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Summer 2011 National Rural Health Association



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Rural Roads was awarded a KC IABC 2009 Bronze Quill Award for most improved publication.

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Write us

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

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



Share your story.

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

Contact Lindsey Corey at editor@NRHArural.org to share your ideas, innovations and experiences.

Editorial suggestions must not be advertisements.

Favorable comments

We just received the latest issue of *Rural Roads*, and there are many very favorable comments around here. The piece ("Pictures don't lie," spring 2011) is really great – a very nice journalistic style and nice blending of people, stories, data, etc. I'm very pleased with the finished product.

Thanks,

David Hartley, PhD

Maine Rural Health Research Center research professor

Proud and grateful mom

I just wanted to tell you that Lindsey Corey did a wonderful job on the Pages of Love article (spring 2011). We enjoyed reading it so very much. It was neat to also hear more from Abbe and her mom and the impact my daughter Hannah's project had on their lives.

I think when you do community service you never expect to get a thank you, but it is really nice to hear and know that someone did appreciate something that you took the time to do. Hopefully it will encourage Hannah to extend during her college years and possibly build on her project to give used books to hospitalized children.

Hannah graduated May 21 and was the valedictorian. She has a full academic scholarship to the University of Southern Mississippi for the next four years. Her intentions are still to become involved in pediatric oncology as a doctor. We are truly blessed to be her parents and are excited about her future. This summer she will compete for the Distinguished Young Woman Award in Mobile, Ala. She is hoping to fund graduate school through the process.

Thank you so much for taking the time to write such a wonderful article.

Sincerely,

Danna Roberts

Mount Olive, Miss.

Impressive story

I just received the spring edition of *Rural Roads*. Angela Lutz's article about the Montana communities fighting the war on meth is impressive – very well done. It gives us good ideas to try in this area.

As always, I enjoy your magazine.

Benjamin D. Anderson

Ashland (Kan.) Health Center CEO

Sharing ideas in exciting times



These are exciting times for rural health.

The Administration recently established the first White House Rural Council. I'm pleased that access to affordable health care will be among the council's top priorities.

The National Rural Health Association's priority is to continue working to make your voice louder in Washington, D.C., and beyond.

I look forward to seeing many of you at our Rural Health Clinic and Critical Access Hospital conferences in Kansas City, Mo., next month. As much as we try to use the technology available to us such as conference calls, video conferences and webinars, it is really wonderful to have the opportunity to share ideas face to face.

I'm excited to learn about innovations at rural health clinics and hospitals across the country and how NRHA can continue its support.

Kris Sparks
2011 NRHA president

pit stop

5 things I picked up in this issue:

1. Veterans' crisis hotline staff help more than 400 callers a day. *page 18*
2. Ashland (Kan.) Health Center was without a doctor for 10 years before its new recruiting strategy. *page 6*
3. On a motorcycle adventure, Bill Altland spoke at 13 pharmacy schools about rural practice. *page 46*
4. NRHA's Critical Access Hospital Conference is 5 times larger than the inaugural event. *page 28*
5. Rural Texas hospital rivals teamed up to be among the first in the nation to achieve an electronic health record milestone. *page 24*

Dan Shuman helps Haitian earthquake victims in February, 2010. He was enticed to rural Ashland, Kan., in part because the health system encourages its physicians to volunteer overseas for eight weeks a year.



Mission accomplished

Remote Kansas town recruits mission-focused physician

By Lindsey V. Corey

**Ashland, Kan., is a tough sell.
Turns out that was a selling point for Dan Shuman, DO.**

"I don't think it's coincidental," he says. "Hard-to-place locations have the highest need, so that's where we're supposed to be."

Ashland Health Center had seen 11 providers come and go in 18 years. For a solid decade, there was no doctor serving the 24-bed critical access hospital, nursing home and rural health clinic.

It was a physician recruiter's nightmare.

But physician recruiter Benjamin Anderson isn't easily intimidated. He thought he could help, so he left Dallas to become the hospital's eighth CEO in less than two decades.

In a remote town of 855, he couldn't rely on a desirable location or high earnings to attract doctors. And the hospital's old approach wasn't working.

"There are always exceptions, but typically four types of docs go to small towns," Anderson explains. "You have the

local guy, which is the best case scenario because he stays to raise a family where he grew up. You get the creep with something to hide who can't work around other doctors. You get foreign doctors, and I don't want to discount work visas, but from what I've seen they stay for their required three years and then go to an urban area, so it's not a long-term fix. And then you have missionary docs. If you don't have access to a local, that's the answer."

But if it were that easy, rural communities wouldn't have health care workforce woes. So Anderson sought advice from the Via Christi Family Medicine Residency Program faculty a few hours away in Wichita, Kan.

"Benjamin, being a visionary sort of guy, realized the need to find the right kind of character for whom medicine isn't a job, it's a calling," says Scott Stringfield, MD, associate director of the residency program and a University of Kansas clinical associate professor. "Desperately recruiting any warm body is a short-term solution. He recognized that it's not just about the skill set but about who the person is. A typical ad will say we'll pay you big money to work in a beautiful, exciting location. But he wants to attract a person looking for meaning. It's what drives a physician to forgo prestige, power and financial opportunities. We talked a lot about how they've got to give them that meaning and then set him or her free to pursue their calling to serve people."

The same physicians who want to serve Third World countries would be well-qualified to work in a critical access hospital and well-suited for life without big city conveniences, Anderson explains.

"A family that is willing to live in a mud hut in Africa is also willing to live in remote America. It's not that rural represents the developing world," he says. "These are the best places to live if you're not out for ego, money, prestige, shopping malls, reservation-only restaurants. Our location being what it is in western Kansas, we could maybe entice them with low cost of living, quality of life, small classrooms, but there are thousands of tiny towns that need a doc and have those things. We want someone who comes because they want to serve."

A plan with purpose

So Anderson convinced the hospital's board to create a physician recruitment package that included eight weeks paid time off for mission work, and pretty soon candidates started calling them.

"Mission-centered physicians are at the top of their class," Anderson says. "You don't go to Africa if you're not motivated. They're actively seeking a job with a point and don't want to show up and work for the man and go home. In rural America, we can give them quality of life and a job with purpose. But the challenge is that many of them end up overseas. We can sit around and complain and say they should have more sense of duty to their countries, or we can create environments where they want to stay here. The more people in this little village of Ashland who go to a little village in Zimbabwe will have their lives changed and come back to build a culture

here with a broad focus and thus better care. We have to not only allow them time to work overseas but encourage it."

Stringfield, who practiced in Lyons, Kan., population 3,400, for eight years before "burning out," called Anderson's approach brilliant. It's timely too, he says.

"Dan's heart beats for the underserved and populations where it's hard to get physicians to go. Ashland is exactly that."

Meredith Shuman, wife of Dan Shuman,
Ashland Health Center chief medical officer

"This generation of medical students has a greater desire to serve than past generations," Stringfield says. "More than ever, they are looking for a broad spectrum of training so they can serve in very challenging settings. It means Ashland can get a highly trained physician who has passion. He's created a unique fit for a lot of doctors who see themselves as short-term medical missionaries abroad who also want to practice in the states with their families where they have a sense of significance and purpose. What you get is a physician who is refreshed, encouraged, fulfilled and greatly endeared to that small town. Those eight weeks are well worth the investment."

Rethinking recruiting

Based on his experience as a rural physician, Stringfield also encouraged Anderson to recruit a second physician, which Shuman is helping with, to limit on-call time and clinic hours. That doctor would work part time in Ashland and part time in a nearby

Make it your mission to learn more

Join Ashland Health Center's Benjamin Anderson and Dan Shuman as they present on mission-focused recruiting during the National Rural Health Association's 10th annual Critical Access Hospital Conference at 10:30 a.m. Thursday, Sept. 29, in Kansas City, Mo.

For the full agenda and to register, go to RuralHealthWeb.org/kc.

continues



Top: The Shuman children pull weeds at a taro farm to help a farmer on Molokai, Hawaii. Above: The Shuman family recently moved to rural Kansas, where Dan is the town's only doctor. Back row: Jordan, Meredith, Griffin, Dan and Leidi. Front row: Monica and Andrea.

rural community.

"Recruiting is hard in those settings because the need is so great and the workload so high, physicians worry about being isolated and overworked," Stringfield says. "However you can offset those things makes a huge difference. Sure it's inconvenient to drive an hour to a Wal-Mart or a theater, but it's livable if you're fulfilled. You've got to care for and to listen to the doctor and be an advocate for them. Benjamin did that for the Shumans."

Shuman, who left the country's fifth-largest multispecialty group in the country for Ashland in July, said the interview process was as unique as the offer.

"From the start, he was very interested in who we are and less about my resume," Shuman recalls. "It was a much more personal approach. We talked about how we want our kids to understand there's a bigger world out there. Then, when we got to the nitty gritty about my capabilities and the contract, we trusted each other, so it was easy."

Shuman says when he, his wife Meredith and five children visited

Ashland in December, most of their time was spent outside the health care center. The Shumans, whose three daughters were adopted from Colombia, say they felt welcomed to the community by Latino residents hosting a fiesta.

"When you recruit mission-focused people, you show them opportunities to serve. It's not the traditional come-to-paradise approach."

