for five years.

In his new position, Patterson will lead research projects and help oversee all aspects of the WWAMI Rural Health Research Center, including management of the center's cooperative agreement with the Office of Rural Health Policy, its largest source of funding.

"The research we do is meant to provide policymakers and practitioners with information they can act upon," Patterson says. "Our success depends on being grounded in the health issues that are most important to rural communities. The National Rural Health Association gives me that essential grounding. NRHA events and resources allow me to connect with those who are actually providing the care and making the decisions that have an impact on the health of rural people. It's a place where I can share what we are learning and learn from others."

Patterson joined NRHA in 2009.

Former Rural Health Fellow becomes associate dean



Kathleen Quinn

After serving as program director at the University of Missouri Area Health Education Center School of Medicine for a decade, Kathleen Quinn, PhD, was promoted to associate dean.

In her new role, Quinn, a former National Rural Health Association Rural Health Fellow, will ensure all School of Medicine programs meet the health care needs in rural Missouri, including the university's Rural Track Pipeline Program. As part of her appointment,

Quinn has also been promoted to associate teaching professor in the Department of Family and Community Medicine.

Quinn is an active NRHA member. She regularly attends the Rural Health Policy Institute, has been involved with the Rural Medical Educators constituency group for 10 years, and served as senior co-chair of the Rural Medical Education Conference this year.

"Being a member of NRHA has been extremely beneficial," Quinn says. "Collaborating with others about rural medical education and actually contributing and gaining knowledge of best practices has been very satisfying and practical. Working with my rural colleagues always encourages me to move forward and do more."

Quinn joined NRHA in 1999.

Read more about the pipeline program Kathleen Quinn leads on page 12.

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NRHA news

NRHA, RAC partner for 3rd photo contest

The National Rural Health Association's Communications Committee has again partnered with the Rural Assistance Center (RAC) for the third annual Rural Lens competition.

Photos will be accepted through Dec. 20 across three categories: community and people; landscape; and rural health, a new category intended to highlight rural care.

"We all know that rural America has some of the most beautiful places on earth with the most dedicated and hardworking people in America," says Kristine Sande, RAC director and NRHA Communications Committee member. "There's nothing like sharing rural health pictures from scenery, community outreach and the wonderful people who serve our rural communities across the nation."

Modern Healthcare magazine recently published several Rural Lens photo submissions in its print issue featuring an article with comments from NRHA's Brock Slabach.

NRHA Facebook fans will select their favorite photos in early 2015. The grand prize winner will receive an iPad from the NRHA Partnership Program, and the winner in each category will have their image featured in *Rural Roads*.

Visit RuralHealthWeb.org for contest rules.

NRHA to accept award nominations

The National Rural Health Association will accept nominations for its 2015 Rural Health Awards at RuralHealthWeb.org Dec. 8 through Feb. 9.

Winners will be selected by a committee of NRHA members and honored during the 38th Annual Rural Health Conference April 14-17 in Philadelphia.

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

NRHA well-represented at White House Rural Council meeting

National Rural Health Association staff and members represented rural health providers and patients nationwide at this year's White House Rural Council Investment Conference, an event focusing on job creation and rural infrastructure investment.

USDA Secretary Tom Vilsack opened the conference with NRHA 2014 president Raymond Christensen, MD, NRHA CEO Alan Morgan and NRHA members Tommy Barnhart and Graham Adams participating.

"We were certainly pleased to see the focus on rural economic development," Morgan says. "Health care is an important aspect of local rural economies, and as such, it is necessary for NRHA to have a voice in this process."

The White House Rural Council announced a \$10 billion investment fund to promote rural economic development, and the president's Improving Rural Health Care Initiative also includes \$9.9 million in grants.

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



Alan Morgan

National Rural Health Association CEO Alan Morgan made *Modern Healthcare* magazine's 2014 list of the 100 Most Influential People in Healthcare.

Morgan has worked for NRHA for nearly 14 years and this is the third time he has made the annual list.

"It's great to see that readers of *Modern Healthcare* magazine recognize the efforts of NRHA," Morgan says.

Modern Healthcare's list honors individuals in health care who are deemed by their peers and an expert panel

Send your career updates
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to be the most influential individuals in the industry in terms of leadership and impact.

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 million votes were cast.

NRHA gathers foundations for rural health innovation

The National Rural Health Association hosted the second annual Opportunities for Collaboration in Rural Health Care meeting in May in Washington, D.C.

Then Health and Human Services Secretary Kathleen Sebelius opened the two-day meeting of staff from 50 foundations gathered to help generate new ideas and gaps in rural research for developing innovative rural health programs.

"Private sector foundations play an important role in

rural health innovation," says Alan Morgan, NRHA CEO. "We are excited that NRHA can provide the leadership necessary to bring together leading national foundations, highlighting opportunities to transform our nation's rural health system."

The meeting is designed to foster public-private alliances to address rural health issues and stems from NRHA's partnership with the federal Office of Rural Health Policy, on behalf of the White House Rural Health Council and Grantmakers in Health.

"After attending the first meeting last year, the first action I took after hearing about all the great efforts in rural was to make our foundation a member of NRHA," Charles Dwyer, Maine Health Access Foundation program director, said during the 2014 meeting.

