

rural roads

Winter 2012 National Rural Health Association



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the most dangerous place

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Welcome to 2012.

The health care debate rages on, and it's vital that rural is represented and has a seat at the table.

It's not enough to depend on our state and national organizations, or their staff lobbyists for that matter, to speak on our behalf. We must dedicate the time, effort and resources to make the calls, write the letters and travel the many miles to spread the word that rural matters.

I encourage you to get involved with the National Rural Health Association this year. NRHA consists of a network of 20,000 members represented through councils, committees and constituency groups. I will be working with NRHA staff, in unison with the Board of Trustees and committee chairs, on a plan to increase member involvement in our organization.

Any organization is only as strong as its members and your support and involvement is crucial to our future success.

In a highly energized political battle over health reform, it's our responsibility to stand up and be heard and, just as importantly, stand together to show unity in rural health care.

2012 will be an exciting, fast-paced year in health reform on a state and national level, and I look forward to serving as NRHA's president.

Lance Keilers

2012 NRHA president

pit stop

5 things I picked up in this issue:

1. Women living in disadvantaged areas are more than twice as likely to be victims of domestic violence than women in more advantaged areas. *page 6*
2. 23.5 million Americans live in a food desert. *page 12*
3. Every additional rural physician adds \$1.5 million in revenue and creates 23 jobs annually for his or her community. *page 20*
4. NRHA staff initially thought email was just a passing fad. *page 25*
5. Spring is a perfect time for skiing in the Rockies, before or after NRHA's Annual Conference in April in Denver. *page 30*

When home is the most dangerous place

Missouri nonprofits provide shelter and hope for rural victims of abuse

By Julia M. Johnson



If you're the target of domestic abuse, there's no such concept as "safe at home."

Instead of providing refuge and security, the confines of home can trap a woman in a cycle of physical and psychological violence that seems unbreakable.

Four walls become a cloak for the abuser, a place where violent secrets are hidden from the rest of the world. Sometimes the only way a victim can break the web of suffering is to turn to a shelter for help.

But that's not always an option for many wives, girlfriends, mothers and daughters who need it most.

According to the Jefferson City-based Missouri Coalition Against Domestic and Sexual Violence, for every two women who used Missouri domestic violence shelters in 2009, three more were turned away due to lack of space. That translates into a lot of women forced to remain in situations where their lives and families aren't safe from the violent hands and volatile tempers of abusers.

And the challenges often multiply for women in rural areas where services are fewer and farther between, transportation can be tough to come by, and distance magnifies isolation.

Turning the tide

In Missouri, a number of dedicated nonprofits are working to reverse these unfortunate circumstances. Some organizations provide a safe, welcoming place to stay, away from the violence; others offer legal assistance, education, support groups and programs that help abused women and their children feel whole again. Many receive critical funding from the Missouri Foundation for Health (MFH), an independent, St. Louis-based philanthropy supporting health-focused nonprofits.

In areas outside the urban core, many of these nonprofits tailor their services to the special needs of rural women, helping them survive and thrive once the cycle of violence is broken.

“Abused women spend so much of their energy trying to maintain the peace, their relationships and their kids, they often don’t take care of themselves.”

Mary Ann Allen, Haven House executive director

Since it began in 2008, MFH’s Women’s Health funding program has provided \$7 million in grants to 50 Missouri nonprofits that help women rebuild lives scarred by domestic and sexual abuse. The grants have been given to organizations across most of the state, including many in rural communities. These nonprofits engage women and children in a variety of programs that provide safe shelter, offer support services to meet their mental and physical needs, and teach life skills to help them move forward.

“Abused women spend so much of their energy trying to maintain the peace, their relationships and their kids, they often don’t take care of themselves,” says Mary Ann Allen, executive director of Haven House in the southeast Missouri town of Poplar Bluff, population 17,045.

Haven House is a 27-bed shelter for women and children that also offers group and support services.

“When women aren’t able to set themselves as a priority, it can lead to chronic health problems,” Allen says. “They feel isolated, and the stress of their relationships causes them to withdraw from other people. Many haven’t had the kind of nurturing that makes them feel they have the right to ask for help as an adult. And more than half of the women we serve report that their partners also abuse their children.”

Allen’s organization received \$129,309 in Women’s Health funds to help provide daily support groups, education, referrals and visits with advocates who help abused women learn about services available to them. Haven House also prides itself in offering what many consider nontraditional domestic violence services, including classes on maintaining a checking account, workshops on the therapeutic benefits

of laughter, and visits by a cosmetic representative.

“We’ve tried to address every aspect of women’s and families’ health that we could think of,” Allen explains.

Meeting the need

Larissa Warren, executive director of the Polk County House of Hope, a shelter in the southwest Missouri town of Bolivar, population 11,017, says abused women in outlying areas face a special set of challenges.

“Domestic violence services often are spread out between rural communities,” she explains. “We work in five rural counties, but there is only one hospital for outpatient services. And there’s no public transportation

continues



Karen Scott, a specially trained sexual assault nurse examiner in Joplin, Mo., helps abused women make the first steps toward recovery. Photo courtesy of Freeman Health System.

