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Lisa Kilawee

Sun shining on rural

As I write this column from the village of Amherst, Wis., on a cool day, my mind wanders to thoughts of summer.

As the days become warmer and brighter, isn't it easier to be a little more hopeful about everything? Including the future of rural health.

Undoubtedly, rural Americans will continue to face issues accessing health care. However, summer is a time to consider limitless opportunities.

Despite the barriers, technology marches on, and telehealth activities continue to grow and bring improvements in care previously thought impossible.

We have a wealth of medical information available at our fingertips every minute of every day, which will continue to drive demand for more patient-centered care.

I encourage you to join us for the National Rural Health Association's Rural Quality and Clinical Conference in Oakland, Calif., July 13-15. This 12th annual event offers opportunities to learn about model programs and initiatives transforming care in rural communities. Gain the tools that can help ease the pain of those long winters of discontent in rural health.

Lisa Kilawee
2016 NRHA president

pit stop

things I picked up in this issue:

1. Rural Americans are more vulnerable to prescription painkiller abuse and overdoses, and the rate of opioid-related overdose deaths in non-metro counties is 45 percent higher than in metro counties, according to the CDC. *page 37*
2. "Allowing the current wave of rural hospital closures to continue defies our most basic values. The very institutions that trained me and cared for the people I love are facing extinction if nothing changes," writes one rural doctor. *page 18*
3. In addition to the redwoods, visitors to Oakland, Calif., will be excited to discover the many popular films set there. NRHA will host its 12th annual Rural Quality and Clinical Conference July 13-15 in Oakland. *page 39*
4. Approximately 15 percent of men and 30 percent of women in local jails have a serious mental illness. And one in four people killed in officer-involved shootings has a serious mental illness. *page 7*
5. As rural veterans return home, it's key for them to find employment in their communities. Clinics are working with the Department of Veterans Affairs on its compensated therapy work program to give them that opportunity. *page 16*

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First on the scene

Rural law enforcement learn mental health crisis skills

Story and photos by Miles Bryan

A few weeks after Cody, Wyo., Police officer Seth Horn completed crisis intervention training (CIT), he went out on a call to see a man who was potentially suicidal.

“I started speaking with this person, and some things were lining up with the report that we got,” Horn says. “And then, using the training, I started to ask some very specific questions.”

Horn wasn’t fresh on the force – he had encountered people in a mental health crisis many times. Before CIT, Horn might ask those people something along the lines of, “Are you planning on hurting yourself?”

But during CIT’s 40 hours of intensive training with other cops and local mental health workers on how to deal with people who have mental health issues, Horn learned that “Are you planning on hurting yourself?” is a vague question that can yield misleading answers. Some suicide methods might not be thought of as physically painful by the person in crisis.

So Horn went with something more difficult, but more direct: “Are you thinking about killing yourself?”

The man said yes.

“Those kinds of questions are uncomfortable to ask until you start doing it regularly,” Horn says. “And then it flows into the conversation. So it’s little things like that with the training that I think make a difference.”

Across the country, a law enforcement officer is often the first professional responder someone in a mental health crisis sees. That’s especially the case in Wyoming, where the suicide rate is double the national average, and the mostly rural state lacks the mental health resources of more urban areas.



Cody, Wyo., Police sergeant Bo Edgar and officer Seth Horn.

CIT has been used since the late 1980s by law enforcement agencies across the country to improve officers’ interactions with people in a mental health crisis. The program was introduced in Wyoming a decade ago, but it’s been slow to spread, especially to more rural communities.

Park County was treading new ground when it started crisis intervention training in 2009. Since then, the way the training was implemented in Cody and Powell, Wyo., has become a model for other small communities. But it’s been a long road to get there. And it didn’t start with the cops.

Terresa Humphries-Wadsworth is the director of statewide suicide prevention for the Prevention Management Organization of Wyoming. Back in 2009, she was working at a mental health center in Cody. At the time, the status of mental health services in the area was bleak.

“In 2009, we didn’t even have a psychiatrist,” Humphries-Wadsworth says.

She said Park County, like other rural counties in the state, lacks mental health professionals and psychiatric hospital beds. That means when cops can’t calm someone in a mental health crisis down, that individual may end up in jail. And Humphries-Wadsworth said the mental health professionals who were there weren’t communicating well with law enforcement.

In Park County in 2012, between 50 and 80 people were treated for serious mental health issues against their will; that year there were only around 200 such cases in the entire state.

“Really, it was a huge problem,” she says. “We said, ‘OK, let’s fix it locally. What’s the best thing we can offer with what we have?’”

continues



Powell Police chief Roy Eckerdt with an award from Wyoming's National Alliance on Mental Illness for his work on crisis intervention training.



Ashley Overfield at a Cody group home in Cody.

Humphries-Wadsworth and others in the local mental health community settled on crisis intervention training. But right away they ran into some problems. Training in cities like Cheyenne and Casper, Wyo., took 40 hours over the course of five days. Cody and Powell's much smaller police departments couldn't leave the streets empty to do that. And in Park County, almost everyone was going to have to get the training for it to be effective.

“We said OK, let’s fix it locally. What’s the best thing we can offer with what we have?”

Terresa Humphries-Wadsworth, Prevention Management Organization of Wyoming statewide suicide prevention director

“In big cities they have special teams that go out and do [interventions with people in a mental health crisis],” Humphries-Wadsworth says. “In small cities, they only have a couple officers on. You are the team.”

So Cody and Powell broke the training into two: a three-day session and a two-day session, held a few months apart. And they incentivized it by giving continuing education credits, which law enforcement officers are required to earn.

The last big barrier was convincing cops CIT was worth their time. Initially, many were skeptical of the notion that mental health workers knew how to police better than they did. Powell Police chief Roy Eckerdt said that the buy-in largely stemmed from the fact that local cops were just frustrated the same old strategies weren't working.

“We would deal with the frustration, as officers, of going to the same

house time and time and time again,” Eckerdt says, “because people weren't getting the resources that they need.”

The Powell Police Department doesn't have hard numbers on how CIT has affected its policing. But Eckerdt says since CIT, the number of cases labeled as related to mental health crises has gone up by about 50 percent, even though the total number of calls has stayed the same. According to Eckerdt, that means more cases are being recognized as related to mental health, and not shuffled into other designations like public nuisance.

Humphries-Wadsworth says she would like CIT to spread faster, but organizers can't pick up the pace alone.

“We are community-driven,” she says. “So the decisions about what happens in community, happens in the community. Wyoming doesn't like being told what to do.”

State organizers don't have the authority to mandate CIT for individual enforcement agencies. Humphries-Wadsworth says, so far, the training has spread in a piecemeal fashion: A police department will send one officer to a training happening somewhere else; he or she goes back afterward and makes the case to their coworkers that it's worth doing, and, eventually, that department starts planning its own training.

Humphries-Wadsworth says Douglas and Riverton, Wyo., are interested in starting CIT using Park County's idea of breaking the training into two sessions while Gillette, Wyo., just had its first session. But the process can take years from start to finish.

Ashley Overfield is thankful that her local cops in Cody have gone through crisis intervention training.

"I've lost track of how many times I've been arrested," she says, sitting in the basement of a Cody group home. "Probably 17, at least."

"We would deal with the frustration, as officers, of going to the same house time and time and time again because people weren't getting the resources that they need."

Roy Eckerdt, Powell, Wyo., Police chief

Overfield is 35, and her diagnosis of bipolar and schizoaffective disorder has contributed to frequent run-ins with the police over the years, as well as an attempted suicide. She has ended up in jail many times and says in the past officers could be aggressive, which make her crises worse. But Overfield says there has been a real change in the last few years. Recently her mom called the police to do a welfare check on her.

"Three officers showed up at the house. They were all very calm, nice, respectful. And it made things a lot smoother," Overfield says. "I was more willing to just go with the flow." 

This story originally aired on Wyoming Public Radio on Jan. 8, 2016.

Insights on intervention

Each year, 2 million jail bookings involve a person with mental illness.

Approximately 15 percent of men and 30 percent of women in local jails have a serious mental illness.

One in four people killed in officer-involved shootings has a serious mental illness.

Since 1988, the National Alliance on Mental Illness and its national network of local and state organizations have partnered with law enforcement agencies on Crisis Intervention Team (CIT) programs, which help law enforcement cope with difficult calls for service and increase safety for officers, individuals in crisis and bystanders.