Benjamin Anderson, Ashland Health Center CEO

"Typically when you bring a family in for an interview, a realtor shows them the nicest homes and best parts of the town and avoids everything else," Anderson says. "When you recruit mission-focused people, you show them opportunities to serve. It's not the traditional come-to-paradise approach. We lead off saying there's an intense need you can fill, which drew me here. With this model, the more remote you are, the better. And poverty is suddenly not a bad thing. At the Mexican dinner, families told them stories about having to drive almost three hours to the nearest Spanish-speaking obstetrician. That captivated them."

Community connection

Prior to working as a staff physician at the large health system in an Austin, Texas, suburb, Shuman had opened a federally qualified health center on Molokai, Hawaii.

"We missed the intimacy and sense of community you get in a small setting," Shuman says. "A lot of doctors are comfortable with anonymity and rigid boundaries outside the hospital. For us, there's an advantage to knowing people outside of it, and with family medicine, it gives you a perspective you don't get any other way. I think you build trust more quickly, and it's deeper than if you only know them for 20 minutes every six months or so. I'm not just a doctor from 9 to 5 and then go home. In a community like this, they're investing in us so we want to meet them and help where we can."

Shuman says he was first called to be a physician in junior high. The family of seven prayed about the move to Ashland.

“Dan’s heart beats for the underserved and populations where it’s hard to get physicians to go,” says his wife Meredith Shuman. “Ashland is exactly that.”


And while faith may have brought the Shumans to Ashland, he doesn’t bring it up in the exam room.

“You can come in here and not know my religion, but hopefully you know you’ve been cared for in a really genuine way and maybe feel there’s something a little different about that experience,” he says.

“Everybody has a motivation for what they do; mine comes from wanting to relieve suffering the way I was

taught through Christ’s example. If a patient initiates it, I don’t ignore spiritual concerns because that’s part of the whole person, so it would be disingenuous to blow that off. But I’m not their pastor, and I won’t be imposing or try to influence how others think.”

The Shumans say they’ve been humbled by the community’s welcome.

“We really see this as a privilege,” Shuman says. “They will only recruit one or two physicians, so it’s a big deal. They’re entrusting us, and it’s interesting because we feel more like they’re doing us a favor than the other way around. We’re just so thankful to have the opportunity to erase disparities and to serve here.” 



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Rural rights

Report identifies health care disparities, opportunities for LGBT populations

By Angela Lutz

Increasing numbers of population-based surveys in the United States have started including questions designed to measure sexual orientation and gender identity, and results have indicated that gay and lesbian couples live in nearly every county of the country.

And as the lesbian, gay, bisexual and transgender (LGBT) population gains visibility in national surveys, according to Tom Sullivan, Human Rights Campaign Family Project deputy director, society's "level of openness and laws are also changing in favor of LGBT people."

But increased acceptance and awareness of LGBT populations does not necessarily translate into increased health care quality and access.

"LGBT populations are everywhere – it's a reality," Sullivan says. "But they still might not be identifying when they go to the hospital or clinic."

Because LGBT individuals may not disclose their sexual orientation to health care providers, researchers have a difficult time determining

how LGBT health care experiences measure up to the general population. Health care-related studies on sexual minorities are also limited, but research suggests that they experience a higher burden of health care disparities and more barriers to care.

To gain a better understanding of the health care experiences of LGBT individuals and identify possible disparities and barriers, in 2010 the Institute of Medicine convened a committee of 17 health care professionals from different disciplines to develop a report for the National Institutes of Health on LGBT health issues, research gaps and opportunities for improvement. The publication, "The Health of Lesbian, Gay, Bisexual and Transgender People: Building a

Foundation for Better Understanding,” was announced in March and released in July.

Through the committee’s combined efforts to compile new and existing data, it became apparent that from a research perspective, the health care needs of LGBT populations have long been overlooked.

“The overriding conclusion from our work is that there’s a lot we don’t know,” says Charlotte Patterson, PhD, University of Virginia psychology professor. “This is particularly true for rural populations.”

Identifying disparities

To form a comprehensive overview of LGBT health, the committee mostly used existing research, surveys and literature reviews. One of the first challenges they encountered was the common umbrella term “LGBT” itself; as the study specifies, “each of these letters represents a distinct population with its own health concerns.”

“The report is organized along the lines of the lifespan, beginning with childhood and moving on to adolescence and middle adulthood, then on into later adulthood,” Patterson explains. “In each of these periods of life you see somewhat different issues, and of course gender, race and ethnicity are all factors as well.”

Despite the inherent challenge of gathering data about such a diverse group of individuals, the committee was able to identify several distinct factors that influence the health of different segments of the population. For example, increased mental health concerns were present for all groups, particularly adolescents.

“LGBT youth are at increased risk for suicidal ideation and depression, and you see an elevated risk in rural areas,” Patterson says. “Rates of smoking, substance abuse and alcohol abuse are all higher among LGBT youth than heterosexual youth, and they’re disproportionately affected by discrimination and violence.”

One reason for increased reports of violence among LGBT adolescents is a higher rate of homelessness among the population.

“Have they been rejected from the home or fled?” Patterson asks. “When you put it all together, when there’s an elevated number of LGBT youths on the street, they report more victimization and harassment.”

Despite the heightened risk for different mental health concerns in LGBT adolescents, Patterson notes

that many are “growing up in positive, healthy environments.”

“Many are resilient and coping in healthy ways,” she adds. “When we think about suicidality, it’s a tiny minority of kids in the general population who are suffering from suicidal thoughts. Among sexual minority youths there’s a larger minority, but it’s a minority nonetheless.”

Into early, middle and later adulthood, research shows that LGBT individuals continue to experience higher rates of mood and anxiety disorders, depression and suicidal thoughts, as well as alcohol and substance abuse.

According to Patterson, possible physical health disparities for adult lesbian and bisexual women include greater risks of obesity and breast cancer, since having never borne a child is a risk factor for breast cancer, and many lesbian couples either remain childless or adopt.

“Education is one of the key issues for providers. The openness to learning about sexual minorities and knowing what to expect is a really important step to take.”

Charlotte Patterson, University of Virginia psychology professor

“But when [gay and lesbian couples] do have children,” Patterson adds, “they are developmentally well adjusted.”

And according to John Peterson, PhD, Georgia State University psychology professor, HIV and AIDS still take the greatest toll on adult homosexual men, particularly African-Americans and Latinos.

“The rates of HIV diagnosis among all age groups are higher in black men who have sex with men than others – that’s well established,” he says. “And many young, HIV-infected men are unaware of their infection, so they unknowingly expose their partners to HIV.”

Peterson says other risk factors include a “lack of peer or societal norms that support condom use, as well as optimistic belief of HIV treatment.”

These beliefs, he says, including the incorrect perception that HIV treatment is advancing rapidly toward a cure, give men the impression that they don’t need to use condoms and have contributed to the spread of the disease.

Ensuring health

Regarding access to health care, research indicates that transgender individuals experience some of the worst stigma and discrimination, largely because there are treatments needed for transgender patients that often aren’t standard with traditional care. Providers who may not be adequately trained to treat transgender individuals in a culturally competent manner can create problems as well.

“There was a recent incident where a male-to-female transgender patient went to the hospital with a lung infection, and the staff and frontline people doing evaluations were disrespectful,” Sullivan says. “They said, ‘We can’t

continues

treat someone like you.’ She ended up leaving the hospital without receiving care for her infection. This happens more often than it’s reported.”

Lesbian, gay and bisexual individuals have also reported discrimination, but according to Peterson, perceived discrimination is just as problematic, as it can prevent LGBT individuals from seeking care in the first place.

“Perception of discrimination – the fear of discrimination from providers – matters more than actual discrimination,” he says. “It may be a significant barrier to accessing and utilizing health care services.”

“This is going to be a process of transformation over time; it won’t happen overnight. But individual providers can make a lot of difference. This is part of the effort to ensure the health of all Americans.”

Charlotte Patterson, University of Virginia psychology professor

Patterson agrees, noting that “medical training often doesn’t include much information about sexuality in general, and much less sexual minorities.”

She also notes that because LGBT family relationships are less likely to be recognized by law, LGBT individuals are less likely to have health insurance than their heterosexual counterparts. Laws prohibiting same-sex marriage also affect LGBT individuals’ ability to access health care via their partners’ employer-sponsored health insurance.

“LGBT adults and families may have less access to health care overall, and then there are questions about the quality of care if and when it’s accessed,” Patterson says. “There’s research indicating the quality of care might be lower than for the overall population.”

For future research, the committee recommended continuing to determine what disparities exist, health care provider attitudes, and interventions and educational programs.


“Education is one of the key issues for providers,” Patterson says. “The openness to learning about sexual minorities and knowing what to expect is a really important step to take.”

She also suggests providers communicate their openness to LGBT populations not only through their practice, but in their brochures, signs and materials.

“When a new patient arrives, do forms say ‘your spouse or partner’ or just ‘your spouse?’” she explains. “Providers can ask questions that suggest openness to same-sex partners.”

Additionally, the committee found that more data and research needs to be collected to determine how LGBT health care disparities measure up to the general population, particularly in bisexual and transgender populations, for which the least amount of research has been focused.