Startling stats

About one in four women will experience domestic violence in her lifetime.

The percentage of female murder victims killed by intimate or former partners has remained at about 30 percent since 1976.

Women living in disadvantaged areas are more than twice as likely to be victims of intimate violence compared with women in more advantaged neighborhoods.

in our counties, except for OATS [Older Adults Transportation Service]. Access to services may be impossible if there's no friend or family member to provide transportation."

The lack of anonymity also worsens the domestic violence epidemic in rural areas, Warren says.

"If you seek services, there's a fear everyone will know about it, and no one will believe what you say about your abuser."

Larissa Warren, Polk County House of Hope executive director

"Everyone knows your business," she says. "The majority of towns in our service area are under 2,000 people. So, often, the abuser is related to or friends with local authorities. If you seek services, there's a fear everyone will know about it, and no one will believe what you say about your abuser."

According to Warren, these concerns often discourage women from asking for the help they need.

To help counteract these issues, House of Hope has used \$190,000 in Women's Health grants to provide transportation, shelter, counseling and other services to women and families in need. Warren says these programs are a lifeline for rural women whose abusers try to control them by denying money and transportation, and threatening harm if they leave.

Breaking the cycle

"I think we will see an increase in the need for domestic violence services in the next few years," says Sherry Levin, executive director of Audrain County Crisis Intervention Services, a 13-bed shelter in Mexico, Mo., population 10,852.

Her organization serves women in two central Missouri counties, and offers a crisis hotline and other services. Women in Audrain County continue to deal with a lack of affordable housing, rising rents and utilities and few job opportunities – problems that increasingly thwart their efforts to break away from abusers, who may be their only means of financial support.

"Most of us are so used to having our cars. We don't realize how much of a struggle it is for a person who can't afford a tank of gas," Levin says. "When an abused woman in a rural area asks for help, she also may run into the mentality of, 'Your husband's just been drinking; he'll sleep it off and be fine.' Other people don't want to deal with her situation, and often, reports don't get written. Many law enforcement agencies are very dedicated and cooperative, but sometimes there is a 'cry wolf' pattern in rural areas. An officer may say to a victim, 'I've come all the way out to your house 10 times this year; you need to deal with this yourself now.'"

Often, Levin says, the officer gets frustrated, doesn't understand why the woman can't leave her abuser and may not know what else to do for her.

To fill the gaps for women in these situations, Levin's organization is using a \$44,333 MFH grant to provide court advocate services to women who need help navigating the legal system and filing orders of protection against abusers. The advocate program also helps women learn about safety planning and working with law enforcement to protect themselves and their families.

After the storm

Times of disaster and hardship send stress levels soaring, and that can result in heightened family violence as abusers react to material losses. No one knows that better than the care providers at

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National Domestic
Violence Hotline
800-799-SAFE (7233)
800-787-3224 (TTY)
thehotline.org

Audrain County Crisis
Intervention Services
Central Missouri
Crisis hotline: 573-581-2280

Freeman Health System
Southwest Missouri
Sexual Assault Nurse Examiner
program: 417-347-SANE (7263)
freemanhealth.org

Haven House
Southeast Missouri
Office: 573-686-4873

Polk County House of Hope
Southwest Missouri
Crisis hotline: 417-399-6744
pchouseofhope.org

Safe Connections
St. Louis area
Crisis helpline: 314-531-2003
safeconnections.org

Freeman Health System based in Joplin, Mo., population 49,024.


The three-hospital system anticipates a growing need for long-term domestic violence services following the May 2011 tornado that destroyed a third of the town and tracked across rural portions of Jasper and Newton counties, killing 162 people and causing more than \$2 billion in damage.

Freeman, which cares for patients from surrounding rural areas as well as Joplin, has established a Sexual Assault Nurse Examiner (SANE) program to train nurses to care for victims of sexual violence. The health system's \$150,000 Women's Health grant supports forensic examination services, assault victim care and post-assault referrals. The grant also helped Freeman purchase new forensic exam room equipment and educate law enforcement and the community about preventing domestic violence.

"Abusers tend to ramp up their behavior in times of crisis," cautions Karen Scott, Freeman's SANE

coordinator. "Add in the stressors caused by the tornado – people displaced, houses demolished, more than 800 businesses ruined – and you can see that recovery will be a long, drawn-out process. We think we'll continue to see an increase in domestic violence and post-traumatic stress-related health needs in the coming months and years."

Other domestic violence care providers agree that the need for services will continue to grow. The help they provide, especially in isolated rural areas, is often an abused woman's only chance at building a normal life.

Regardless of the environment in which it occurs, reversing the tide of domestic violence is about "helping women deal with the past, learning new ways of trusting people, and establishing healthy boundaries," says Ilene Bloom-Ellis, director of clinical services for the St. Louis-based crisis assistance provider Safe Connections. "What would seem like small accomplishments to most people are actually of major significance in an abused woman's life." 

Julia M. Johnson is the Missouri Foundation for Health communications and media specialist.