In more than 2,700 communities, CIT programs have provided training for officers.

Training elements

CIT programs provide officers with 40 hours of intensive training, including:

- learning from mental health professionals and experienced officers.
- personal interaction with people who have experienced and recovered from mental health crises and with family members who have cared for loved ones with mental illness.
- verbal de-escalation skills.
- scenario-based training on responding to crises.

Benefits of officer training

CIT gives officers more tools to do their job safely and effectively. It helps keep people with mental illness out of jail and get them into treatment, where they are more likely to get on the road to recovery.

- After the introduction of CIT in Memphis, Tenn., officer injuries sustained during responses to "mental disturbance" calls dropped 80 percent.
- Compared to other jail diversion programs, officers say CIT is better at minimizing the amount of time they spend on mental disturbance calls, more effective at meeting the needs of people with mental illness and better at maintaining community safety.
- Pre-booking jail diversion programs, including CIT, reduce the number of re-arrests of people with mental illness by 58 percent. Individuals who encounter a CIT-trained officer receive more counseling, medication and other forms of treatment than individuals who are not diverted — services that keep them out of expensive jail beds and hospitals.

Learn more at nami.org.

Source: *National Alliance on Mental Illness*



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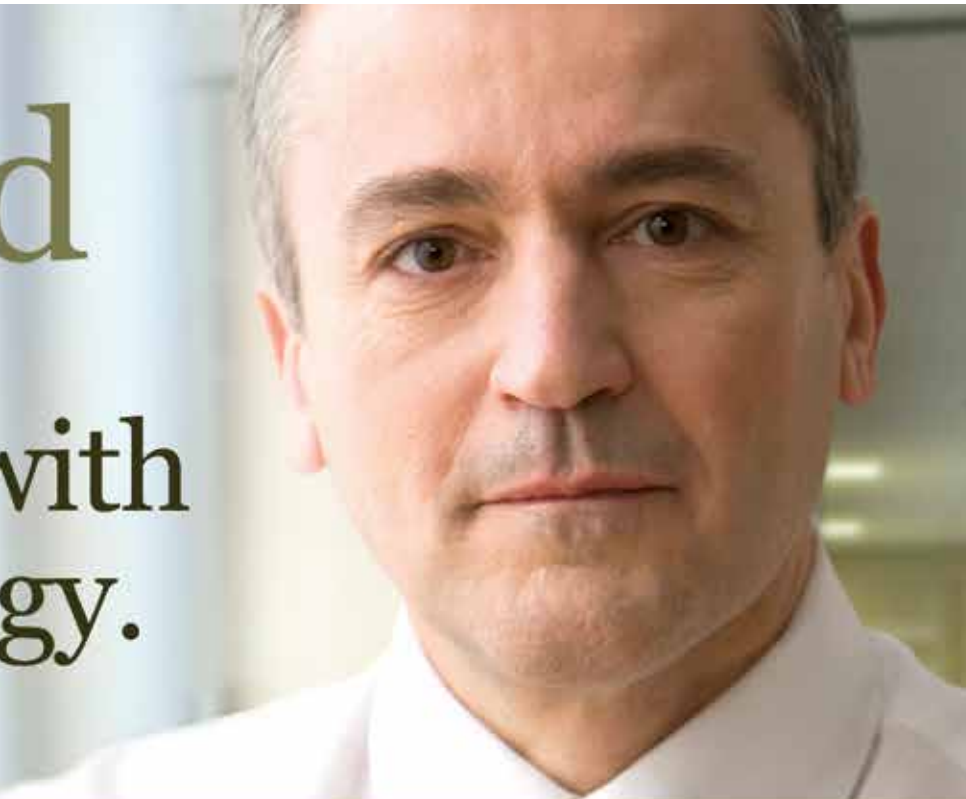


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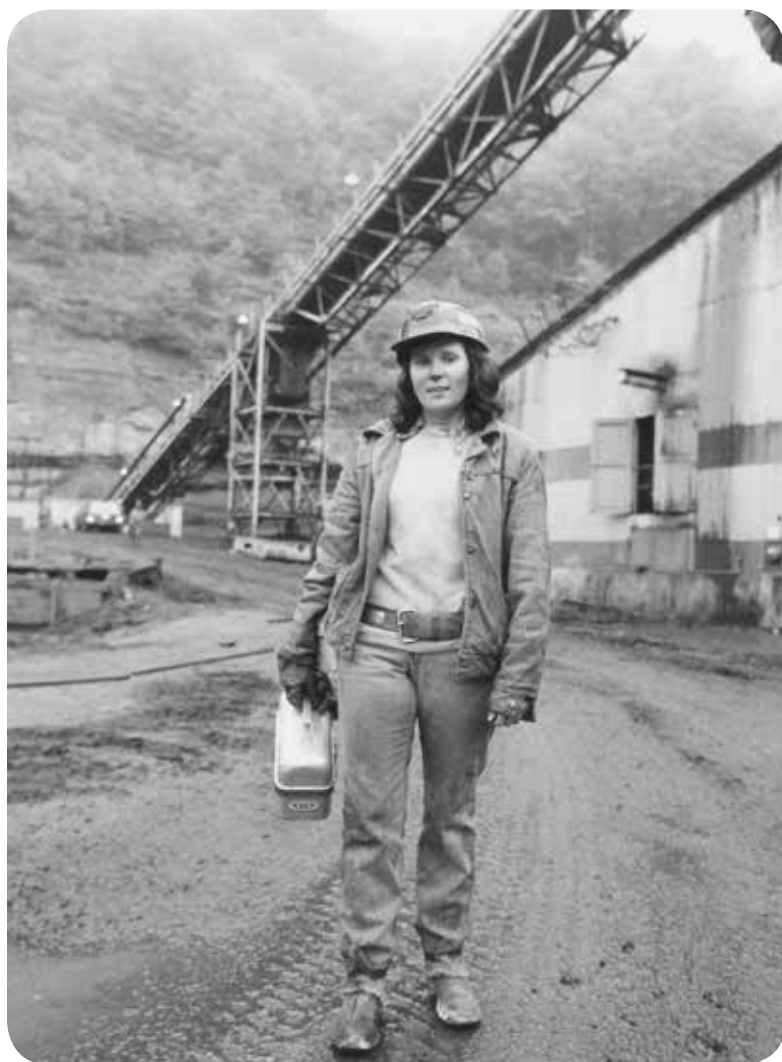
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Coal dust and camaraderie

Tales from women working in mines

By Allison Hutchings and Bethany Applebaum



In 1979, Linda King found working as a roof bolter's helper at the Bullitt Mine in Big Stone Gap, Va., more challenging and better paying than her previous job in a garment factory. Photo by Kenneth Murray via the National Archives.

Today, women comprise a little more than 5 percent of the coal mining workforce, according to the Bureau of Labor Statistics. However, back in the 1960s and early 1970s, few women worked in the industry, and those who did typically held clerical or service positions, which often paid less than production positions. The first female coal miner was officially hired in 1973 in West Virginia.

The increased readiness of women to demand entry into a wide range of higher-wage occupations previously reserved exclusively for men, coupled

with a number of successful legal actions filed under federal or state equal employment opportunity laws, resulted in the number of women employed in coal mining doubling between 1975 and 1979, according to a 1981 article in *The Monthly Labor Review*.

In 1976, a former female miner from Kentucky, with a daughter and a nephew to raise on her own, sought a higher-paying job working in the mines. At the time, she was making \$3 per hour as a surgical technician, while the mines paid \$10 per hour.

“They say that coal mining gets in your blood, and I believe it.”
former female coal miner

Another woman explains, “I was divorced with two kids, making \$4 an hour, no insurance. The decision to go to work in the mine was simple: It paid more than double. By the time I retired, I was making \$140 per day.”

The work was hard, the hours long, and it could be dangerous, but these women were determined to provide a good life for their families.

By 1982, women constituted around 8.6 percent of all new underground miner hires. However, subsequent declines in the coal mining industry meant that female coal miners were often the “last hired, first fired,” according to a 1988 *Christian Science Monitor* article.

But women didn't necessarily feel unwelcome in the mines. One woman relayed that she “never had no trouble from men . . . Some guys would tell [women] which guys to avoid or who not to bother. By the time I retired, some of the men I was told not to bother became my best friends.”