Peterson suggests gathering data on sexual orientation and gender identity with electronic health records, as well as having standard inclusion in the census and national surveys. He also sees opportunities to improve health care for LGBT populations through specific inclusions in National Institutes of Health grant applications, something that is already addressed for health care issues concerning racial minorities and women.

“This is going to be a process of transformation over time; it won’t happen overnight,” Patterson adds. “But individual providers can make a lot of difference. This is part of the effort to ensure the health of all Americans.” 

Opportunities for improvement

At the request of the National Institutes of Health, the Institute of Medicine convened a 17-member committee to identify lesbian, gay, bisexual and transgender (LGBT) health issues, research gaps and opportunities.

Some of the committee’s findings include:

- LGBT individuals are frequently the targets of stigma, discrimination and violence.
- The burden of HIV/AIDS falls most heavily on young, homosexual African-American men.
- LGBT youth and adults may be at increased risk for suicidal ideation and depression.
- Rates of smoking, alcohol consumption and substance abuse may be higher among LGBT youth and adults.
- A disproportionate number of LGBT youth experience homelessness, violence, victimization and harassment.
- Lesbians and bisexual women may be at greater risk for obesity and breast cancer.

To discover how to implement non-discrimination and cultural competency policies for LGBT populations, as well as how different health care facilities nationwide are faring, check out the Healthcare Equality Index at hrc.org/hei.

For more LGBT health care research and recommendations, visit gaydata.org.

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Responders at the veterans' crisis line's national headquarters answer more than 400 calls a day.

On the line

Crisis hotline reaches veterans in need

By Angela Lutz

The woman on the line wouldn't say her name, only that she was driving to the woods to take some pills.

Her husband and kids would be better off without her, she said, and she just wanted them to know she loved them.

But the responder – one of 160 mental health professionals who staff the U.S. Department of Veterans Affairs (VA) veterans' crisis line – kept her on the line for hours while she drove.

And gradually she began to share more about herself. She told the responder her name and where she lived, so another staff member was able to contact her husband. He told them the make and model of her car, which allowed local police to track down her vehicle parked alongside the road.

"They found her and got her into the VA, and a few months later she was back home, doing well and very happy to be alive," says Janet Kemp, PhD, VA National Suicide Prevention Program director. "Things like this happen all the time."

Veterans in crisis

Since the VA partnered with the Substance Abuse and Mental Health Services Administration to open the hotline in July 2007, the national call center in Canandaigua, N.Y., population 11,197, has received more than 431,970 calls resulting in more than 15,580 rescues. But the majority of veterans who call aren't facing an immediate crisis. Many are simply lonely or needing emotional support, according to Kemp.

"The most common call is from people who aren't in immediate need, but things have been getting worse and worse for them," Kemp says. "There's usually something that happens that's the last straw – their wife leaves; they lose a job; they get in a fight. It's kind of when they realize they can't go on like this. They may

have post-traumatic stress disorder, alcoholism or other underlying problems, but it's usually something specific that happens that triggers the call."

Veterans in crisis reach out from communities all over the United States, everywhere from remote Alaska to Puerto Rico. Twenty or more phone lines are open 24 hours a day, and a staff of trained mental health professionals including nurses, counselors and social workers – many of whom are veterans themselves – answer more than 400 phone calls per day. Callers range from active-duty soldiers and veterans of recent conflicts to 80-year-old Korean War vets.

"I see it as a confessional; it allows for the person who's calling to be as open as they need to be at that moment."

Caitlin Thompson, Veterans Affairs Suicide Prevention Program clinical care coordinator

According to Caitlin Thompson, VA Suicide Prevention Program clinical care coordinator, who worked as a responder for six months, many of the callers are experiencing struggles with the transition from the battlefield back to daily life at home.

"In military culture, the main goal is survival," she says. "You can't be the weak link, particularly in combat, and if you're seen as a weak link, you're ostracized. That's what I hear from a lot of veterans: 'They turned me on, and then they couldn't shut me down.'"

Thompson says the military is trying to make changes and encourage soldiers to discuss the difficult transition from being a soldier to being a veteran. The veterans' crisis line is one way the VA is reaching out to both active soldiers and veterans.

"Veterans are asking for help more than they ever have before about things that continue to be stigmatized and things they've shoved down," Thompson says. "To be a part of lessening that stigma is extremely powerful."

Connecting to care

Through the hotline, the VA has been able to connect with thousands of veterans who otherwise might not have sought help, particularly in rural areas, where the nearest VA center may be several hours away.



To help a caller in need, veterans' crisis line responders will do whatever it takes. Since 2007 their efforts have resulted in more than 15,580 rescues.

According to Kemp, the hotline guarantees veterans immediate access to the attention they need without worrying up front about their eligibility. And after a veteran calls the hotline, someone from a VA facility in their area will follow up with them within 24 hours.

"We felt there were veterans who needed help who didn't know how to get it or weren't comfortable walking into a VA medical center, and they needed someone to help them do that," Kemp says. "There are resources available that veterans may not know about, and we can connect them so they're not traveling miles to a VA and not getting what they need."

Geographic location can be a challenge for VA staff as well. Because the hotline's national headquarters is located in New York, fielding calls from all over the country can make finding resources to assist veterans difficult, particularly in rural and remote areas.

"We get calls from the middle of Alaska, and if they need resources or services, it can sometimes be a challenge," Thompson says. "We're more limited in terms of saying to someone who lives 200 miles from the VA that we'll find transportation for them. We struggle with those limitations, but we can counter that with emotional support and problem-solving strategies."

But Thompson says that providing emotional support to veterans over the phone is only part of what they do. The long-term process of caring for veterans' mental health needs includes connecting them to local resources so they can continue getting help in their own communities.

"One young, 27-year-old veteran had never been to the VA, but he'd just come home and was feeling depressed," she says. "I was able to put him in touch with local suicide prevention coordinators to follow up, and

continues

that interaction between the national call center and local VA is so powerful. Every day we hear from people who are getting into group therapy and residential programs. One of the most important things we do is connect people to their local resources.”

Intense work

Another important aspect of running the call center is teaching the staff to pay attention to their own mental and emotional health needs. Even with high levels of mental health education and training, responders can become overwhelmed and exhausted doing what Kemp calls a “high-stress, difficult job.”

“It’s very intense work,” Thompson adds. “You don’t know what type of call you’ll be getting at any second. It might be someone who’s just lost their home, or someone has a gun next to them, or it might be a prank. That level of hyper-vigilance on the part of the responder can be tough.”

Despite these inherent challenges, Kemp says her staff’s dedication is what makes the hotline work.

“Veterans are asking for help more than they ever have before about things that continue to be stigmatized and things they’ve shoved down.”

Caitlin Thompson, Veterans Affairs Suicide Prevention Program clinical care coordinator

“I’m really proud of the responders when they don’t give up,” she says. “A lot of times people call and it’s hard to find out where they are, and we know they’re in trouble. The staff goes through every extreme. They’ve talked an Oakland (Calif.) train company into stopping the train because a vet was going to jump onto the tracks. Their perseverance and how much they care is evident in everything they do.”

Kemp says most staff members are extremely satisfied with their jobs, largely due to the direct, immediate impact they make in the lives of veterans.

Hotline help

Since opening in 2007, the Department of Veterans Affairs crisis line has received more than **431,970** calls from veterans, resulting in more than **15,580** rescues.

To call the hotline, dial 800-273-TALK (8255).

To access Veterans Chat, visit veteranscrisisline.net.

Both have trained VA counselors standing by 24 hours a day, seven days a week.



Janet Kemp, Veterans Affairs National Suicide Prevention Program director, is proud of call center staff because “they don’t give up.”

Staff are also supportive of one another – they discuss their calls, what they did well and what they could have done differently – and they are encouraged to take advantage of on-site health and wellness facilities and counselors.


“We try to help them recognize when they need to take a break,” Kemp says.

“Teaching them to pay attention to themselves is important.”

In 2009, the VA further expanded outreach to veterans by launching Veterans Chat, an online forum in which veterans, friends and family can chat one-on-one with a VA counselor. If at any point a chatter is determined to be in crisis, responders transfer him or her to the hotline. In addition to phone lines, the suicide prevention center has the capacity to operate six to eight chats 24 hours a day.

“It’s been especially helpful for people in rural areas,” Kemp says.

And though the call center may be a great distance from many of the veterans it serves, even this particular challenge can be viewed as a strength.

“On the phone, all you hear is their voice and their story,” Thompson says. “There’s less of a distraction. You can delve into what’s going on emotionally for the person. I see it as a confessional; it allows for the person who’s calling to be as open as they need to be at that moment. It opens up the opportunity to really get to the depths of what the veteran might be going through.” 

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Texas tech

Rival rural hospitals become partners for patients

By Lindsey V. Corey



Rural Texas hospitals teamed up to transition from paper records to electronic health records.

Competition is tough in Texas. And in four small West Texas towns within 25 miles of each other, rivalries are real.

“You’ve heard of ‘Friday Night Lights,’” explains Rick DeFoore, CEO of Stamford Memorial Hospital, referring to a book, film and TV drama about high school football. “Two of these towns are fierce sports rivals, and you would think, ‘So what?’ But I promise you, it affects everything out here.”