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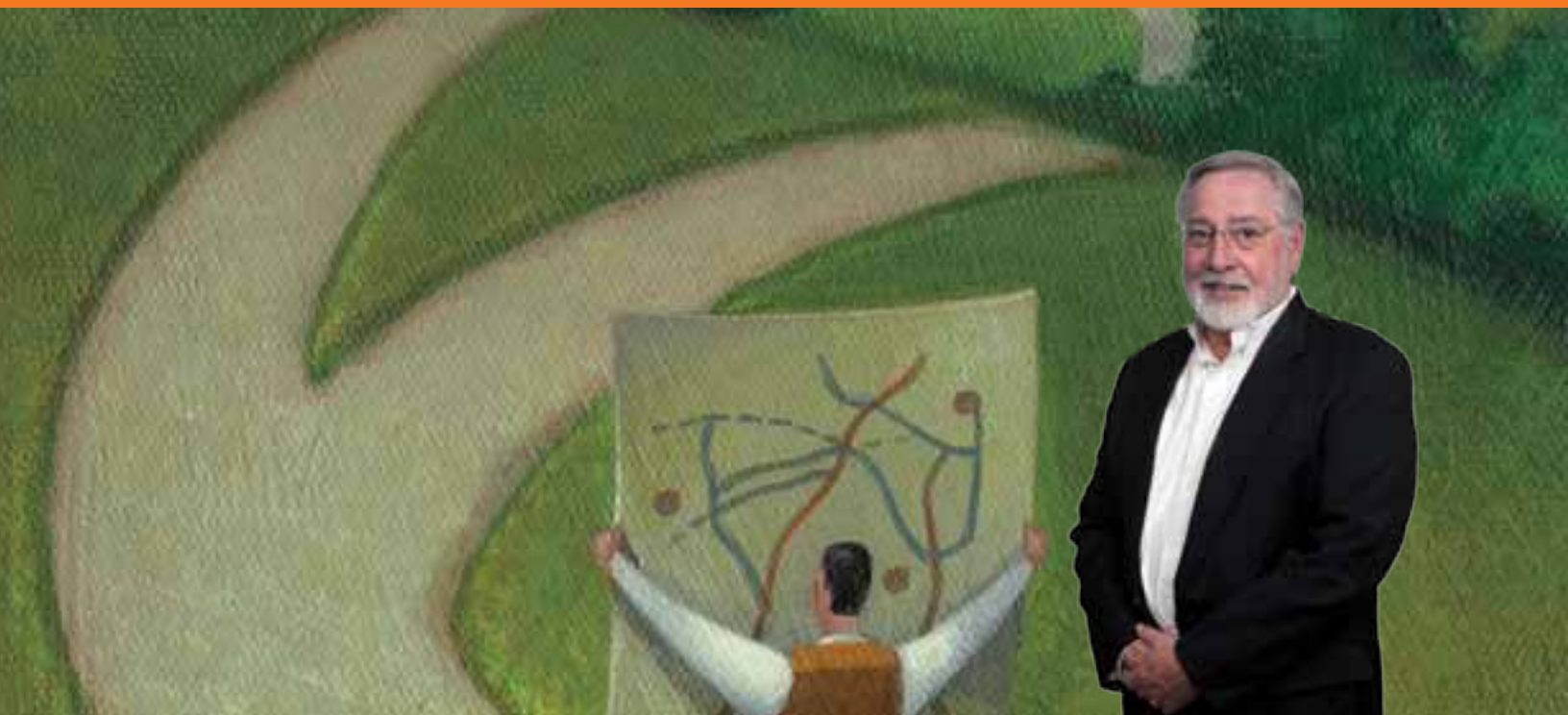
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Abandoned grocery stores can be found in many rural communities, leaving residents with minimal healthy options.

Hunger pains

Rural food deserts leave residents hungry for nutritious options

By Angela Lutz

Standing in the middle of a grassy field just outside Cody, Neb., population 130, John Johnson, village board chairman, points to the .96-acre of land where the town's new grocery store will be built.

"It's a perfect location," he says via video report by Harvest Public Media (HPM), a collaborative National Public Radio project dedicated to covering food, fuel and agriculture in Midwestern communities. "We couldn't ask for any better."

Clay Masters, HPM reporter, says the grocery store is especially important to Cody because the town is located in the center of a rural food desert, which the United States Department of Agriculture (USDA) defines

as anywhere residents have to travel 10 or more miles to reach a full-service grocery store (or more than one mile in urban areas). Approximately 23.5 million Americans live in a food desert and experience a lack of ready access to fresh, healthy and affordable food, which contributes to a poor diet and can lead to higher rates of obesity, diabetes and heart disease.

“There have been studies saying you need X number of population to support a grocery store, but you need much less if everyone in a community buys in.”

Steph Larsen, Center for Rural Affairs assistant director of organizing

“The residents [of Cody] have to travel up to 40 miles to get to the nearest store,” Masters explains. “There was a store in town 10 years ago, but it closed. One woman has lived there since 1963, and she said that when someone stops through while driving along Highway 20 and asks where the nearest store is, when they say they don’t have one, people wonder, ‘What’s wrong? Why can’t we buy groceries here?’ It creates a certain vulnerability.”