Another woman recounted that although some men said they didn't want to work with her because she worked them hard, “we were like brothers and sisters, all of us.”

continues on page 15



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continued from page 13

Although these miners reminisce with fondness about the camaraderie they felt working in the mines, the job often took a toll on their health. They endured physical trauma, such as knee and shoulder injuries, and some suffered from black lung disease, also known as coal worker's pneumoconiosis, caused by the inhalation and accumulation of coal mine dust in the lungs.

The Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) funds black lung clinics around the country to provide medical services, outreach and education, and benefits counseling to coal miners and their families regardless of their ability to pay.

From July 1, 2014, to June 30, 2015, these FORHP-funded black lung clinics provided services to nearly 12,000 active, inactive, retired, and/or disabled coal miners, fewer than 1 percent of whom were women, according to grantees.

Although women represent a small portion of the patient population in the black lung clinics, clinic staff report that these women often differ from men in unique ways.

Laura Creager, a benefits counselor at the Coal Miners' Respiratory Clinic of Owensboro Health Muhlenberg Community Hospital, a FORHP-funded black lung clinic in Greenville, Ky., notes that the women she sees in the clinic are "exceptional historians." She says this is an asset, particularly in the context of the black lung benefits claims process, which relies "so heavily on the details of what claimants physically endured during their entire mining tenures."

Cecile Rose, MD, director of the Miners Clinic of Colorado in Denver, agrees that women miners are typically both "excellent historians and vivid storytellers. Many overcame phenomenal odds to work alongside men in a setting that wasn't always hospitable to their health and welfare."

Creager says she has noticed that female miners were less likely to smoke than male miners. Akshay Sood, MD, and colleagues at the University of New Mexico and Miners Colfax Medical Center, another HRSA-funded black lung clinic, have noticed similar trends among coal miners in the Southwest, with data




Staff of the Coal Miners' Respiratory Clinic of Owensboro Health Muhlenberg Community Hospital. Front row: Krystal Hambrick, Sanjay Chavda and Laura Creager. Back row: Sandra Gootee, Kim Brumfield, Donald Givens, Malinda Hale, Martha Roberts and Paige Bilbro.

suggesting that female coal miners are significantly less likely to have ever smoked or consumed alcohol than their male counterparts.

Creager has also observed that the women she assists who used to work in the mines "worked at faster speeds and for longer periods of time" to compensate for their smaller statures.

This was especially difficult given that equipment for women did not always exist. As one former miner recalls, for a long time, "They didn't have miners' boots for women, and the men's boots were heavy. Women didn't have any special clothing. We all wore the same equipment."

But she wasn't complaining: "They say that coal mining gets in your blood, and I believe it." 

Allison Hutchings is a public health analyst in HRSA's Federal Office of Rural Health Policy, and Bethany Applebaum is a public health analyst in HRSA's Office of Women's Health.

Dig deeper

Review current federal Black Lung Clinics Program initiatives and funding opportunities at [hrsa.gov/gethealthcare/conditions/blacklung](https://www.hrsa.gov/gethealthcare/conditions/blacklung).

And read about HRSA's focus on women's health at [hrsa.gov/womenshealth](https://www.hrsa.gov/womenshealth).

Rural clinics provide care to veterans close to home

By Angela Lutz



John Mengenhausen

For John Mengenhausen, CEO of Horizon Health Care in Howard, S.D., the challenges of caring for veterans in rural and frontier communities require innovative solutions.

In operation since 1977, Horizon now has 19 medical clinics and five dental clinics across the state, many in communities of less than 1,000 people.

For the last 15 years, Horizon partnered with the Department of Veterans Affairs (VA) to bring care to rural veterans at four community-based outpatient clinics (CBOCs). With more than 800 similar locations across the country, VA CBOCs help veterans get the care they need closer to home.

Twenty-four percent of veterans – or 5.3 million – live in rural areas.

“Rural veterans in South Dakota face the same challenges the community members do, except maybe a little more extreme,” Mengenhausen says. “If they have a service-connected disability, they may have to travel 150 to 200 miles to the nearest VA facility to get care.”

Because CBOCs are linked directly to VA electronic medical records, staff can assist veterans with everything from acute care and mental health, to routine follow-up care and medication management. Due to the geographically remote nature of some rural communities and the nationwide shortage of rural health care providers, all 19 of Horizon’s locations have telemedicine capabilities, which allow patients and staff to connect with providers up to hundreds of miles away.

“Rural veterans in South Dakota face the same challenges the community members do, except maybe a little more extreme.”

John Mengenhausen, Horizon Health Care CEO

To increase rural veterans’ access to care, VA is expanding its community care model and increasing public/private health care partnerships. The Veterans Choice Program allows veterans to receive care within their communities if they live more than 40 miles from a VA facility or need to wait more than 30 days for VA medical care. Most of Horizon’s sites are located in areas that fill the distance gap for rural veterans.

“They’re well over 40 miles from the nearest VA facility,” Mengenhausen says.

Distance and travel barriers are especially significant for elderly veterans – and most of the veterans within Horizon’s patient population served in World War II or the Korean and Vietnam wars, according to Mengenhausen. The Veterans Choice Program allows Horizon to help these veterans remain at home as much as possible.


“A lot of older veterans tend to be on a lot of medication – it’s chronic care management,” he explains. “We work closely with their VA provider, so maybe they only have to go in once a quarter or every six months versus having to go back monthly.”

The desire to help veterans is personal as well as professional for Mengenhausen, as he and both of his sons are veterans.

Mengenhause is also starting his second two-year appointment on the Veterans Rural Health Advisory Committee, which works in collaboration with the VA Office of Rural Health to study and analyze the challenges rural veterans face when accessing health care and advise the VA secretary accordingly.

“It’s been a great opportunity to share a lot of the concerns coming straight from the front lines providing health care in small rural and frontier communities,” Mengenhause says.

This year Horizon also began working with the VA on its compensated therapy work program, a vocational rehabilitation program that matched several veterans with custodial jobs at Horizon’s clinics. They also signed an agreement with the Army Partnership for Youth Success program, which guarantees qualified veterans a job interview and possible employment.

“I look at it as a great recruitment opportunity for us, as well as an opportunity to help the veterans,” Mengenhause adds. “As [veterans] are coming home, it’s key for them to find employment in these small rural communities. If it’s their desire to come home and work, we’re giving them that opportunity.” 

Veterans Choice Program increases access to care

The Veterans Choice Program allows eligible veterans the choice to receive pre-authorized health care in their communities from community providers, rather than wait an extended time for a VA appointment or travel a significant distance to a VA medical facility.

The U.S. Department of Veterans Affairs recently modified the Veterans Choice Program to enhance veterans’ access to care and reduce payment delays for community providers.

Community providers enrolled in the program are no longer required to submit veterans’ medical records prior to payment. This increases the speed with which Veterans Choice Program third-party administrators are able to pay providers.

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Rural doctor's take: What a hospital closure really means for a rural community

By Christine Hancock



Christine Hancock

After 66 years in business, my hometown hospital recently closed its doors to patients. Gone is the emergency room, skilled nursing facility, lab, radiology, and physical therapy services — as well as 67 full-time jobs.

Meanwhile, in the past six years, 72 rural hospitals in the U.S. have closed, including nine already in 2016.

One in three rural hospitals is at risk of closing, and according to the National Rural Health Association's *Journal of Rural Health*, closure rates have increased 600 percent in the past five years.

Across the country, small towns are literally losing their lifelines.

What gets lost in this story is what these closures mean for the towns whose hospitals are shuttered. Sure, it's obvious that jobs, public safety and community institutions are at stake. But what are we really doing by letting

these institutions die? Where is this all going?

I was fortunate enough to have been raised in a town of 2,000, and I've also had the chance to see the world beyond its horizons. My first job at age 12 was cleaning the house where the emergency room physicians stayed while they took call for our ER.

“The very institutions that trained me and cared for the people I love are facing extinction if nothing changes.”

I've also worked as an EMT on our local ambulance and a medical assistant in our rural health clinic. I went to college and earned a master's degree with research focused on rural physician recruitment before pursuing medical school and a family medicine residency. My parents and extended community still live in the small town where I grew up.