Money-saving water agreements have been nixed, and forget about school consolidation. For years, four hospitals in those rural towns were as separate as separate can be.

Then came the American Recovery and Reinvestment Act (ARRA) and incentives for facilities adopting electronic health records (EHR). Forty-five bed Anson General, 25-bed Stamford Memorial, 20-bed Stonewall Memorial and 14-bed Throckmorton County Memorial

hospitals were each solely using paper patient files.

“We looked into it, but our hospital was struggling to make ends meet, so the idea of taking on something like that, regardless of incentive, was beyond our reach,” DeFoore remembers. “But the push behind EHR was sharing medical information, so it made sense to have a network of hospitals working on a similar system, because we do share patients in a competitive kind of way and in a cooperative kind of way.”

Just down the road, Nathan Tudor, who was then CEO of Stonewall Memorial, was in a similar position.

“None of us had the luxury of access to capital, but we all wanted to provide a higher quality of care for our patients, and EHR is a tool to help us do that,” says Tudor. “There was a friendly competition amongst us all, but for the betterment of the whole we set the egos aside and came together.”

The hospital CEOs decided collaboration was their best chance at converting to EHR. And the unlikely foursome received a grant from the Texas Department of Rural Affairs to kick start the rural health information exchange.

“We’re a bunch of overachievers here.”
Rick DeFoore, Stamford Memorial Hospital CEO

“Even though we’re at small hospitals, CEOs are used to getting our way, so there was some inevitable jockeying for position,” DeFoore says. “But it was a pretty harmonious team with everybody taking a role that fit them.”

He vetted the web-based provider contract. Ted Matthews, Anson’s then CEO, applied for funds. Tudor took on the role of negotiator. And Randy King, CEO of Throckmorton County Memorial, provided clinical expertise as a former nurse practitioner.

“It was comforting having a group of peers you can call and rely on,

because we're going through the same thing," Tudor says. "Sure, we were competitors, but there was a level of trust. Nobody was out to one-up anybody on this deal. We knew it wouldn't be sustainable if we couldn't count on each other."

Within six months of teaming up, all four hospitals had begun implementing EHR. Today, two – Stamford and Anson – have received meaningful use incentive checks from ARRA that more than covered their technology investment. According to the Centers for Medicare and Medicaid, only 35 hospitals of any size in the nation have met stage one meaningful use requirements.

“Even though we’re at small hospitals, CEOs are used to getting our way, so there was some inevitable jockeying for position.”

Rick DeFoore, Stamford Memorial Hospital CEO

“We’re a bunch of overachievers here,” DeFoore says. “We’re very proud that we worked together to achieve this significant milestone for patient care in our communities.”

Throughout the process, networking staffs shared struggles and solutions, and nurses in rival towns traded tips to adapt to the new patient care system.

“That synergy happened naturally as a result of us admins agreeing to work together,” DeFoore says. “We get in a rut of doing things the way we always did, but they were able to capitalize on best practices together and get past the ‘Friday Night Lights’ attitude.”

Still, there were workforce obstacles, he said.

“The IT expertise to manage a system like this is a significant challenge in rural areas,” DeFoore says. “It’s like driving a Lamborghini but living in the country where no one knows how to change the oil on that kind of car.”

But once the West Texas rural health exchange figured it out, word spread.

“At the time no group of independent hospitals had established this kind of collaborative that we know of,” Tudor says. “We were way ahead of the curve. In a rural area, you have to be because you don’t have the resources so you have to do creative thinking on a limited budget to get things done.”

Soon, other rural hospital CEOs were asking to join the EHR partnership. And when Tudor moved five hours away to lead 25-bed Otto Kaiser Memorial Hospital in Kenedy, Texas, he

Texas rural health information network partnering hospitals

Anson General Hospital, Anson, 45 beds

Eastland Memorial Hospital, Eastland, 52 beds

Hamlin Memorial Hospital, Hamlin, 25 beds

Otto Kaiser Memorial Hospital, Kenedy, 25 beds

Seymour Hospital, Seymour, 49 beds

Stamford Memorial Hospital, Stamford, 25 beds


Stonewall Memorial Hospital, Aspermont, 20 beds

Throckmorton County Memorial Hospital,
Throckmorton, 14 beds

continued the connection. Matthews relocated to become CEO at 52-bed Eastland (Texas) Memorial Hospital and added it to the exchange network too.

“Instead of having four hospitals in one region of Texas, we now have eight, and that gives us strength in potential future negotiations with the vendor and when vying for grant money,” DeFoore says. “This kind of collaboration opens the doors for other opportunities for collaboration and improvement. There’s been far too much competition between small hospitals. This just makes sense.”

DeFoore says he’s noticed community pride in the region in light of the EHR effort.

“In addition to the financial incentive and moving ahead technologically, there’s a morale boost to be on the leading edge of something. I realize how far we have to go, so it’s hard for me to put my feet on my desk and say, ‘Ain’t we great?’” he says. “But it has helped us in recruiting staff. People say, ‘Really? In Stamford?’ There’s bragging rights.” 



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Critical connections

NRHA's Critical Access Hospital Conference celebrates its 10th anniversary of working for rural communities

By Angela Lutz



Jodi Schmidt, president and CEO of Labette Health in Parsons, Kan., was one of 139 attendees at the first Critical Access Hospital Conference in 2002. The annual event now attracts nearly 700.

Like most things in rural America, critical access hospitals are unique.

Facilities are smaller, so the emergency room might double as an exam room for specialists. But specialists aren't always available in small towns, so rural health care providers need to be especially creative and tenacious to overcome challenges, seek solutions and provide optimal patient care.

No one knows this better than the founders and original attendees of the National Rural Health Association's Critical Access Hospital (CAH) Conference, which was in Kansas City, Mo., for the first time in 2002. This year marks the event's 10th anniversary, and it's back in Kansas City.

"There are far more resources to handle the issues at a large system," says Dave Sniff, E-Code Solutions president and NRHA past-president, who worked in

leadership capacities in rural and urban hospitals in Illinois over the course of 35 years. "Larger places have expertise in virtually any category. There's usually someone who can handle the project or answer the question. At rural hospitals there's limited staff, so you get very creative and innovative, and you establish a broad network of colleagues."

The establishment of such a network – as well as an annual event where rural hospital leaders and staff could gather to share what they'd tried and what worked – was the impetus behind the first CAH Conference.

"At statewide conferences, it's more difficult to relate to urban hospitals while working at a rural hospital

where everyone wears six hats," says Jodi Schmidt, president and CEO of Labette Health in Parsons, Kan., and NRHA Hospitals and Health Systems Constituency Group (CG) chair. "The issues are the same for CAHs, but the solutions will look a little different. And that's why I think the CAH Conference is so important – it's a great opportunity to network and talk about solutions with peers who are in the same boat."

Survival and evolution

Schmidt has been involved with NRHA's Hospitals and Health Systems CG for approximately 15 years. Prior to her position at Labette Health, she was chief development officer at Hays Medical Center in Hays, Kan., which serves as a supporting hospital for 23 CAHs across the state. The network of hospitals affiliated with Hays Medical Center was one of the first in the country to participate in the Essential Access Community Hospital/Rural Primary Care Hospital demonstration program.

But then the Balanced Budget Act of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs through the Centers for Medicare and Medicaid Services, under which qualified hospitals could

achieve CAH designation. Under this legislation, Medicare-participating hospitals that had either closed or been downgraded to clinics or health centers could re-open as CAHs, allowing them to remain financially viable and continue serving the rural communities that needed them. Today there are more than 1,400 CAHs nationwide.

“In the hospitals I worked with to make the decision whether or not to convert, a key concern was financial survival,” Schmidt says. “[Becoming a CAH] provided reimbursement and networking to coordinate and collaborate on quality and performance improvement, specialty outreach and telemedicine, as well as a platform to come together to meet the unique challenges all rural hospitals face.”

“CAH administrators have said it was the most meaningful conference attended in terms of their day-to-day work.”

Jodi Schmidt, Labette Health president and CEO

Once CAHs’ financial situations improved, administrators were able to shift their primary focus from survival to quality improvement. Keith Mueller, PhD, University of Iowa College of Public Health’s Health Management and Policy Department head, Rural Health Policy Research Institute Center for Rural Health Policy Analysis director and NRHA past-president, has been a rural health educator for more than three decades, and he’s seen CAH designation improve the overall performance of many hospitals by removing financial pressure.

“[CAH designation] enabled a lot of hospitals that might have closed or been in difficult financial straits to stabilize,” he says. “They’ve been able to do some better things in terms of services and quality improvement, things that start with not having to worry about this month’s payroll.”

What works for rural

CAH leaders and staff still gather annually to network and share what’s working for health care providers in rural America. And the conference has grown from 139 attendees in 2002 to 656 in 2010, including a trade show featuring more than 112 exhibitors familiar with CAHs. As the major issues facing CAHs have changed following health care reform legislation, the content of the conference has advanced as well.

“The focus of the conference has evolved in the same way the CAH program has evolved,” Schmidt says. “In the early days it was providing a financial safety net for survival. Then the focus shifted toward quality, and then the conversation shifted toward governance, and health information technology became an important piece. The conference has reflected what’s going on in the bigger health care conversation. It’s taken broader-picture stuff and made it work for CAHs.”