A desert in relationships

Masters says that when stores close, individuals in small towns often have trouble opening new ones because running a viable, profitable independent business is always a challenge, particularly in places with populations as small as Cody. That’s why community leaders in Cody are utilizing a USDA grant to make their store a certified nonprofit, which will be used as a part of hands-on business curriculum for local high school students. It will also be constructed using energy-efficient hay bales.

“[In small towns] there are often not enough people to sustain that kind of business, and individuals can’t support long-term debt,” Masters explains. “The key is finding innovative solutions.”

In addition to the lack of access to nutritious sustenance, food deserts also contribute to the dissolution of rural communities.

“In rural situations, the grocery store closing is another example of the community’s fading,” Masters says. “It’s a sense of your community going away.”

According to Steph Larsen, Center for Rural Affairs assistant director of organizing, a grocery store is vital to a rural community because it connects townspeople.

“Grocery stores are more than just stores, because everyone needs to eat, and everyone needs a place to access healthy food,” she explains. “It’s different than when the dress shop closes, or the hardware store closes, because they don’t share that sort of role as a cornerstone business. Grocery stores are also places where people socialize.”

Because many small businesses must compete with large, national retailers, Larsen points out that the support of the community is also vital to the survival of independent businesses.

“Towns can check in with the grocer and make sure they’re doing okay,” she says. “They can shop at the local store, which is extremely important. Grocers can also involve the community more by being out on the floor, knowing people’s names and being open to suggestions and products people want. That kind of openness is how a small grocery store competes with something like Wal-Mart or any big-box store. It’s the feeling of customer service, and if people feel good when they walk in the door, they’re going to remember that.”

In a movement away from national chains and industrialized food production, Dennis Berens, Nebraska Department of Health and Human Services director and National Rural Health Association past-president, has witnessed communities return to relationships with their food and those who grow it by shopping at farmers’ markets.

“Part of the food desert may be the fact that we allowed a desert in relationships to be established,” he says. “But I see families every week selling whatever they’re harvesting. We have a new food-relational model that’s beginning to be reestablished. It’s the relation between the producer, the person who creates something from the product, and the consumer, who knows the people between all of this.”

Berens says that moving food growth, harvesting and production back to the local or regional level will help rebuild and sustain communities by

Information oasis

To use the United States Department of Agriculture’s food desert locator to discover the location of food deserts nationwide, visit ers.usda.gov/data/fooddesert.

To watch Harvest Public Media’s video on Cody, Neb., as well as other reports, visit harvestpublicmedia.org.

continues

creating a food supply as well as employment opportunities. He also views rural food shortages and rural health care shortages as parallel problems.

“I liken what’s going on with food to what’s going on in health care delivery systems,” he says. “The common word is access. Do you have access to healthy food that will nourish your body and become a positive determinant of health? Do you have access to quality health care providers who will care for your body and mind? The linkage is health and access, as well as food and health. From my perspective, you have a responsibility to not only help that community survive but also to grow and prosper.”

Community support

But one possible concern about moving food production to the local level – and increasing availability of fruits and vegetables in general – is that fresh, locally produced food is often more expensive than processed, pre-packaged foods. Additionally, extreme weather in some regions, particularly during the winter months, can make local farming challenging if not impossible.

According to California Watch, a nonprofit branch of the Center for Investigative Reporting that’s located in a state where more than 1 million people live in a food desert, merely building more grocery stores will not solve the problem. Because the majority of food deserts are located in economically disadvantaged areas, the healthy option must also become the easy, default, affordable option, says a recent report.

According to Larsen, one way policies are shifting in order to ensure healthy food is available to people who need it most is by allowing Supplemental Nutrition Assistance Program benefits at farmers’ markets, as well as including fresh produce in government benefits packages for seniors and moms enrolled in USDA’s Women, Infants and Children program. She also points to the Farm to School effort, which connects farmers to schools to serve healthy meals in cafeterias and promotes school gardens.

Overcoming financial concerns is a significant challenge in grocery store operations as well. Even in towns such as Cody that are able to secure grant funding, Masters says there are still significant barriers that must be overcome, and “there’s just so much red tape involved.”

“For example, they thought they could use any architect, and only once they had the plans done they realized they had to use someone from Nebraska,” he explains. “And the last time I talked with the village board president, he said it would cost \$30,000 more than expected, and that would be money they’d have to raise. There’s a lot of frustration that they can’t get this thing built.”

Larsen suggests that community leaders should first ensure a potential store has the residents’ support before looking at issues of funding or grants.

“Instead of thinking of where they need to get the money, they need to think about where they’ll get customers,” she says. “There have been studies saying you need X number of population to support a grocery store, but

you need much less if everyone in a community buys in. The very first thing I suggest to anyone is to get the community together and make sure this is something the community wants.”