I have been shocked by the latest series of hospital closures, which are rivaled historically only by the closure of 440 U.S. hospitals in the 1980s resulting from changes to how Medicare paid for their services.

In addition to my hometown hospital, five others that I have worked at or gotten to know through my research have either closed or are teetering on the brink.

The very institutions that trained me and cared for the people I love are facing extinction if nothing changes. And so I return to this central question: What does it really mean for a town to lose its hospital?

The first loss is a sense of safety and security, one that is backed up by hard evidence. A 2014 study in *Health Affairs* showed that the death rates for patients in towns where the ER recently closed increased 5 percent across the board and 15 percent when patients had a heart attack or stroke.

This study didn't analyze data on major trauma, where the time between getting injured and receiving

care is even more critical. Heaven forbid one of my own parents suffered a stroke or a heart attack; they would likely be outside the window for brain- or heart-saving medications with their current travel time to a facility with an ER.

Any patient with seizures, anaphylaxis or any other life-threatening medical condition would literally have to consider moving out of town to a place with better access to care. In Tonopah, Nev., a recent hospital closure means that residents have a 110-mile drive across state lines to the nearest emergency room.

A shuttered hospital is also a near-death sentence to many small-town economies. On average, according to the *Health Services Research Journal*, closure of a local hospital reduces per capita income by \$703 and increases unemployment by 1.6 percent. Undoubtedly, the more remote the community, the greater the effect, since lost jobs can't be replaced by people driving to other nearby communities to find work.

Hospital closures also drive down property values, make towns far less attractive to retirees with their often complex health problems, and gut the local professional community, taking a hit on local pharmacies and other local health-related businesses as well. My hometown pharmacy was in the process of being sold when the hospital recently closed, and now that sale is anything but sure.

With doctors and other clinicians frequently employed by hospitals, the loss of a hospital can also mean the loss of nearly all medical care in that community. A patient's doctor for the past five, 10 or 20 years can move on despite a heartfelt commitment to rural health and his or her patients. An ambulance service can disappear, leaving residents to drive deathly ill friends and family members to the hospital without any medical support.

Providers who cost tens of thousands of dollars and months or years to recruit can all be gone within weeks. Without a hospital to support them, many move on to more sustainable medical communities where they have more resources and are less isolated.


Finally, as in my case, hospitals are frequently a key provider of career opportunities and a path to the

middle class for rural people who often have few options besides leaving town to be educated elsewhere. They are sources of the "homegrown" rural clinicians and health professionals that every government program is struggling to produce and retain.

"Above all, as a nation, we have stood up again and again to support equality, access and fairness. Allowing the current wave of rural hospital closures to continue defies our most basic values."

I have seen dozens of classmates and friends start as hospital cafeteria employees or laundry workers and rise through the ranks of CNAs, EMTs, nurses and physicians during their careers. Few other institutions in small towns offer similar possibilities. By undercutting the hospitals that foster this process, we are reversing decades of work to improve the supply of rural providers and other health professionals throughout the country.

Above all, as a nation, we have stood up again and again to support equality, access and fairness. Allowing the current wave of rural hospital closures to continue defies our most basic values. It widens the gaps in a tiered system of health care where we support urban hospitals with our legislative and regulatory efforts and leave rural hospitals to struggle and die.

This is not acceptable. Please join me in supporting rural hospitals and the 62 million Americans who depend on them. 

Christine Hancock, MD, grew up in Lone Pine, Calif. She has been practicing family medicine at Sea Mar Community Health Centers in Bellingham, Wash., for the last three years and also works at Western Washington University as an adjunct faculty member in community health. She is a 2016 National Rural Health Association Rural Health Fellow.

Stop the bleeding

Seventy-two rural hospitals have closed since 2010.

And a recent study indicates 673 more are at risk of closure.

"The trend has escalated into a national crisis, and we believe it is the No. 1 crisis in rural health care delivery," says Maggie Elehwany, National Rural Health Association government affairs and advocacy vice president.

NRHA's bipartisan Save Rural Hospitals Act will create a unique payment designation to offer a path forward for struggling rural hospitals. Help protect vulnerable facilities by asking your representative to support the legislation today.

Learn more at RuralHealthWeb.org.

Rural health pros gather in Twin Cities

The National Rural Health Association's 39th Annual Rural Health Conference and inaugural Rural Hospital Innovation Summit brought more than 825 health professionals to Minneapolis to represent rural, network with colleagues, and participate in more than 70 diverse sessions related to rural health progress.

The events were preceded by NRHA's Health Equity and Rural Medical Education conferences.

The Annual Conference kicked off with a presentation by Regina Benjamin, MD, America's 18th surgeon general and founder of a rural health clinic, who spoke on the dynamics of leadership, ethics and human rights in health care. She also reminded attendees that healthy behaviors should be made enjoyable and invited them to join her and NRHA CEO Alan Morgan in a dance party.

"Dr. Benjamin is an inspiration to rural health advocates about what one determined and compassionate woman can accomplish to alter our course

to stand our ground as a lighthouse for rural America," wrote attendee Patty Crawford.

One of CNN's 10 Heroes of 2015, Rev. Richard Joyner presented an inspirational session on his work battling high mortality rates in his rural community of Conetoe, N.C., by founding a local movement for healthy living through hands-on farming.

NRHA also honored its 2016 Rural Health Award recipients during a conference luncheon. (This year's honorees are listed on page 34.)

NRHA's 40th Annual Rural Health Conference and second Rural Hospital Innovation Summit will be May 9-12 in San Diego. The 2017 Health Equity and Rural Medical Education conferences will be there on May 9.



Alan Morgan and Stephanie Pace congratulate Bill Sexton on his winning bid for NFL suite tickets and sideline passes donated by RX Waste Solutions for NRHA's Rural Health Foundation. Students and staff from the West Virginia School of Osteopathic Medicine gather for a group photo after presenting posters.



Clockwise: Regina Benjamin meets with attendees following her keynote address. Hubert Seiler congratulates Dustin Hager on being named NRHA's Rural Health Practitioner of the Year. Seilers won the award in 2014 and nominated his colleague, Hager, for the 2016 honor. Terry Hill, Paul Moore and Marsha Brand catch up at the conference. Attendees call Richard Joyner's session the most inspiring.



More friendly faces

Continue your trip down Memory Lane or see what you may have missed in Minneapolis with more photos from NRHA's spring conferences and other NRHA events at facebook.com/ruralhealth.



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Nicole Clapp, FACHE
President/CEO
Grant Regional Health Center



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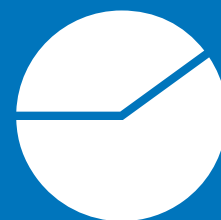


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Enjoying Oakland with an NRHA member

By Lynn Barr

Side trip



Golden Gate Bridge

I'm thrilled to welcome fellow rural health pros to Oakland, Calif., July 13-15 for the National Rural Health Association's 12th annual Rural Quality and Clinical Conference.

Sunny California is the perfect place to enjoy America's favorite pastime. See the Oakland A's play the Toronto Blue Jays at the Coliseum after NRHA's event.

Make plans to mountain bike or hike in the picturesque Oakland Hills.

And I highly recommend going for a three-mile stroll along the heart-shaped shoreline of Lake Merritt, home to the oldest designated wildlife refuge (1870) in the United States. After the conference concludes on July 15, stop by the lake and mingle with the locals for gourmet food trucks, local beer and wine, live music and dance lessons.



John Muir State Park

Take in the enormous redwoods at John Muir State Park in Marin County. Prepare to be amazed.

Both Rockridge and College Avenue offer great restaurants and unique shopping. Watch the street vendors in Berkeley on Telegraph Avenue, and

listen to the musicians on every corner.

Cross the Golden Gate Bridge by foot or by bike, or drive to beautiful Sausalito and the incomparable Stinson Beach.

I suggest taking the ferry from Jack London Square across the Bay to beautiful San Francisco.



Alcatraz

And no trip to San Francisco is complete without a trip to Alcatraz. Buy your tickets early, and remember that summer days on the Bay can get as cool as 50 degrees when the fog comes in, verifying what Mark Twain wrote: "The coldest winter I ever spent was a summer in San Francisco." It's sure to be a lovely change of pace for those from hotter climates.

Check out Oakland's famous film sites to explore on page 39.