And with health care reform presenting CAHs with what Sniff calls an


“exhaustive list of objectives for a short time frame,” finding solutions that work for rural hospitals and communities may be more important than ever.

“Networking is tremendously helpful, because what works for large facilities doesn’t always work for rural,” he says. “Electronic medical records and health information technology are very capital-driven decisions that have to be made right the first time.”

The rural-specific information available at the conference – and the presenters’ willingness to share what doesn’t work as well as what does – is what keeps Schmidt coming back year after year.

“We can learn from each other’s mistakes as well as successes,” she says. “It feels like drinking from a fire hose sometimes, so it’s good to talk with your peers and discover what they’re doing step-by-step to address the issues. Over the years individual CAH administrators have said it was the most meaningful conference attended in terms of their day-to-day work.”

Mueller agrees, noting that in addition to the relationships built through networking and the exhibit hall tailored specifically to suit the needs of CAHs, the No. 1 reason he attends is the “knowledge gained from the sessions at the conference.”

“Much of that knowledge is almost immediately translatable to something attendees can use back at their CAHs,” he adds. “It’s the benefit of having this specific conference. And as one of the people involved in coming up with the idea and seeing it put in place, it’s good to know that it has met a lot of the potential we all thought it could.” 

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Maternity care scarce in rural South Carolina

By Angela Lutz



Since 2008, at least four hospitals in rural South Carolina have closed their obstetrics-gynecology departments, affecting some of the state's poorest and most vulnerable women.

Known as the “corridor of shame,” the stretch of land along Interstate 95 that cuts across central South Carolina is plagued by poverty, failing school systems and neglect.

Residents of counties in this region are also frequently uninsured and experience financial and transportation barriers in accessing even the most basic health care services, a problem compounded by the recent closure of obstetrics-gynecology (OB-GYN) departments in hospitals in the area due to rising costs and low Medicare reimbursement.

Since 2008, Allendale County Hospital, Bamberg County Hospital, Barnwell County Hospital and Hampton Regional Medical Center have closed their delivery rooms, requiring women to travel out-of-county, sometimes for hours, to reach the nearest hospital that is adequately equipped to meet their prenatal and perinatal health care needs.

“All of the hospitals [that stopped delivering] cited the same problem – high malpractice insurance, low Medicaid reimbursement and inability to attract physicians to provide services,” says Paul Browne, MD, University of South Carolina maternal-fetal medicine director. “You could draw a triangle around Walterboro, Aiken and Orangeburg where there are no obstetricians.”

And according to Amy Brock-Martin, PhD, South Carolina Rural Health Research Center director, these closures are happening in “very rural counties where there are higher-than-national-and-state infant mortality

rates” and where a large majority of the population consists of unemployed Hispanic migrant workers and Medicaid-dependent minorities.

Brock-Martin says one reason for the higher infant mortality rates is insufficient prenatal care. While many women seek prenatal care at federally qualified health centers and community health centers, these settings aren’t ideal when a woman is ready to deliver, particularly if she has a complicated pregnancy. And many women don’t receive prenatal care at all, due largely to transportation barriers.

“We don’t have public transportation in South Carolina, so you have to beg and borrow to get people to take you places,” Brock-Martin explains. “There are Medicaid transportation services out there, which will work if you don’t have to travel far. If you have to travel great distances, you’re looking at being gone all day, because they are transporting large numbers of people.”

Browne says an inability to access prenatal care can cause minor complications during a pregnancy to become a full-blown crisis.

“Patients have opted to receive less care because of the

transportation issue,” he explains. “They can’t afford to buy gas and drive two hours one way for prenatal care. By the time they have a problem, it’s often beyond the point where we can manage it. It hasn’t given doctors the option to manage minor problems, so we end up doing triage and managing major problems.”

Nathan Hale, South Carolina Rural Health Research Center assistant professor, also notes that due to a lack of prenatal care many women end up delivering at “region one” facilities, which are only equipped to deal with a certain level of underlying risk, when they should be delivering at level two or three facilities.

“When these points of entry are eroded, it affects the whole system.”

Nathan Hale, South Carolina Rural Health Research Center assistant professor

“If a woman has a complicated pregnancy, she probably won’t deliver at a rural hospital,” he says. “She’ll be transferred to a larger hospital. But this is also contingent on the level of prenatal care. Oftentimes a woman will just show up in a state of crisis, and then we’ll have to transfer the infant afterward, which isn’t as optimal. When these points of entry are eroded, it affects the whole system.”

The closure of OB-GYN departments has affected providers as well. Due to recruitment and retention challenges and losing much-needed health care professionals to larger, urban centers, many rural physicians are the only ones in town.

“We had a primary care doctor in one town who was the only one in town with emergency C-section privileges, and he could not leave the county lines without finding someone to cover for him,” Brock-Martin says. “He didn’t leave the county for three years. He has since moved on.”


Though Browne says he does not expect Medicaid reimbursement rates to improve anytime soon, through a \$100,000 grant funded by federal stimulus dollars and the South Carolina March of Dimes, he has distributed 40 sets of web conferencing hardware to emergency rooms of rural hospitals without OB-GYN departments across the state to allow for remote consul-

tations with specialists.

Browne says he’d also like the University of South Carolina to send medical students and residents into rural facilities to provide care and receive training with remote supervision.

“But they have strict rules about supervision, and in many cases that requirement cannot be met by resident physicians in rural South Carolina,” he explains. “We have to find a way to allow training in these hospitals even if supervision doesn’t include the latest technology and specialists. It’s different medicine, but it’s valid medicine. Physicians-in-training can provide support even if their supervision is remote.”

Though many expect the problem to get worse before it gets better, to reverse the trend of rural OB-GYN department closures, “you have to address policy issues,” Hale says, “such as Medicaid eligibility and reimbursement.”

“It also takes organic growth and campaigns on the local level to expand services and get women into care,” he adds. “People who work at the state level need to be aware of the local level and support communities, be champions. It’s an underestimated factor a lot of times, because people trust people they have relationships with. It’s not only policy, but what goes on in communities.” 

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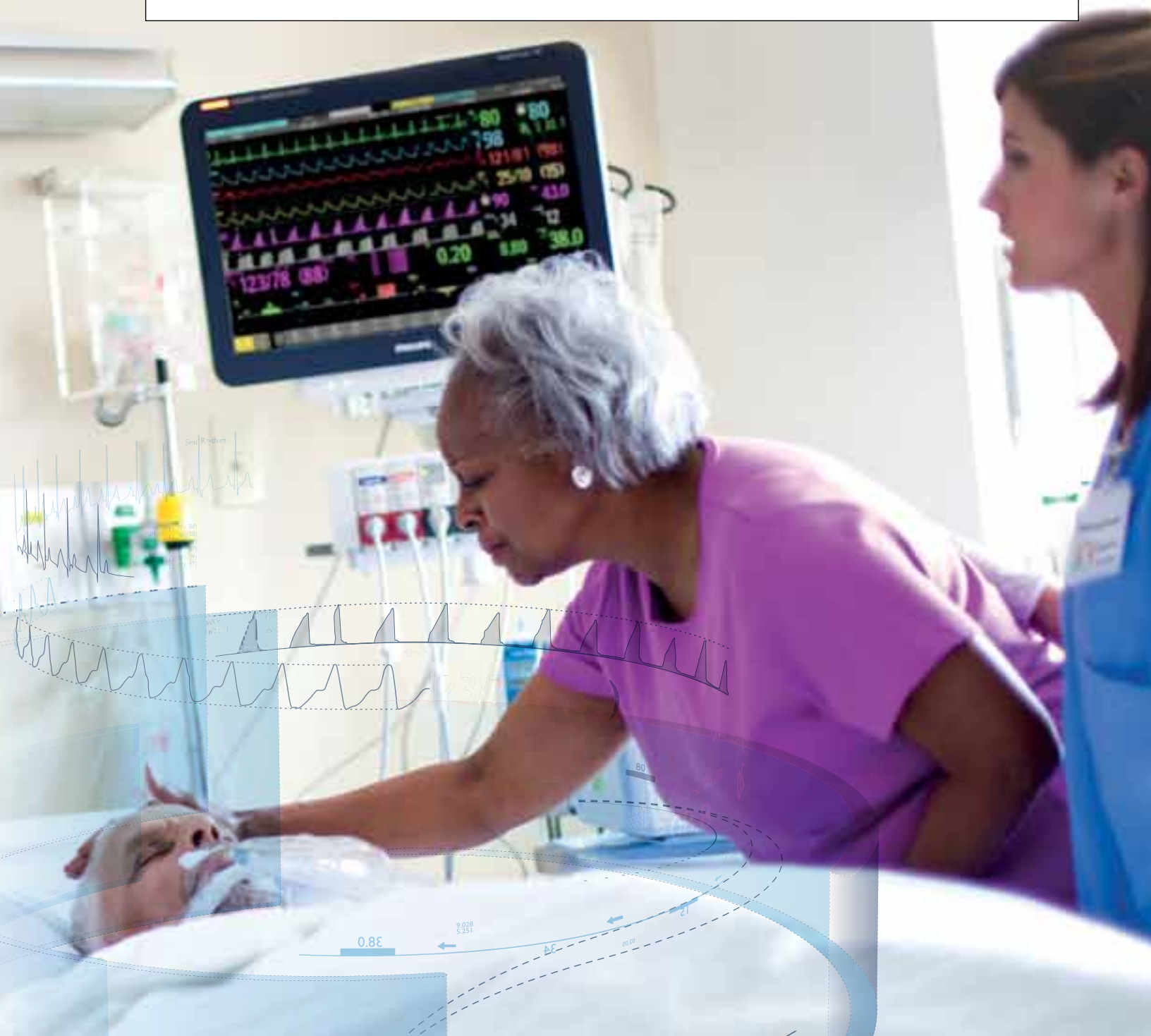
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Rural Healthy People project creates objectives for healthy communities

By Angela Lutz



As part of the Rural Healthy People project, Gail Bellamy works to identify national health care improvement objectives that are relevant to rural communities.