Once a community does open a store, or rally to support the survival of an existing store, Larsen suggests considering ways to lower operating costs, especially utilities, the highest cost for most stores. The Rural Energy for America program provides grants for energy audits and renewable energy development assistance, she says.

“I liken what’s going on with food to what’s going on in health care delivery systems. The common word is access.”

Dennis Berens, Nebraska Department of Health and Human Services director

“A lot of coolers, if you think about it, are open-faced, which is extremely inefficient,” she says. “The Rural Energy for America program can help do energy assessments for rural businesses and help with grants to purchase more energy efficient appliances or coolers to bring down energy costs and make the store more viable overall. Some towns have also used renewable energy tax credits to put solar panels on the roofs.”

Another money-saving suggestion Larsen recommends that can both help cut costs and rebuild a sense of community, is what she calls stacked enterprises, in which multiple businesses utilize the same infrastructure.

“The more people you get in the store, the more profit you’ll make,” she explains. “The pharmacy, the bank, the post office, coffee shops and restaurants can all utilize the same building and the same utilities. The more you can stack those things on top of each other, the lower your overhead cost is, and the more profitable your business will be. And the more profitable a store is, the less likely it will close and create a food desert.” 

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Rural vets benefit from new local services

By Allen Berkowitz



A physical therapist in the Veterans Affairs Stephens City, Va., outpatient clinic helps a patient. Rural health funding was instrumental in staffing and equipping this clinic.

Dozens of miles from the U.S. Department of Veterans Affairs (VA) central office buildings in Washington, D.C., a veteran named Jim* panhandles outside local shops and sleeps each night in a tent near a small town in northern Virginia.

Although Jim is a regular in and out of VA and private health care facilities in the area, he doesn't know much about the resources available to him to get housing or apply for Social Security benefits to help make lasting changes in his life.

But he knows and trusts VA. He turns to them, and thanks to a new VA homeless outreach program, Jim has applied for a number of resources through VA and other government agencies and is now eligible for public housing.

The VA Capitol Health Care Network, which serves veterans from Maryland, the District of Columbia,

and portions of Virginia, West Virginia and Pennsylvania, has collaborated with several organizations on 16 new rural health initiatives, including this rural homeless outreach program, designed to improve access to and quality of care for rural veterans. These initiatives were made possible by grants through VA's Office of Rural Health and encompass four major components:

- Expanding access and services to veterans
- Enhancing the quality of care environment
- Improving outreach and enrollment
- Providing effective evaluation and measurement

While veterans in metropolitan areas can take advantage of public transportation to travel to and from their appointments at their local VA medical centers, veterans living in rural areas sometimes have a more difficult time accessing VA health care facilities. Compounding this, many rural veterans, particularly those who are women or disabled, have unique health needs beyond those of their neighbors and friends, making it difficult for them to find the care they need in communities where specialists are often scarce.


One such veteran, Susan*, who recently relocated to a community within the VA Capitol Health Care Network, knows all too well what some of these health care problems can be. After struggling for years with drug and alcohol abuse, in addition to episodes of homelessness, Susan went to a VA clinic in Florida where she met with a social worker who helped her with her living situation and her issues related to military sexual trauma suffered early in her service. Now in her mid-50s, Susan told network personnel in an interview in Virginia she had never realized that the trauma she experienced could have been a contributing factor to her failed marriages and substance abuse issues. Susan moved back to Virginia to be near family and has been receiving health care at a VA clinic for several months.

The network has also spent the past year implementing an extensive health program for women veterans. With the growth of women entering the military and subsequently completing their service, the network is putting extra emphasis on promoting the health and welfare of female veterans by developing training programs and materials to educate rural providers within and outside of VA about their unique health issues, including military sexual trauma possibly resulting in post-traumatic stress disorder and substance abuse, and a greater number of reproductive health issues, these vets may face.

The network's Mini Mobile Residency project provides didactic and care-based instruction of gender-specific health care topics and hands-on training to 127 providers, both VA and community providers. Additionally, the Women Veterans Rural Health Program provides three nurse practitioners for four of the network's rural outpatient clinics dedicated to the treatment of women veterans.

"The availability of these nurse practitioners in these rural outpatient clinics has increased access to women veterans for both primary and specialty care, increased our women veteran panel size, increased the number of comprehensive women's health office visits as well as improved access to mental health services," says Paula Gorman, VA Capitol Health Care Network lead women veteran program manager.

Perhaps one of the most visible changes vets might see in this network is the recent addition of physical and occupational rehabilitative services for veterans in rural areas by adding rehabilitative capacity within various community-based outpatient clinics in the western part of the region. Other improvements include the introduction of van and shuttle services to the Martinsburg, W.V.; Baltimore, Md.; and Perry Point, Md., VA Medical Centers from veterans' homes in rural communities. The shuttles help veterans living far from facilities get to their appointments faster and more safely. Previous VA transportation capabilities were limited not only in how many veterans they could serve but also in the ability to accommodate veterans with special medical needs, like those who use wheelchairs or oxygen equipment.