Lynn Barr joined the National Rural Health Association in 2012. She is a 2013 graduate of NRHA's Rural Health Fellows program and will be presenting at this year's Rural Quality and Clinical Conference.

Branch out

Join experts and colleagues in Oakland, Calif., July 13-15 at NRHA's Rural Quality and Clinical Conference.

Visit RuralHealthWeb.org/quality for the agenda, scholarships and special rates.

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Beginnings & Passages



Julie and her father, John Middleton

“It was truly a privilege to train in a rural community.”

Med student looks forward to returning to rural

By Julie Middleton

Inspired by my dad, a general surgeon and advocate for rural trauma care, I knew as a child that I wanted to be a doctor.

Fast forward to college, where I worked at the Montana Office of Rural Health and Area Health Education Center. For over three years, I found myself immersed in an environment with a strong emphasis on improving the health care workforce.

Attending advisory board meetings, chatting with coworkers in the hallway, and perusing health care workforce reports brought to my attention the enormous need for providers in rural and underserved areas.

I discovered that most providers are located in three of Montana's 56 counties. Several counties still have no primary care provider at all.

I also learned about and developed unique ways to address health needs within rural areas. My work focused on comparing the population-level equivalent of clinical guidelines to what's actually happening in rural and frontier communities in Montana. The creativity and innovation of health care professionals in small towns was impressive, to say the least.

This was particularly true for Butte, Mont., where I recently completed six months of outpatient clinical rotations. Butte has an unparalleled sense of community, unlike anywhere I've encountered on the safari of medical school rotations.

Working closely with rural physicians passionate about providing care to the underserved, I felt at home in this close-knit community. With their guidance, I accomplished many educational milestones, including correctly diagnosing a disease and knowing the treatment, using a scalpel in the operating room, and completing an entire office visit in less than 30 minutes.

I encountered many typical situations for rural docs, like seeing my patients at the grocery store, limited specialty services, and challenges retaining physicians.

It was truly a privilege to train in a rural community and have the support of both students at my university and across the nation also interested in rural health.

At this point, I plan to apply to obstetrics/gynecology residencies and look forward to the day I can return to rural to serve patients, fill a need, and carry on the work inspired by my dad.

Julie Middleton is a third-year medical student in the Targeted Rural and Underserved Track at the University of Washington. She joined the National Rural Health Association in 2013, was a 2015 Rural Health Fellow, and is the current chair of NRHA's Student Constituency Group.

Innovative rookies and seasoned professionals share their experiences.

“I get to see the results of my work every day in people who might not be saying hello in the grocery or hardware store if I hadn’t been on call when they needed me.”



Tyler Hughes

For doc with conscience and heart, rural career a heck of a ride

By Tyler Hughes

In 1993 I was sitting at a stoplight in heavy traffic on the way between the five hospitals at which I practiced as a young surgeon in Dallas, Texas. At the time, carjackings were common in Dallas, and the part of town where I was driving was not one of the more exclusive neighborhoods. I was working 12 to 18 hours a day.

Additionally, my daughter was about to enter middle school, and we had just learned that armed guards would be part of her school security. Private school offered bankrupting tuitions and the chance for my children to live inside a well-feathered cocoon of affluent children.

At the same time, I had just been offered a job heading up a multispecialty group that was to negotiate managed care contracts. The catch was I’d have to give up operating.

I thought, “Is this the life I told the medical school admissions committee I wanted to pursue?”

The answer was no, of course. I decided it was time to take charge of my destiny rather than have my life drift in directions I didn’t find fulfilling. So I contacted a friend, Jim Peterson, who practiced in the small Kansas town of McPherson. He was a radiologist and seemed awfully happy.

Within two years I found myself in rural surgical practice. My first day on call was spent managing a woman bleeding out from placenta percreta (successfully, I might add). About 10,000 cases later, I find I’ve had a heck of a ride through surgery and life. At first, I didn’t know anybody in town, but now I know most everybody – and an awful lot of them have had a procedure by me.

It’s been a lot of on-call time and more than a few heartaches, but I can’t see myself going back, ever, to the big city. My patients and I need each other. I get to see the results of my work every day in people who might not be saying hello in the grocery or hardware store if I hadn’t been on call when they needed me. I’m now beginning to see the grandchildren of the grandparents I operated on two decades ago.

Rural practice kept me a doctor with a conscience and a heart. It led me into leadership roles I never dreamed would come to me. I never made a better decision than the one I made that day in Dallas in stop-and-go traffic to become a rural physician.

Tyler Hughes, MD, began as a general surgeon at McPherson Hospital in 1995. He was named the National Rural Health Association’s 2012 Rural Health Practitioner of the Year.

*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.*

Members on the move

Rural nurse leads HIT efforts



Shannon Adams

After working as a registered nurse in rural Kentucky for 20 years, Shannon Adams has accepted a position as project manager of Kentucky Rural Health Information Technology (KRHIT).

In her new role, Adams developed a patient navigation model called PACT (Project Affecting Care Transitions)

to help community members find their way in the ever-changing health care system.

“We’ve seen great success in the 10 months that we have been operating and are making a positive impact in the lives of our clients,” Adams says.

In January, Adams also assumed the executive director role at KRHIT, in which she aims to expand network membership.

“It has been a challenge coming from the hospital to community setting,” Adams says. “Patient issues in the community are a lot less controllable than in the hospital. National Rural Health Association publications have been a great resource for providing information on what’s happening in the rural scene. I enjoy being an NRHA member because, unlike other organizations, NRHA focuses on rural areas, and they meet me where I am as I tackle these issues.”

Adams joined NRHA in 2016.

NRHA member selected as president-elect of state association

After serving on the board for both Mississippi and Louisiana’s state rural health associations, Zach Allen was selected as president-elect of the Louisiana Rural Health Association, with his term beginning in 2017.

As senior vice president of strategy and business development for Children’s International Medical Group, Allen has been serving rural communities through pediatric clinics for many years. Children’s International has 16



Zach Allen

pediatric clinics with plans to expand its rural services.

“Anyone who wants to participate and find a leadership role in the rural health community, the opportunities are endless and the reward for doing so is even greater,” Allen says. “We have amazing associations through the National Rural Health Association and your state chapters to give us a venue and forum to really grow and network. If I have been able to jump into leadership so quickly, I think anyone who is equally motivated can do the same.”

Allen joined NRHA in 2016.

40-year rural health pro becomes hospital CEO

Pat Branco recently became CEO at Heart of America Medical Center in Rugby, N.D.

Heart of America is a critical access hospital (CAH), skilled nursing, assisted living and basic care facility where Branco looks forward to “helping the organization move forward on an adventure in the new era of health care delivery with a sense of hope and great optimism,” he says.

In a career spanning 40 years, Branco has served as the

Send your career updates
to editor@NRHArural.org.



Pat Branco

president of two CAHs, eight clinics and four physical therapy centers on behalf of Essentia Health Care in Idaho, as well as regional CEO of Ketchikan Medical Center in Alaska.

“It has been an incredible blessing to have learned of and become associated with the National Rural Health Association,” Branco says. “Finally an organization that understands the logistic and operational challenges faced in rural settings but also the incredible opportunity to deliver deeply personalized care to community of family, friends and visitors. NRHA has led the way in preserving rural medicine and advocating for sound policies enabling us to continue this trusted mission of service.”

Branco joined NRHA in 2009.

New role allows NRHA award winner to align time and talent

After serving as the chief of health and wellness for Mariposa Community Health Center in Nogales, Ariz., for the past eight years, Susan Kunz has accepted a new role as chief of program development for the organization.

Kunz previously worked in the community health services department, best known as Platicamos Salud (Let’s Talk Health) for its use of community health workers. Platicamos Salud was named the 2014

Outstanding Rural Health Program by the National Rural Health Association.

In her new role, Kunz will focus on fund development for the entire health center.

“Matching resources with needs has been my public health passion, so the ability to dedicate my time where my talents are is a gift,” she says.

“My involvement in NRHA has allowed me to connect with like-minded professionals that inspire me to better serve my own rural community on the U.S.-Mexico border,” Kunz adds. “I see the National Rural Health Association as an increasingly diverse cross-section of rural America.”

Kunz received NRHA’s 2013 Rosemary McKenzie Legacy Award. She also joined NRHA in 2013.