What works for urban doesn't always work for rural. That was one of the first concerns Jane Bolin, JD, PhD, Southwest Rural Health Research Center director and Texas A&M University Health Science Center School of Rural Public Health professor, had when reading through the 38 priorities of Healthy People 2020, a U.S. Department of Health and Human Services-sponsored project that establishes objectives for health promotion and disease prevention to improve the health of all Americans over the next decade.

"What we noticed about Healthy People 2020 is that it doesn't mention rural, and it only mentions underserved once," she says. "The concern was that rural populations are unique and may not match the more generalized objectives of Healthy People."

To ensure rural populations weren't left out, Bolin and Gail Bellamy, PhD, Blue Cross and Blue Shield of Florida Center for Rural Health Research and Policy

director and Florida State University College of Medicine professor, surveyed rural health care stakeholders, including National Rural Health Association members, critical access hospitals, community health centers, rural health clinics, state offices of rural health, area health education centers and National Rural Assembly members. From more than 700 responses, they determined which of the Healthy People priorities are most relevant to rural health care.

"We were able to see which were most pressing for rural communities," Bolin says. "Access to quality health services was No. 1, which may not be true for Healthy People 2020. The ranking of priorities is different in terms of rural stakeholders."

As they continue to sort through the identified priorities to determine the top 10

most important to include in the Rural Healthy People 2020 companion project, Bolin and Bellamy are also planning to solicit successful models and best practices addressing those priorities to create toolkits and webinars that will be available on the Rural Assistance Center web site.

"If we can meet the objectives we identify as being most important, hopefully we will have healthier residents, which will lead to healthier communities."

Gail Bellamy, Blue Cross and Blue Shield of Florida Center for Rural Health Research and Policy director and Florida State University College of Medicine professor

"What do we know about rural America today as we begin this next decade that is important that we want to be able to change?" Bellamy says, regarding the project's focus. "What are successful programs around the country in rural communities that people have used to address health problems in their areas? Did they measure it? Was it successful? What did they learn?"

This is the second Rural Healthy People companion project – the first was for 2010 – and during the next decade they hope to both broaden the project’s focus and track the results, which is difficult due to challenges of small population numbers, confidentiality and anonymity in rural communities.

“It’s one of the areas we’ve been weakest in as a nation,” Bellamy explains. “We provide funding to communities to do good things, but we don’t give them the skills to measure progress or do an evaluation. Hopefully by the time we’re in 2020, we can identify projects and results within specific communities.”


One way they’re hoping to track measurable results is by including Rural Healthy People 2020 objectives in grant applications.

“When federal grants are announced for special programs, there’s often a question asking which Healthy People 2020 objective it addresses,” Bellamy says. “We hope they’ll use the equivalent statement for grants addressing Rural Healthy People objectives.”

According to Bolin, Rural Healthy People 2010 continues to be a frequent download by universities that teach rural health courses. As Rural Healthy People 2020 advances – they hope to have the majority of the toolkits and webinars online by 2012 – she expects its popularity among educators to grow.

“It’s used as a textbook,” she says. “We hope to continue updating that and having it there as a resource for students interested in the needs of rural populations as well as a tool and resource for rural providers, grant writers and program developers.”

Still, Bellamy notes that the Rural Healthy People project is primarily “a labor of love and passion, because prevention and healthy communities get lost in the shuffle.”

“We hope it’s the residents who live, work and play in rural America who benefit the most,” Bellamy says. “If we can meet the objectives we identify as being most important, hopefully we will have healthier residents, which will lead to healthier communities.” 

Healthy People online

To learn more about Healthy People 2020, visit healthypeople.gov.

To learn more about Rural Healthy People 2010, visit srph.tamhsc.edu/centers/rhp2010.

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Georgia celebrates 30 years of rural advocacy

By Lindsey V. Corey



Georgia Rural Health Association members gather at the state capitol for Georgia Rural Health Day, an annual event.

AIDS was new, and HIT didn't stand for health information technology when the Georgia Rural Health Association (GRHA) got its start in 1981.

Three decades later, 10 founding members have grown to more than 300 individuals and organizations working to improve health care in rural Georgia.

"We're well-connected and willing to go to bat for rural."

Matt Caseman, Georgia Rural Health Association executive director

"We have a very dedicated group of individuals who – like every rural provider – have always had to do more with less, but it's their passion to improve the health care of their community that keeps them involved, engaged and committed," says Matt Caseman, GRHA executive director. "We're well-connected and willing to go to bat for rural."

Rita Salain has been active in the nation's oldest rural health association for nearly 25 years. She was hired to develop Georgia's office of rural health in 1987.

"Because GRHA was there, there was already a strong interest in rural health, and there was a platform," Salain remembers. "GRHA members reached out to me, and it made a huge difference."

Now a rural resident herself and a self-employed health care consultant, Salain continues to value the

connections she's made through both the state and national rural health associations.

"Rural health associations are totally non-self-serving," she says. "They are the only group in the whole state or country who looks out for rural health. Hospital and nursing associations look out for urban members too and may not focus on what's best for rural. There's no gain for GRHA or the National Rural Health Association itself; the gain is for rural people. I stay involved because it's important to have a state, national and community presence."

Salain said she's most proud of GRHA's work in educating state and national politicians.

"Rural health is a distinct concern," she says. "Some people don't understand that it's different, not just smaller. Each time we get new legislators we have to create that understanding all over again. But we have members who have real strength and real connections so we are able to do that well."

Caseman also said GRHA's "connection with NRHA is extremely valuable."

"The information and resources NRHA provides are of great value here and have been successfully implemented throughout Georgia," he says. "There's no doubt that having a strong national association helps all state associations and rural health throughout the country."

Likewise, NRHA is strengthened by state associations like Georgia's.

"State rural health associations serve as the collective pulse of NRHA, as they each provide the voice for rural health issues in their state," says Amy Elizondo, NRHA's program services vice president. "With 43 of these around the country, state associations continue the framework of NRHA's local rural community outreach program and serve as a conduit for communicating needs and successes at a regional and national level."

North Dakota is the newest state rural health association, chartered in 2008, and rural health stakeholders in Kansas are in the preliminary stages of forming an organization there.

GRHA introduced its first rural health clinic conference this year and will celebrate its 30th anniversary by honoring past-presidents during its annual meeting Sept. 19 in Pine Mountain, Ga.

Happy anniversary

These state rural health associations are celebrating milestone anniversaries in 2011 and 2012.

30 years
Georgia, est. 1981

20 years
Alabama, est. 1991
Louisiana, est. 1992
Nebraska, est. 1992

15 years
Maryland, est. 1996



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Like many rural CEO's, Jim Blackwood stepped into a tough position. The career-long litigator was tasked with turning around Tallahatchie General Hospital: a hospital in the Mississippi Delta that had a history of losses, a Hill-Burton facility that had been duct-taped together and a prevailing community perception of "you only went to his hospital to die."

Blackwood had to change the community's perception of the hospital if he was going to save the hospital. He did so by calling Wellness Environments, a CAH Design and Construction Firm specializing in CAH Image Transformations. His message to the firm was simple: "Bring your tape measure."

Within 4 months, Wellness Environments had allocated \$1.75M in financing from their \$25M Fund for Hill-Burton Renovations, brought in a local architect and was breaking ground on a 17 Patient Room Renovation.

"Replacing a Hill-Burton Hospital isn't the only game in town anymore. Renovation is a great option at a tenth of the cost."

— Jim Blackwood
CEO- Tallahatchie General Hospital

The Patient Rooms developed by Wellness Environments are considered to be equipment and have a 10-year depreciable life, thereby significantly increasing the reimbursement to the hospital. This is what made the project financeable — moreover, the payment is only \$1,000/month for the first six months while the hospital gets on track.

"The immediate impact in the community was unbelievable. As a result of the community's perceptual change, our census went from 5% to 80% capacity! **We had to hire an additional 20 FTE's to shoulder the load.** The community cannot wait for the completion of the rooms — the sense of pride gained by the staff alone is amazing," says Blackwood. "Along with a strong management plan, these new Wellness Patient Rooms have been a catalyst for positive change. Replacing a Hill-Burton Hospital isn't the only game in town anymore. Renovation is a great option at a tenth of the cost."