To spread the news about these and other services, two outreach coordinators have been working to connect specifically with rural residents throughout the past year, attending more than 80 events, making more than 20,000 contacts, and enrolling more than 250 veterans in the Veterans Health Administration so far. 

** names changed*

Allen Berkowitz, PhD, is a strategic planning officer and rural health consultant for the Veterans Affairs Capitol Health Care Network.

Call on them

The U.S. Department of Veterans Affairs (VA) is reaching out to veterans to raise awareness about the Veterans Crisis Line, a confidential, 24/7 hotline, online chat and text service.

Veterans and active duty personnel can access the crisis line three ways:

1. Call 1-800-273-8255 and press 1.
2. Go to veteranscrisisline.net.
3. Send a text to 838255.

The hotline connects veterans in crisis and their families and friends with trained VA responders who offer immediate support and referrals for care. As needed, callers can be referred to VA Suicide Prevention Coordinators (SPC), who connect veteran and active duty armed forces members with appropriate services.

Each VA medical center also staffs a SPC. The VA encourages health care professionals to contact the nearest SPC to learn more about how to serve and support veterans in their areas and to visit veteranscrisisline.net to download online ads and print materials to help promote the free crisis line.

For examples of how the hotline helps save lives every day, read a feature story on the Canandaigua, N.Y., call center at RuralRoadsOnline.com/ontheLine.

Serving those who serve

For more information on rural health programs for veterans:

1. Attend the National Rural Health Association's Rural Health Policy Institute Jan. 30 through Feb. 1 in Washington, D.C. Register at RuralHealthWeb.org/pi.
2. Hear from experts across the country, including the Veterans Affairs Capitol Health Care Network, during NRHA's 35th Annual Rural Health Conference in Denver April 17 through 20. For the full agenda, visit RuralHealthWeb.org/annual.

ACI/Boland is one of a select few architectural firms involved in the creation of a "How To" manual for rural hospitals and communities

led by the US Department of Health & Human Services' Office of Rural Health Policy.



Critical Access Hospital Replacement Process: The Manual, U.S. Department of Health and Human Services (2010), Health Resources and Services Administration, Office of Rural Health Policy, Rockville, MD 20857



"Our new hospital is wonderful! ACI/Boland's architectural planning was instrumental to Atchison Hospital achieving a competitive edge." – John Jacobson, CEO Atchison Hospital

"I am very proud of the design our Team was able to develop and I enjoy every opportunity I get to discuss the design from an owner's perspective. Thanks again." – Travis Martin, CHFM, Facilities Director, Clarinda Regional Health Center

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White House outlines progress, plans of its rural council



Doug McKalip at the White House

Six months after President Barack Obama created the White House Rural Council to address challenges in rural America, the National Rural Health Association's *Rural Roads* magazine asked Doug McKalip, White House senior policy advisor for rural affairs, to explain how the council has and hopes to impact rural health.

Why was the council created?

President Obama launched the White House Rural Council in June to help bring more focus and resources to the table to meet the unique economic challenges facing rural America. The Obama administration has invested a tremendous amount of resources to bolster the economic conditions of rural America. But the president wanted to do even more and ensure that all facets of the federal government are contributing and coordinating resources.

The goal is to help spur jobs and economic growth, while also making gains in the quality of life in rural America, including health care, education and infrastructure.

How much does health care and access to health care factor into the council's plans?

Access to affordable health care is an important component of the White House Rural Council's work. From day one, the Department of Health and Human Services (HHS) has been an active participant in the council and has been working with other agencies to advance innovative policies.

For example, one of the initiatives was to ensure critical access hospitals (those with 25 beds or fewer) are able to attract physicians using the National Health Service Corps loan repayment incentives. Under previous policy, this option wasn't available to those small hospitals, often located in rural areas. For small, rural communities, this means an additional tool to improve local health care. We know that every physician added to a rural community results in approximately \$1.5 million in annual total revenue and creates 23 jobs annually. So we're talking about economic development in rural areas, in addition to improving health care.

What is the council's ultimate goal in regards to health care? How will it achieve this goal?

Most people would probably be surprised to know that we still have a divergence in mortality rates in America between rural areas and metro areas. It's certainly a goal of the council to help ensure that an American's life expectancy doesn't have to be determined by location.

We want to take steps to improve the recruitment and retention of doctors in rural areas and to build a better infrastructure of health care professionals in rural areas. The goal should be to ensure rural health care facilities have the local talent pool and trained workforce they need. This approach helps meet the president's goal of putting Americans to work, while also providing improved local health care systems.

Who are the council's key health care members?

In addition to the White House team supporting the White House Rural Council, 19 federal departments and agencies comprise the group. Agriculture Secretary Tom Vilsack serves as chair, and HHS Secretary Kathleen Sebelius' team plays a very central role on the council. Entities like the Appalachian Regional Commission and the Delta Regional Authority have also been very positive contributors and have worked hard on improving rural health care.

Has the council succeeded in better coordinating federal resources across agencies?