Susan Kunz

NRHA member focuses on addiction recovery in new position



Ashley Noland

A former program specialist at the West Virginia Higher Education Policy Commission Division of Health Sciences, Ashley Noland recently started working as statewide director of development at Recovery Point West Virginia.

Recovery Point encompasses four facilities, and Noland’s role incorporates public relations, fundraising, awareness and outreach

about West Virginia’s rampant addiction problem and high overdose rate. Recovery Point provides safe, sober housing and support for individuals wishing to recover from addiction to drugs and/or alcohol.

“The National Rural Health Association gave me integral skills to help me better advocate for underserved populations, including rural communities,” Noland says. “NRHA has provided me with opportunities

continues

continued

to hone my advocacy and communications skills and to network with other individuals. I am honored to have been able to work with and know such ardent advocates for rural health care.”

Noland joined NRHA in 2014.

Former NRHA employee heads primary care association



Shelly Ten Napel

Shelly Ten Napel recently accepted a position as CEO of the Community HealthCare Association of the Dakotas, the primary care association for North and South Dakota.

In her new role, Ten Napel will support and equip federally qualified health centers in the Dakotas and represent their interests at the state and federal level.

Ten Napel previously served as director of health care reform and innovation with the D.C. Department of Health Care Finance, where she worked with stakeholders and Medicaid staff to promote a value-based purchasing agenda designed to improve health outcomes and reduce disparities.

“As a former National Rural Health Association employee, much of my rural health care knowledge base comes from working with the association and its active and engaged members,” Ten Napel says. “We really can provide high quality care in rural settings when we work together, which is one of the central purposes of a primary care association.”

Ten Napel joined NRHA in 2016.

NRHA members serve on National Quality Forum committee



Ira Moscovice



Rob Schmitt

National Rural Health Association members Ira Moscovice and Rob Schmitt were recently nominated by NRHA to serve on the National Quality Forum's Attribution Committee.

The 26-member committee will analyze the different approaches to assign patients and their quality outcomes to organizations and clinicians and recommend how these approaches can be improved.

“NRHA has had an important influence on my career, including providing forums for me to present my research and discuss its implications with key policy-makers ... and organizing a network of professional colleagues with similar interests to mine that I network with,” Moscovice says.

“NRHA has always been a great resource, advocate and strong supporter of rural hospitals and rural advocacy issues,” Schmitt says. “They have always been there to support me, answer questions or provide information on how rural hospitals can remain strong.”

Moscovice joined NRHA in 1980, and Schmitt joined the association in 2013.

List of notable rural hospital CEOs includes 16 NRHA members

Becker's Hospital Review included 16 National Rural Health Association members in its 2016 edition of “50 Rural Hospital CEOs to Know.”

Leaders were selected based on rural health care awards received, rural health care committee and board involvement, regional and national leadership positions and organizational performance.

The list included the following NRHA members:

Donald Babb, Citizens Memorial Healthcare, Bolivar, Mo.

Darrold Bertsch, Sakakawea Medical Center, Hazen and Coal Country Community Health Center, Beulah, N.D.

Dennis Burke, Good Shepherd Community Hospital, Hermiston, Ore.

Charlie Button, Star Valley Medical Center, Afton, Wyo.

Jason Hawkins, J.C. Blair Memorial Hospital, Huntingdon and Fulton County Medical Center, McConnellsburg, Pa.

David Keith, McAlester (Okla.) Regional Health Center

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

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

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

Rachelle H. Schultz, Winona (Minn.) Health

Ken A. Shull, St. Luke's Hospital, Columbus, N.C.

Erik Thorsen, Columbia Memorial Hospital, Astoria, Ore.

Russell Tippin, Permian Regional Medical Center, Andrews, Texas

Randy Wertz, Golden Valley Memorial Healthcare, Clinton, Mo.

Gerald Worrick, Ministry Door County Medical Center, Sturgeon Bay, Wis.

Michael Zimmerman, Sierra Vista Hospital, Truth or Consequences, N.M.

Becker's names NRHA members to top nonprofit health care CEOs list

Becker's Hospital Review selected eight National Rural Health Association members in compiling its list of nonprofit hospital and health system CEOs to know in 2015.

The editors' list includes leaders of some of the largest and most prominent nonprofit health care organizations in the country.

The following NRHA members made the list:

James Hinton, Presbyterian Health Services, Albuquerque, N.M.

David Keith, McAlester (Okla.) Regional Medical Center

Mark Klosterman, Faith Regional Health Services, Norfolk, Neb.

Kelby K. Krabbenhoft, Sanford Health, Sioux Falls, S.D.

Kevin E. Lofton, Catholic Health Initiatives, Englewood, Colo.

John D. McConnell, MD, Wake Forest Baptist Medical Center, Winston-Salem, N.C.

Scott Reiner, Adventist Health, Roseville, Calif.

Nicholas Wolter, MD, Billings (Mont.) Clinic

NRHA members make ranked rural community hospitals list

The highest ranked prospective payment system hospitals in the country, as determined by iVantage Health Analytics, were recognized during the National Rural Health Association's inaugural Rural Hospital Innovation Summit in May in Minneapolis in May.

iVantage selected its "top 20 rural community hospitals" based on nine indices: inpatient market share, outpatient market share, population risk, cost, charge, quality, outcomes, patient perspectives and financial stability.

Eleven NRHA member hospitals made the list:

Aurora Lakeland Medical Center, Elkhorn, Wis.

Childress (Texas) Regional Medical Center

Delta County Memorial Hospital, Delta, Colo.

Hill Country Memorial Hospital, Fredericksburg, Texas

Pomerene Hospital, Millersburg, Ohio

Prairie Lakes Healthcare Systems, Watertown, S.D.

Ransom Memorial Hospital, Ottawa, Kan.

Sevier Valley Medical Center, Richfield, Utah

Spectrum Health Big Rapids Hospital, Big Rapids, Mich.

Spectrum Health Pennock, Hastings, Mich.

Valley View Medical Center, Cedar City, Utah



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National Healthcare Career Network

NRHA honors 2016 Rural Health Award recipients

The National Rural Health Association is proud to announce its 2016 Rural Health Award recipients. The following organizations and individuals were honored during NRHA's 39th Annual Rural Health Conference in Minneapolis in May.

"We're especially proud of this year's winners," says Alan Morgan, NRHA CEO. "They have each already made tremendous strides to advance rural health care, and we're confident they will continue to help improve the lives of rural Americans."

Outstanding Rural Health Program

Disparities Elimination Summer Research Experience, Statesboro, Ga.

Outstanding Rural Health Organization

Richard G. Lugar Center for Rural Health, Terre Haute, Ind.

Rural Health Practitioner of the Year

Dustin Hager, Heart of America Medical Center physician assistant, Rugby, N.D.

Louis Gorin Award for Outstanding Achievement in Rural Health Care

Lynn Barr, National Rural ACO founder, Nevada City, Calif.

Outstanding Researcher Award

Jacob Warren, PhD, Mercer University Center for Rural Health and Health Disparities endowed chair and director, Macon, Ga.

Student Achievement Award

Matt Workman, East Tennessee State University Quillen College of Medicine student, Johnson City, Tenn.

Student Leadership Award

Hallie Foster, University of Toledo College of Medicine and Life Sciences student, Toledo, Ohio

President's Award

Alana Knudson, PhD, NORC at the University of Chicago program area director and Walsh Center for Rural Health Analysis co-director, Bethesda, Md.

Volunteer of the Year

Janice Probst, PhD, South Carolina Rural Health Research Center director, Columbia, S.C.

John Snow Inc. provides scholarships to student awardees to participate in the NRHA conference, the largest gathering of rural health professionals in the nation.

NRHA co-launches National Rural Oral Health Initiative

The National Rural Health Association and the DentaQuest Foundation have created the National Rural Oral Health Initiative to improve oral health in rural America.

The National Rural Oral Health Initiative is the combined effort of NRHA and the DentaQuest Foundation to highlight best practices and improve oral health disparities in rural America through policy, communications, education and research activities.

As oral health issues have long impacted those living in rural communities, the activities included in this initiative are designed to enhance access to quality oral health care.

"We want to identify strategies that engage and establish oral health care as part of primary care," says NRHA CEO Alan Morgan. "NRHA looks forward to leveraging our national and grassroots partnerships as we launch this initiative to bring attention, education and action to address rural oral health disparities."