For more information on Wellness Environments and to apply for their \$25,000,000 fund to renovate Hill-Burton Hospitals, contact Drake Jarman at 615-321-5052 or Drake@wellnessenvironments.net.

Beginnings & Passages



Jennifer Lipka

“There is a real opportunity to make a positive difference in people’s lives as a rural physician.”

Practicing medicine off the beaten path

By Jennifer Lipka

I am originally from southeast Kansas, but I fell in love with Maine when I was in the fifth grade and wrote a report on Acadia National Park.

Today I am a third-year student of the University of New England College of Osteopathic Medicine in Biddeford, Maine. I’m completing my core clinical rotations in Augusta through Maine General Medical Center, home of the Maine Dartmouth Family Medicine Residency made famous by the book “Heirs of General Practice” by John McPhee.

Augusta is the third smallest capital city in the country, and doing my rotations here has not only allowed me to provide care in a community hospital but in outpatient settings in many small towns in the area as well. This has allowed me to experience continuity of care in multiple settings. One night in the emergency room I sutured the lacerated forehead of a high school basketball player, and a week later I removed his sutures at the health clinic in his school, where I spent one day each week on my pediatrics rotation.

My best rotation to date has been at the federally qualified Katahdin Valley Health Center in Patten. At the foot of the state’s highest peak in the wilderness of northern Maine, the health center is 40 miles in either direction from the nearest small hospitals and 90 miles from the nearest major hospital. I really got to experience medicine off the beaten path, where you are all things to all people.

I like the sense of community in small town America, and I like the thought of really getting to know my patients. I also like the challenge of rural practice, where you are miles from the nearest specialists and have to play a big role in providing and managing the health care of your patients.

I believe there is a real opportunity to make a positive difference in people’s lives as a rural physician, and that is exactly why I am proud to be a future rural family practice physician.

Jennifer Lipka is a third-year medical student at the University of New England College of Osteopathic Medicine and the incoming student outreach coordinator for NRHA’s Student Constituency Group. She joined NRHA in 2011.

Are you relatively new to rural health or looking back on years of serving rural America?
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Innovative rookies and seasoned professionals share their experiences.

“The challenges of rural health are undeniably great, but so are the rewards.”



Tim Putnam

The essence of health care

By Tim Putnam

Like many other leaders in rural health care, I grew up in the country and learned to value life in a small community. My career took me into large academic medical centers and health care systems before I finally circled back to life in a small town.

What I learned along this journey was this: The challenges of rural health are undeniably great, but so are the rewards.

I realized the true essence of health care several years ago when we evaluated the need for dialysis services in the community. The closest dialysis unit was a 45-minute drive from our small town, and our elderly patients had three choices: travel into the city three times a week for treatment; move to the city where they would have easier access to dialysis; or forgo treatment, stay in our community and die at home. One of the physicians on the board said we would be surprised at the number of patients who choose the third option.

The decisions we make in rural health care are about how to provide the care our patients need with our limited resources. In many urban areas there is no shortage of providers who compete for the same patients. In our small

communities, there is no one to care for our patients if we fail to deliver the care they need.

One thing is clear in these ever-turbulent times: The mission of our hospital remains the same. We stay committed to caring for our communities regardless of any changes, rules and regulations that come our way.

When I left my job at a large health care system to take my first CEO position at a community hospital, a mentor of mine warned me, “Be careful. A lot of good leaders go into rural health care and never return.”

As each day goes by, I gain a deeper understanding of the rewards of serving the people in rural America. So many good leaders never return to the city because they have seen firsthand how their work can make a difference for their friends and neighbors.

Tim Putnam, PhD, is CEO of Margaret Mary Community Hospital in Batesville, Ind. He joined NRHA in 2009.



Bill Altland makes a pit stop at a pharmacy in rural Arkansas. In one month he spoke at 13 pharmacy schools in seven states and visited many rural pharmacies along the way.

The adventures of Biker Bill

Rural pharmacist visits students

By Bill Altland

This spring, Bill Altland, co-owner of Whale Tail Pharmacy on Prince of Wales Island, Alaska, traveled the country on his motorcycle visiting 13 pharmacy schools to discuss running a rural pharmacy. Meanwhile, his wife Sarah held down the fort at home, continuing to provide care to the 1,100 people on the island.

Below are excerpts from his travel journal.

March 22

I am getting a bit anxious about the trip, but I'm excited as well. If the bike keeps running and the creeks don't rise, I know that I will be meeting lots of people, not just pharmacy students and faculty but also along the way. I know from my experiences on past trips that my Alaska license plates will allow me to meet many folks.

April 8

Greetings from rural central Mississippi.

After retrieving my motorcycle in northwest Arkansas, I rode two days through Oklahoma and much of Texas to get to the Texas Tech University School of Pharmacy in Abilene. My talk was also teleconferenced to the two other Tech campuses in Lubbock and Dallas. Technology is amazing, and the Tech students were great!

I also visited small-town pharmacies in both states on my way south. I met an owner in Sulfur Springs, Texas, who owns a new pharmacy converted from an old diner that still has the diner's fixtures as part of the pharmacy décor – very cool. The original counters and bar stools are there as well as the booths, and he uses the walk-in freezer as storage.

My next stop was the University of Mississippi School of Pharmacy in Oxford, Miss. That campus is about 800 miles from Abilene, which meant

I had two days of hard riding to get there. The wind was howling in north Texas, but it was a tail wind for most of the trip.

Most of the owners of the small pharmacies I encountered en route were suspicious when I asked to talk to the pharmacy owner, but when they saw my Whale Tail Pharmacy business card from Alaska, I was usually welcomed with open arms.

I had lunch with students from Ole Miss, and then I spoke to first- and second-year students from Christian Pharmacists Fellowship International and National Christian Pharmacists Association chapters. There seemed to be lots of interest in medical missions.

I'm on my way to the Auburn School of Pharmacy in Auburn, Ala. The weather is holding. Folks are very friendly here in rural Mississippi.

April 29

I had a great time visiting students and faculty at pharmacy schools in Tennessee. I stayed with a pharmacist in Knoxville who worked for us at Whale



Clockwise from top left: East Tennessee State University pharmacy students; the pharmacy in Sulfur Springs, Texas, was converted from an old diner, retaining many of the original fixtures; Bill Altland stops for a bite in Chapel Hill, N.C.; University of North Carolina students in the school's pharmacy information technology command center; Bill Altland chats with students in the medicine compounding lab at Lipscomb University in Nashville, Tenn.

Tail Pharmacy this past summer and is assistant dean of a brand-new pharmacy school at South College in Knoxville, Tenn. They hope to have their first class this summer.

After Knoxville I took back roads to Nashville and discovered one of the best bike riding roads I've found in the lower 48, with twisty turns and no shoulders between a river and some bluffs. Not much traffic and no room for error, but that's what made it so great!


I talked to students at Belmont and Lipscomb universities in Nashville. Again, several students expressed an interest in both medical missions and working in Alaska. I played my harmonica at one of the campuses just so I could say I played Nashville.

Next, I rode to Jackson, Tenn., to speak at Union University's school of pharmacy. I arrived in town just before the rain started, and there was a tornado warning in effect for several hours. The next morning I discovered the building I would be speaking in was brand new because a tornado had destroyed their other building a couple of years ago.

The next day I woke up to clear skies and rode the back highways into Arkansas. Fields were flooded for miles around, and vast areas looked more like lakes.

I stopped at three small-town pharmacies in rural

Arkansas, two of which were owned by women. One gal said she had not taken a day off in three years. The other lady said she had given birth four months after buying her store. She was confined to bed rest near term, so she set up a cot in the pharmacy, trained her husband as a pharmacy tech and counseled patients from the cot. She has off one day per week but has not had a vacation since she bought her pharmacy five years ago. There are some really dedicated pharmacy owners out there.

The last stop on my speaking tour is at the Harding University College of Pharmacy in Searcy, Ark. This will be the 13th school I've visited since I left Alaska a month ago. It's been a great trip, and I've only been rained on a couple of times. The Kawasaki has been running just fine. Thanks for coming along. 

Ride along with Bill

- **March 29:** University of Washington, Seattle
- **April 3:** Texas Tech University, Abilene
- **April 7:** University of Mississippi, Oxford
- **April 11:** Auburn University, Auburn, Ala.
- **April 14:** Campbell University, Buies Creek, N.C.
- **April 18:** University of North Carolina, Chapel Hill
- **April 19:** Wingate University, Wingate, N.C.
- **April 21:** East Tennessee State University, Johnson City
- **April 23:** South College, Knoxville, Tenn.
- **April 25:** Belmont University, Nashville, Tenn.
- **April 26:** Lipscomb University, Nashville, Tenn.
- **April 27:** Union University, Jackson, Tenn.
- **April 29:** Harding University, Searcy, Ark.



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Members on the move



2011 NRHA Rural Health Award recipients

NRHA honors excellence in rural health

Each year, the National Rural Health Association celebrates excellence by honoring outstanding individuals and organizations serving rural health, and this year was no exception.

“We’re 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.”

Honorees were recognized in May during NRHA’s 34th Annual Rural Health Conference in Austin, Texas.