Absolutely. We have already seen cooperative efforts across agency boundaries flourish. In addition to the successful step of ensuring that rural critical access hospitals are able to better recruit physicians, we also have seen exciting collaboration between HHS and agencies such as the departments of agriculture, labor, education and housing and urban development, to name a few. These agencies are ensuring that rural development dollars are available to support health care information technology.


Will the council be permanent, or when do you expect it to complete its work?

The council was created to address long-standing issues, challenges and opportunities in rural America. Many of the challenges rural America faces did not appear overnight. Thus many of the solutions and the path toward prosperity and a better future will not happen overnight. The commitment on the part of the administration to addressing the needs of rural America is a long-term approach.

How can NRHA members provide input to council members and get updates on its progress?

Members of the public are welcome to email us at ruralaffairs@who.eop.gov.

Information is also posted at whitehouse.gov/administration/eop/rural-council.

And the White House Rural Council has already provided a policy assessment; "Jobs and Economic Security for Rural America" is available on the White House website. 

Functions and focus

Obama outlined these core functions of the White House Rural Council:

1. Streamline and improve the effectiveness of federal programs serving rural America.
2. Engage stakeholders, including farmers, ranchers and local citizens, on issues and solutions in rural communities.
3. Promote and coordinate private-sector partnerships.

Naming economic development the council's top priority, the president asked members to focus on:

1. Opportunity: Increasing the flow of capital to rural areas, job creation and workforce development
2. Innovation: Including expansion of telecommunications, renewable energy and new markets for rural communities
3. Quality of life: Including increased access to quality health care, education and housing, and particularly in persistent poverty counties and tribal areas
4. Conservation: Including expansion of outdoor opportunities and economic growth

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Beginnings & Passages



Dustin Summers

“While working at NRHA, I discovered that rural America is not limited to small towns in the South.”

NRHA shows doctor-to-be real scope of rural practice

By Dustin Summers

It was a miracle I was ever hired at the National Rural Health Association – a miracle.

The more time that passes between today and my first day at NRHA, the more acutely aware I am of this fact.

Two years ago, NRHA was searching for a program services coordinator. Although I was unsure as to what exactly that entailed, I submitted my résumé and was invited to interview a week later. I barely made my allotted time, arriving in a sweat that stuck my dress shirt to my back and ran from the edge of my shaggy hair through the unkempt beard that had been slated for elimination earlier in the day. However, I had spent my morning in a Maryland junkyard retrieving my beloved Jeep Cherokee that had been stolen 10 days earlier from behind my house in southeast D.C., a neighborhood I am proud to say lies in the nation's sixth most dangerous zip code.

Arriving flustered and out of breath, I answered questions, chugged some water, and left thinking there was no way in hell I would be given a second thought. I was wrong. Two weeks later, I reported to the second floor of the only Swiss ski chalet on K Street to begin working for the nation's largest rural health organization.

Over the next 18 months, I lost emails, misheard phone messages, wandered through airports and worked with the most dedicated, caring professionals from around the country. I toured rural hospitals in South Dakota, learned about rural preservation in Colorado, planned rural conferences in Minnesota, met with border health stakeholders in California, and fumbled through legislative updates in Tennessee and Texas.

Before moving to D.C., my perception of rural health had been limited to my experiences growing up in Paris, Tenn., a community of about 10,000 folks tucked into the northwestern corner of the state near the borders of Arkansas and Kentucky. While working at NRHA, I discovered that rural America is not limited to small towns in the South. Rural Kansas needs doctors. Rural New York struggles with access to health care, and rural Ohio seeks to eliminate their health care worker disparity. These areas of the country are comprised of unique fibers yet share many characteristics. This discovery finally supplied the last piece of the puzzle as to what I had always envisioned pursuing in my life.

It was a miracle I was ever accepted into medical school – a miracle.

It took me two graduate degrees, six years, dozens of friends, 41 rejection letters and thousands of miles.

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Innovative rookies and seasoned professionals share their experiences.

“NRHA and I grew together and experienced many new firsts.”



Rob McVay

Typewriter tales: CFO reminisces on 25 years at NRHA

By Rob McVay

My first day at the National Rural Association was not what you might consider a regular first day.

It was more like a bunch of friends getting together to help each other out. That is the best way to describe what working for NRHA was like when I dropped by during the summer of 1986 to visit a friend who worked there, and Bob Van Hook, the executive director, stopped me in the hallway to ask if I could help them “catch up their books” in my spare time.

“I keep the check register in a journal in my right-hand drawer if you want to see how we’re spending the money,” he said, “and the lady across the hall keeps a box of 3-by-5 inch index cards with our members’ names and addresses on them, if you need to look at those.”

I remember Bob was pretty excited to show me the new Macintosh 128k in his office and offered to let me use it if I needed to set up some spreadsheets.

The only other piece of equipment in the office at the time was the typewriter at the receptionist’s desk. I remember that typewriter and that desk very well because it was staffed by a lady with a big, beautiful smile named Rosemary McKenzie. She was the first person I ever met at NRHA, and she made me feel as welcome as if I had just been invited into her

home. I remember her telling me that if I wanted a copy of something, I had to be sure and use carbon paper when I typed it up. Then she promptly and efficiently showed me how it was done.