The first-ever national, rural-focused oral health initiative will highlight best practices, enhance research, advance policy and provide technical assistance for communities in need.

Learn more about this and other successful rural health initiatives at NRHA's Rural Quality and Clinical Conference July 13-15 in Oakland, Calif. View the full agenda and register at RuralHealthWeb.org/quality.

NRHA invited to White House

The National Rural Health Association was invited to the White House in March to learn about the president's Precision Medicine Initiative, a national effort to develop individualized clinical care.

"While it comes with many rural health questions and challenges, the primary goal for rural advocates is to ensure rural America is part of this new era of medicine and that rural patients are not left behind," says NRHA CEO Alan Morgan.

President Barack Obama specifically talked

about rural health and challenges for both patients and providers.

“This is the beginning of a new clinical era and a national effort to greatly improve care and treatment,” Morgan says. “I’m happy NRHA is included in this important national discussion as it moves forward.”

The initiative aims to make it easier for patients to access and share their own health data and engage patients as partners in research.

Attend NRHA’s Rural Quality and Clinical Conference July 13-15 in Oakland, Calif., to learn about the rural implications of the initiative. Register today at RuralHealthWeb.org/quality.

Apply now to become a Rural Health Fellow

The National Rural Health Association is accepting applications for its Rural Health Fellows program. The program aims to educate, develop and inspire a networked community of rural health leaders who will step forward to serve key positions in the association, affiliated rural health advocacy groups and local and state legislative bodies.

NRHA fellows meet in person three times throughout the year for intensive leadership and advocacy training. Fellows also participate in monthly conference calls to supplement their training, receive updates on legislative and regulatory concerns that impact rural health, and take part in a mentorship program with NRHA board members.

“It wasn’t until I was selected as an NRHA Rural Health Fellow that I genuinely understood the obstacles, geographical and policy, people residing in rural areas encounter on a daily basis,” says Jarod Thomas Giger, PhD, assistant professor at the University of Kentucky College of Medicine and College of Public Health.

Apply at RuralHealthWeb.org/go/fellows by Sept. 1 to be considered for the 2017 class.



Donor corner

Tommy Barnhart has given generously to the National Rural Health Association’s Rural Health Foundation each year since it was established in 2012.

Barnhart, Ten Mile Enterprises president, joined NRHA in 2003.

Rural Roads: Why is rural health important to you?

Barnhart: It’s long been important to me in part because of growing up on a farm but more importantly now because of the need I see as I work in various rural areas with providers.

Rural providers are incredibly dedicated to caring for their patients. They often lack the human and financial resources they really need to care for their patients and do the best they can with what they have.

Since rural providers and rural residents are often overlooked or taken for granted, they need advocates to help get them the resources they need, and NRHA has always been a significant source of that advocacy.

Rural Roads: Why do you support the Rural Health Foundation?

Barnhart: I served on the NRHA Board of Trustees when the foundation was established and totally believe in its mission to grow a permanent fund to assist in the development of rural health leaders.

I’m confident NRHA, assisted with the funding of this foundation, is in the perfect position to provide the training, program development and assistance rural leaders of the future will need.

NRHA thanks Tommy Barnhart for his ongoing contributions to the Rural Health Foundation.

For more information and to help build a permanent endowment for rural leaders, visit RuralHealthWeb.org/donate. Donations are tax-deductible.

caring for the future of rural America

NRHA, RHI Hub partner for 4th Rural Lens photo contest

The National Rural Health Association has again partnered with the Rural Health Information Hub for the fourth annual Rural Lens competition.

Photos will be accepted through June 17 across three categories: community and people; landscape; and rural health.

The contest is open to all NRHA Facebook fans, who will also select the

continues

continued

winning photos in July.

The winner in each category will have their image featured in *Rural Roads* and at NRHA events.

Visit RuralHealthWeb.org for contest rules.

NRHA internships prove valuable to students

Did you know the National Rural Health Association offers internships?

Jeslin Jose says her NRHA internship was invaluable.

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

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

Adam Ketchum served as NRHA’s program services intern in the spring. A sophomore at the University of Maryland-College Park, Ketchum is planning a career as a physician specializing in health disparities and global public health. During his time with NRHA, he focused on state and community responses to the opioid abuse epidemic in rural America.

“Working with NRHA has been a fantastic experience,” Ketchum says. “I’ve had the opportunity to meet and work alongside a variety of health care and policy professionals, as well as learn about the diversity of America’s own public health system through exploring the unique challenges facing health care in rural America, which, as a hopeful physician, has been a particularly eye-opening experience.”

Tim Dodd served as NRHA’s government affairs intern this spring. A junior at Wichita State University, Dodd is planning a career in foreign policy. During his time at NRHA, he examined the potential impact of international factors on rural health, focusing especially on the Trans-Pacific Partnership.

“I’d say getting a firsthand view of policy in process has been the most fascinating experience,” he says. “It’s wonderful seeing a diverse rural constituency sending a unified message for legislators.”

NRHA offers internships every semester. Learn more, apply and share this opportunity by visiting RuralHealthWeb.org/go/intern.

Present at NRHA’s biggest conference

The National Rural Health Association is accepting session proposals for its 40th Annual Rural Health Conference May 9-12 in San Diego.

Each year, more than 200 people present more than 55 educational sessions, 20 research papers and up to 100 research and educational posters.

Share innovative and effective models, policies, research and information and provide your colleagues with insights and best practices addressing many of the access, quality and geographic issues confronted by rural communities.

Session proposal submissions for the 2017 event are due by Aug. 10. Visit RuralHealthWeb.org for more information and to submit.

Call for health equity event presentations now open

The National Rural Health Association’s Health Equity Conference will be May 9, just prior to NRHA’s 40th Annual Rural Health Conference in San Diego.

This 22nd annual conference is designed for those who are dedicated to bringing quality health care and services to underserved and often under-represented portions of the rural population.

To submit session proposals for consideration, visit Ruralhealthweb.org/equity by Aug. 10.

NRHA hosts summer events in Bay Area

The National Rural Health Association’s 12th annual Rural Quality and Clinical Conference will demonstrate how to advance quality and clinical care from theory to practice July 13-15 in Oakland, Calif.

Kupiri Ackerman-Barger, PhD, will provide the keynote address on bringing diversity into nursing education and practice by promoting access to health care for rural and underserved populations.

Attendees will also hear updates from federal partners, clinicians, D.C.'s top rural health lobbyist and rural health and telehealth experts.

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

Scholarships are available and will be reviewed and awarded on a first-come, first-serve basis.

Arrive early for the State Rural Health Association Leadership Conference, an opportunity for state association leaders to enhance their skills and network, on July 13.

Register today at RuralHealthWeb.org/quality to save \$100.

NRHA hosts rural training track event

More than 90 participants, representing more than 20 rural training track (RTT) programs and numerous other stakeholders, gathered in February for the 2016 RTT Collaborative Annual Meeting hosted by the National Rural Health Association in Denver.

The sixth annual event brought together RTT site directors, program coordinators, faculty and RTT stakeholders from across the country to discuss opportunities and challenges.

"NRHA is proud to have been able to partner with all members of the Rural Training Track Consortium to help lead this important portion of the program for the last five years," says Amy Elizondo, NRHA program services vice president. "The results of the grants and partnerships that have been developed through this meeting have been key for ensuring the grant program's success."

The RTT Technical Assistance program provided content for the meeting as well as travel support as part of NRHA's cooperative agreement with the Federal Office of Rural Health Policy.

accelerating advocacy

NRHA supports, encourages federal efforts to halt opioid abuse

The opioid epidemic increasing across our country, and particularly rural America, is alarming.

Rural Americans are more vulnerable to prescription painkiller abuse and overdoses, and the rate of opioid-related overdose deaths in non-metro counties is 45 percent higher than in metro counties, according to the Centers for Disease Control and Prevention.

The National Rural Health Association is pleased by federal efforts to address opioid abuse, as a disproportionate number of rural communities struggle with prescription opioids and heroin abuse.

President Barack Obama named Secretary of Agriculture and White House Rural Council Chair Tom Vilsack to lead an interagency effort to combat the use and abuse of opioids and heroin.

Vilsack spoke at NRHA's Rural Health Policy Institute in February, promising to develop policy solutions that

will work in rural communities.