Erika Ziller was presented the 2011 Louis Gorin Award for Outstanding Achievement in Rural Health for her work examining the scope and consequences of rural un-insurance and under-insurance. Ziller is a senior research associate with the Maine Rural Health Research Center at the Muskie School of Public Service, University of Southern Maine in Portland.

“Insurance is such a key piece of access to health care. I think sometimes when researchers and policymakers are talking about all the

numbers, we forget about the impact being uninsured or underinsured has on real peoples’ lives,” she says. “I’m grateful to NRHA, not only for this award, but for their consistent advocacy for the elimination of place-based health disparities.”

The 2011 Rural Health Award recipients are:

Outstanding Rural Health Organization:

St. Mary’s/Clearwater Valley Hospitals and Clinics, Cottonwood and Orofino, Idaho

Rural Health Quality Awards: Johnson County Community Hospital, Mountain City, Tenn.

Outstanding Rural Health Program:

Alaska Federal Health Care Partnership, Anchorage

Louis Gorin Award for Outstanding Achievement in Rural Health:

Erika Ziller, Portland, Maine

Outstanding Researcher:

Robert Elliott, MD, Baton Rouge, La.

Rural Health Practitioner of the Year:

Dennis Kepka, MD, Ellsworth County, Kan.

Send your career updates
to editor@NRHArural.org.

Distinguished Educator of the Year:

Susan Stone, DNSc, Hyden, Ky.

President's Award:

Tommy Barnhart, Winston Salem, N.C.

Volunteer of the Year:

Lance Keilers, Ballinger, Texas

Special Recognition:

Caroline Ford, Reno, Nev.

Special Recognition:

Van Hipp, Washington, D.C.

Student Leadership Award:

Gena Cooper, Madison, Wis.

Student Achievement Award:

Colin Buzza, Iowa City, Iowa

Barrow receives California association promotion

Steve Barrow was recently promoted to become the California State Rural Health Association's executive director.

Barrow served as the association's policy director since 2009 and has more than 30 years of nonprofit experience.

"People forget how rural California is. Rural California makes up 85 percent of our state's landmass, involves 44 of our 58 counties, and involves directly more than five million people, 13 percent of our state's population. One in 60 Americans live in rural California. Dealing with health care and health policy in California is not just a California issue," Barrow says. "Rural health in California is a national issue, and we look to the National Rural Health Association to help shape policies and programs that work here and for the rest of the nation. We are dependent on our affiliation with NRHA in identifying and moving important health policies."

Barrow is a member of the California Healthcare Workforce Development Council, the Office of Statewide Health Planning and Development, the California Immunization Coalition and the California Telehealth Network.

Caseman leads Georgia association

Matt Caseman was named executive director of the Georgia Rural Health Association, the country's oldest state rural health association.

"Health care is one of the top issues facing not only Georgia but our country. For rural communities to grow and succeed, quality health care is needed, or they will see erosion in population and economic development," Caseman says. "The National Rural Health Association and the Georgia Rural Health Association play a critical role in elevating the debate on improving health care in underserved communities. I am honored to work with NRHA in this effort."

Caseman has 15 years of public affairs experience and served as director of the Georgia House of Representatives public information office. He serves on NRHA's Communications Committee.

Longenecker receives teaching award

Randall Longenecker, MD, received the Society of Teachers of Family Medicine 2011 Excellence in Education Award.

He is a clinical professor of family medicine and assistant dean for rural medical education at the Ohio State University College of Medicine. He has been a family physician in group practice in rural Ohio since 1982.

Longenecker was a founding member of the National Rural Health Association's Rural Medical Educators group and is project director for the Rural Training Track Technical Assistance Program, created through a cooperative agreement between NRHA and the Office of Rural Health Policy.



Alan Morgan

News briefs

NRHA CEO contributes to nursing textbook

In his tenth year at the National Rural Health Association, CEO Alan Morgan was approached to write a chapter about rural health for the sixth edition of "Policy and Politics in Nursing and Health Care."

"Meeting the health care needs of rural populations is a challenge that is complicated by archaic state and federal policies that impede people's access to nursing care, including primary care and chronic care management," says Diana Mason, the textbook's co-author. "The sixth edition ensures that rural health is recognized as a

vital component of any efforts to transform health care in the U.S. Alan Morgan's chapter provides an excellent discussion of the leading problems in rural health and the policy options for addressing them."

This is the first time the book, designed for nursing students from baccalaureate to doctoral level, has dedicated a section to rural health issues. Morgan's chapter, "The Rural Health Care Tundra," is the first chapter he's had published and highlights NRHA's advocacy efforts on behalf of rural patients and providers.

NRHA values White House Rural Council

The Obama Administration recently established the first White House Rural Council and named access to affordable health care among the council's top priorities.

The National Rural Health Association is pleased the White House is focused on improving the lives of the 62 million Americans who call rural home.

"We are delighted with the creation of the White House Rural Council," says Alan Morgan, NRHA CEO. "This is something we have supported in the past as a means to better coordinate rural issues across sector within the federal government. However, for this new council to be successful, it will need to place health and health care front and center within its discussions. A coordinated approach to expanding rural health IT within

the federal government is essential, and it must be a priority moving forward."

U.S. Agriculture Secretary Tom Vilsack will chair the new advisory team working toward bettering the economic outlook and quality of life for rural residents. The council will make recommendations for investment in rural areas and will coordinate federal engagement with a variety of rural stakeholders, including organizations, small businesses and state, local and tribal governments.

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accelerating advocacy

Reimbursement cuts on horizon for rural

With Medicare reimbursement rates for physicians decreasing by 29.5 percent on Jan. 1, 2012, unless Congress once again postpones the cuts, rural physicians are anxious about their economic future and the ability to provide access to health care.

The reduction, triggered by Medicare's sustainable growth rate formula for calculating physicians' pay, is just one of the looming cuts.

The National Rural Health Association continues to fight for additional payments and to eliminate long-standing payment inequities for rural providers, including the adjustment of the geographic practice cost indices formula and a 10 percent bonus for physicians whose primary care services account for at least 60 percent of Medicare-allowed charges.

In the Affordable Care Act, NRHA also fought for bonuses for general surgeons who perform operations in health professional shortage areas, but these bonuses are set to expire in 2016.

Because rural Medicaid and Medicare beneficiaries already face greater transportation barriers and provider shortages, changes in reimbursement or benefits could create additional barriers to care. Rural providers are often more dependent on Medicare and Medicaid reimbursement than their urban counterparts, and coupled with rising liability premiums and workforce costs, cuts will have a major effect on the health care infrastructure and access in rural America.

NRHA is concerned cuts in reimbursement rates will cause significant difficulty for rural providers, possibly making them unable to treat Medicaid or Medicare beneficiaries. These sources of funding for providers contribute to both their bottom line and their continued ability to provide services for their communities.

— Erin Mahn, NRHA government affairs and policy assistant



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Barbecue, brew and jousting, oh my!

While you're in town for NRHA's Rural Health Clinic and Critical Access Hospital conferences Sept. 27-30, make time to explore the events and attractions Kansas City, Mo., has to offer this fall.

1. **American Royal BBQ contest** Meet some of the country's most delicious meats at this renowned annual competition. With more than 500 teams, it's the largest barbecue contest in the world.
2. **Boulevard Brewery tour** Discover the origin of some of the Midwest's finest beers on a free brewery tour. Samples included.
3. **Dancing water shows** Across the street from the hotel, one of KC's best-known fountains is synchronized to recorded music by the Kansas City Symphony. The show happens every hour on the hour.
4. **Renaissance Festival** Huzzah! With jousting, magic and comedy shows, kings and queens, and giant smoked turkey legs, this KC tradition's old-timey spirit is contagious.
5. **World War I Museum** Walk from the hotel to check out the country's only museum dedicated to WWI, and take the elevator up the Liberty Memorial tower for a panoramic view of the city.

For more ways to turn your trip into a vacation, go to visitkc.com. Register for the conferences at RuralHealthWeb.org/kc.

shifting gears

Grilling up green

Your Daily Thread (yourdailythread.com), an online guide to green living, knows how to make summer cookouts fun and eco-friendly.

1. Avoid disposable plates and forks.
2. Natural gas is cleaner and more energy efficient than wood or charcoal, which pollute the air and can cause lung and heart health problems.
3. When possible, buy local produce from a farmers' market or co-op instead of chemically-treated, packaged vegetables from the supermarket.
4. If you serve bottled or canned beverages, recycle.
5. When you're done grilling, scrape the grill while it's still hot and clean the grate with baking soda and a wire brush rather than harsh chemicals.

Off the beaten path



Ms. Dinny

Desert dinos

Amid the arid plains and palms of Cabazon, Calif., population 2,229, sit the most unlikely of desert dwellers: A 150-foot-long brontosaurus named Ms. Dinny and a three-story-tall tyrannosaurus named Mr. Rex. Known as the Cabazon dinosaurs, the prehistoric lizards (created more than 30 years ago) are made of concrete and are seen by more than 12 million travelers each year from Interstate 10.

Ms. Dinny has the distinction of not only being the world's largest dinosaur but also hosting a gift shop with a little something for everyone. The site is also home to a dinosaur museum.

To learn more, visit cabazondinosaurs.com.



National Rural Health Association

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