Rural training track program enters fifth year

The Rural Training Track Technical Assistance (RTT TA) Demonstration Program has entered its fifth year.

The program, funded by the federal Office of Rural Health Policy (ORHP) and administered by the National Rural Health Association, is



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accelerating advocacy

NRHA launches plan to prevent further rural hospital closures

Rural America is facing a crisis. Dozens of rural hospitals have closed since 2013, and more are expected to shutter without local, state and federal intervention.

Already the communities that many of you call home are facing the loss of vital health care services and the economic loss of local jobs. Many rural hospitals across the country are on the verge of closure as Congress continues to make further cuts to rural hospital reimbursements. A recent study showed 66 percent of the nation's rural hospitals are operating at a financial loss.

To stop further cuts, restore expired and reduced payments and promote a pro-rural legislative agenda, the National Rural Health Association is launching a battle plan. NRHA will continue to fight to eliminate cuts in reimbursement in Medicare and Medicaid and support pro-rural provisions to stabilize the rural health safety net. NRHA has also developed a policy paper, "The Future of Rural Health," which could transform health care in rural communities.

"In launching this advocacy campaign for rural hospitals, we're going to ensure rural hospitals are protected and rural patients are able to access quality, affordable health care," says Alan Morgan, NRHA CEO. "It's a significant step forward as we continue to stop the bleeding of these hospitals and work to transform a vision of the future of rural health care."

NRHA invites you to join our campaign to save rural hospitals at the 26th annual Rural Health Policy Institute Feb. 3-5 in D.C. Visit RuralHealthWeb.org/pi to register today and save.

Read a member's concerns about further closures on page 34.



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— Brad Anderson
CFO, Community Memorial Hospital
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focused on supporting and developing “1-2” rural training track family medicine residency programs. The program provides RTT medical students with travel support for rural rotation opportunities and for their significant others to join them during on-site interviews. In addition to direct technical assistance to programs and developing programs, RTT TA also conducts research surrounding the impact of these residencies and their residents.

“NRHA is thrilled to continue its works with ORHP on this important project,” said Laura Hudson, NRHA RTT TA staff liaison. “This program supports not only the primary care residencies programs and their staffs, faculty members, organizations and rural communities, but it also directly supports and encourages medical students to train and remain in rural America.”

For more information on the program, including its research policy papers, visit raconline.org/rtt. To learn

more about RTT programs, read student reflections about their rural rotations and apply for travel support, visit the student site at traindocsrural.org.

NRHA receives recognition

The National Rural Health Association recently received the Kansas City Award for Health and Welfare for the second year in a row.

“This recognition is a direct result of the dedication and efforts of the staff and members of NRHA,” says Brock Slabach, NRHA senior vice president. “Our team is now a part of an exclusive group of associations that have achieved this selection.”

The Kansas City Award Program annually honors the accomplishments of organizations throughout the Kansas City area. Recognition is given to companies and nonprofits that have shown the ability to use their best practices and implemented programs to generate long-term value.

NRHA has offices in the Kansas City metro and in Washington, D.C.

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Flora of our founding fathers

The U.S. Botanic Garden is the setting of NRHA's congressional reception

The United States Botanic Garden (USBG) was designed as living art to uniquely display more than 13,000 biodiverse plants collected throughout the world.

USBG sits on more than five acres in the heart of Washington, D.C. It houses two courtyards, two galleries and a park that includes a rose garden, butterfly garden, lawn terrace, First Ladies' Water Garden and 12 unique habitats.

More than 200 years ago, George Washington had a vision for the U.S. capital city that included a botanic garden that would demonstrate and promote the importance of plants to the young nation. Established by the U.S. Congress in 1820, the U.S. Botanic Garden is one of the oldest botanic gardens in North America.

For the 21st Century, the garden is committed to educating the public about sustainability. Learn more about the USBG's sustainability efforts through the short film "America's Sustainable Garden," and take a virtual tour at usb.gov.

Wander through the garden on Feb. 4 when it's closed to the public for the National Rural Health Association's Rural Health Policy Institute congressional reception. Register at RuralHealthWeb.org/pi.



Photo by Ingfbruno

shifting gears

Thanksgiving is a great time to reflect and reassess your holiday preparations with a nod to sustainability.

Visit your local farmers' market to pick up locally grown produce as well as handcrafted goods.

And instead of throwing away any uneaten scraps, why not compost them instead?

If you're hosting a large group of people, it might be tempting to use paper plates and plastic cutlery, but all that paper and plastic ends up in our nation's landfills.

Off the beaten path

A town for "wi-fi refugees"



It's not uncommon to want to get away from it all. Secluded resorts and rustic properties from the foothills of Montana to the African Serengeti capitalize on the need to disconnect from the world and escape the busy rush of daily life, be it temporarily or permanently.

Located inside the Allegheny Mountain Range, Green Bank, W.Va., population 143, has attracted both scientists and techno-refugees due to its federally mandated lack of technology: It is home to the world's largest fully directional radio telescope, among other high-powered radio listening arrays.

The area is designated as the "National Radio Quiet Zone," where electromagnetic and radio broadcast equipment is largely forbidden. Even police and fire radio communications are strictly regulated and coordinated with scientists at the research station.

As of 2013, an estimated 36 people had moved to Green Bank to escape the effects of diagnosed electromagnetic hypersensitivity.



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