NRHA also applauds the recently passed Comprehensive Addiction and Recovery Act of 2016, which acknowledges that rural communities are especially susceptible to heroin and opioid abuse and mandates that the Federal Office of Rural Health Policy will join the Pain Management Best Practices Interagency Task Force.

"This will allow rural voices to be heard and be part of the solution," says Maggie Elehwany, NRHA government affairs vice president. "We applaud members of Congress for reaching across the aisle for a bipartisan agreement."

Learn about strategies to prevent and care for those with opioid addictions at NRHA's Rural Quality and Clinical Conference July 13-15 in Oakland, Calif. View the full agenda at RuralHealthWeb.org/quality, and register today to save \$100.

The Siemens logo is displayed in a bold, teal, sans-serif font. It is positioned in the upper left corner of the advertisement, set against a white rectangular background that partially overlaps the main image.

SIEMENS

The background image shows three young girls in the foreground, seen from behind, wearing hats and holding small American flags. They are looking towards a parade in the distance where many people are gathered on a street lined with trees and houses under a clear sky.

usa.siemens.com/healthcare

Your hospital is vital to the health of the whole community.

Siemens systems and solutions help you thrive, not just survive.

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Learn more about the solutions that can help you thrive, not just survive with Sustainable Healthcare Technology™ from Siemens.

Lights, camera, Oakland

In addition to museums, zoos and the Redwood Regional Park, visitors to Oakland, Calif., will be excited to discover the many popular films set in this city.

Baseball fans will recognize sites from **“Moneyball”** and **“Angels in to the Outfield.”**

For those who love Pixar films, Oakland is also the inspiration behind Fentons Ice Cream, the Merritt Bakery burger cake and the theater marquee from **“Up,”** as well as the lake in the middle of the city in **“The Incredibles.”**

You can also seek out key scenery from **“Mrs. Doubtfire,”** **“Who Framed Roger Rabbit”** and **“The Matrix: Reloaded.”** And its residents claim the Port of Oakland Cranes resembles the AT-AT snow walkers of the planet Hoth in **“Star Wars: Episode V The Empire Strikes Back.”**

For more on the location of scenes from these movies and others, check out visitoakland.org.

The National Rural Health Association will host its 12th annual Rural Quality and Clinical Conference in Oakland July 13-15.



Near the end of *“The Incredibles”* the protagonists enjoy ice cream on the curb in front of Fentons Creamery & Restaurant. Fentons is located on Piedmont Avenue. Photo via Visit Oakland.

Off the beaten path



Igloo City. Photo by Vincenzo Corbo.

Ice ice maybe

A remote tourist destination in Alaska (about 180 miles north of Anchorage) is about as far “off the beaten path” as it gets. But that is exactly where a traveler of George Parks Highway will find “Igloo City.” For some of us in these summer months, an igloo hotel might have its perks. Unfortunately, this would-be hotel is not up to code, and none of its owners have been able to execute the original vision and make the property inhabitable.

This often-vandalized structure, what some now call “a shell,” has had a string of reluctant owners since its conception in the 1970s. But none of the investors have been able to make the 80-foot tall property functional.

The nearest city is Cantwell, Alaska, population 219. While it is 20 miles from town, tourism documents indicate the area is ideal for snowboarding and hiking enthusiasts. And for the movie aficionado planning to tour the slightly more populated and warmer Oakland this summer, a trip to Cantwell would also allow you to see a filming location from *“Into the Wild.”*

up to speed

Color me calm

Coloring books targeting adults have gained momentum and earned spots atop various bestseller lists because of the potentially stress-relieving benefits. This so-called “art therapy” is now being studied at Johns Hopkins.

The designs often are intricate and repetitive, using mandala shapes based on ancient tranquility practices.

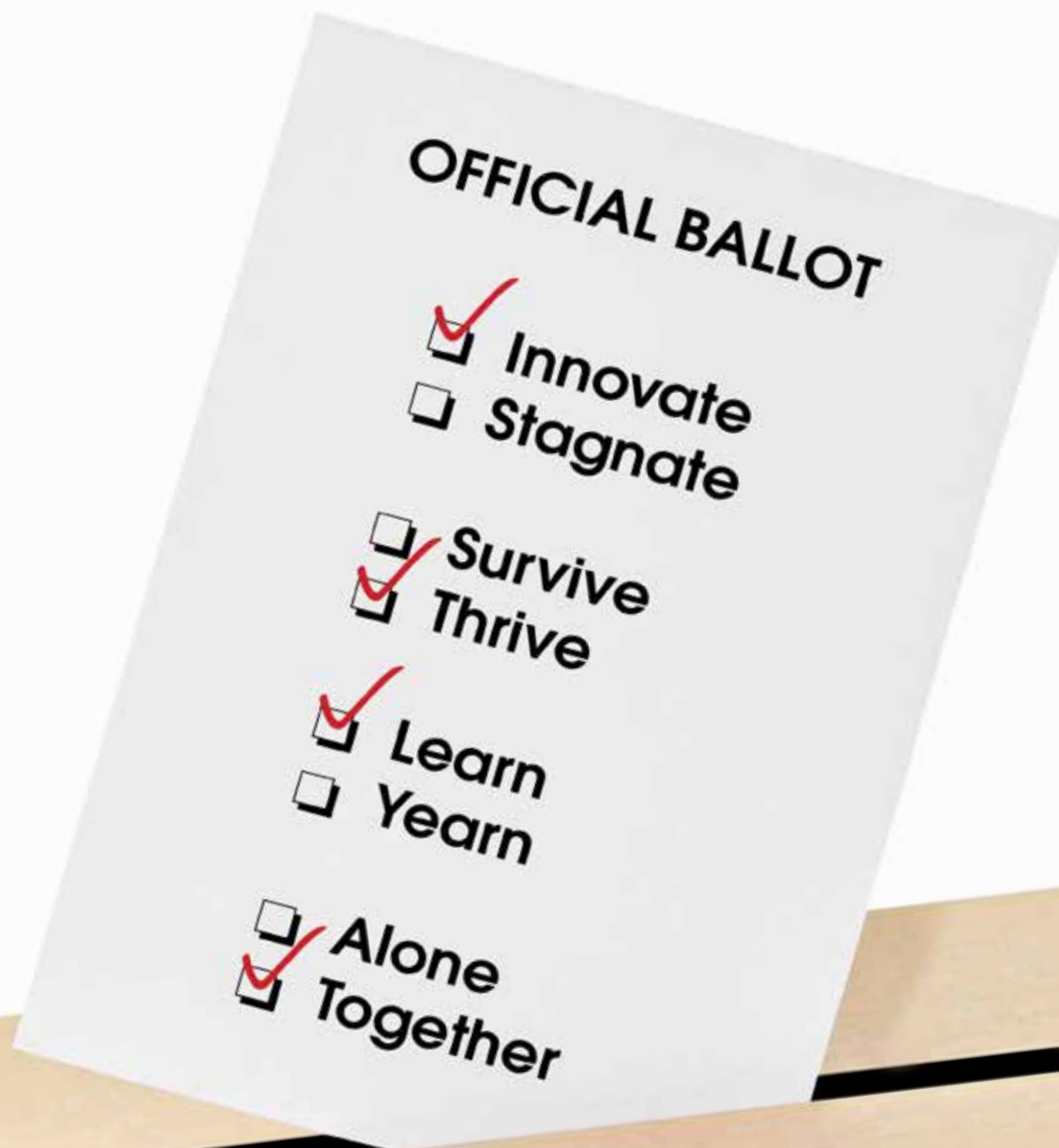
Psychologists confirm that coloring can “activate” different parts of our brain. And when we concentrate on the artful design and task in front of us (many of which are very complex), we aren’t focusing on our daily stresses and worries.

Sharpen your colored pencils and give it a try. You have nothing to lose but stress!



National Rural Health Association

4501 College Blvd. #225
Leawood, KS 66211



Choose wisely in 2016.

Vote NRHA for these educational and networking opportunities:

Rural Quality and Clinical Conference
July 13-15
Oakland, Calif.

Rural Health Clinic Conference
Sept. 20-21
Kansas City, Mo.

Critical Access Hospital Conference
Sept. 21-23
Kansas City, Mo.

Rural Health Policy Institute
Feb. 7-9
Washington, D.C.

Visit RuralHealthWeb.org to register today and save.