Despite the lack of formality or anything resembling an orientation, I felt a real sense of connectedness at NRHA that I did not feel when I had started working for other, larger organizations that put me through formal interview and orientation processes. There was a sense of urgency and purpose that pulled me in and made me feel like I was part of a cause.

As the years passed by, NRHA and I grew together and experienced many new firsts. I remember thinking what a waste of time it was putting effort into the cumbersome process of connecting two of our computers with a cable just so one of them could read the files on the other one. It was much easier at the time to save the file to a floppy disk, walk down the hall and hand it to the other person. I had no idea at the time that someday I would simultaneously send files, much too large for my hard drive at the time, to the computers of all our board members and staff at various locations across the country.

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Beginnings & Passages

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My interview at Lincoln Memorial University's DeBusk College of Osteopathic Medicine took place in the middle of a snowstorm. I drove the same Jeep that I had rescued from that junkyard the day of my NRHA interview. This time, I sat in an office and answered questions about why I wanted to be a doctor. It didn't seem like the interview was going well. The professor pressed me for explanations that I found difficult to articulate, and I fell short of conveying my unique background and desire to serve rural communities and patients.

At one point, the interviewer asked me if I thought I would have a problem going from a job in Washington, D.C., that dealt with emerging policy issues shaping the future of rural health care back to being a "lowly medical student." I didn't follow what he was implying and asked him to help me out. He said, "Do you think it will be difficult to go from leading the band to being just another member in the band?" I paused and thought about the long path I had traveled to get to this point, about my parents who have always supported me, about my college professors both helpful and harmful, about my hometown and finally about how NRHA had been an instrumental factor in my medical school application. All of these people and places had come together to deliver me to this place.

I reconsidered his analogy and offered my answer, "I have no intention of being just another member of the band." With that, the interview ended, and I was pretty confident I would soon be receiving rejection letter No. 42.

I was wrong. A week later, I got the call informing me that I had been accepted to medical school and would have the opportunity to return to Tennessee to finally begin the last leg of my journey to becoming a family practitioner in rural America.

When I originally set out to become a physician, I had a simple roadmap in my mind: ace my college courses, make a 30 on the MCAT, carefully weigh all of my medical school options, then enroll at the University of Tennessee.

I did none of those things. Instead, I took a winding path that carried me across the country and introduced me to a wealth of dedicated professionals who strive to improve the health and wellbeing of America's rural communities. I never planned to begin medical school at 28. My envisioned path was straight and short, but my route would have never been as rich, as meaningful and, quite frankly, as fun as it has otherwise turned out. My time at NRHA, while brief, was what ultimately made it all possible.

I now find myself in the middle of the NRHA world – in an isolated mountain community where the need for quality health care is apparent and real. Where families struggle to provide for their children. Where teenagers often believe there is no hope of continued education and dreams beyond the county line. Where roofers with accents that make mine sound down-right cosmopolitan beg me with pleading eyes, "please stay when you graduate." These are the people NRHA strives to serve; these are the people whose lives NRHA is changing.

I still have the Jeep. He waits just outside my bedroom window, underneath an ink black sky pierced with silent glowing stars. In the mornings, the peaks of the Smokey Mountains emerge from the mist as white wisps of clouds roll slowly over the empty green Tennessee fields. The Jeep has traveled 204,000 miles to get here, yet he sits quietly – waiting for whatever miracle comes next.

Dustin Summers worked in NRHA's government affairs office from 2009 to 2011. He now attends medical school at Lincoln Memorial University in Harrogate, Tenn.

Innovative rookies and seasoned professionals share their experiences.

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Before the age of the Internet and social networks, we used to spend days – even weeks – pulling together the agenda for our board meetings and gathering, copying, collating, three-hole punching and organizing the agenda and reports in carefully marked binders and shipping them out via “snail mail” hoping the packages would arrive at the board members’ offices so they had time to review them before the meeting. The idea that I could almost instantly upload those reports electronically to a private, secure group on NRHA Connect, where a board member could download them and print them out from the comfort of their own home on a weekend morning, is something that I could never have imagined at the time.

“There was a sense of urgency that pulled me in and made me feel like I was part of a cause.”

Rob McVay

And I remember the day we got the (rather long) memo telling us about a new experiment whereby we were going to send each other electronic communications from one computer to another computer just down the hall. It is hard to believe now, but most of the staff laughed and rolled their eyes upon receiving this memo. “Oh, this is ridiculous; it will never last,” we said, “why would any of us send each other an electronic message when we could get up, walk down the hall, and tell the other person what they need to know?”

We all thought it was another goofy time-waster dreamt up by some tech geek sitting in a cubicle somewhere in Silicon Valley. It would be over within the week, and we would no longer have to worry about keeping up with these electronic messages or having to respond to them. Now I – like most of the office workers around the world – spend half my day sending, responding to, and looking up old emails.

While we are a much more efficient staff today, and much more “connected” because of these innovations, I am surprised at how often we talk about the need to “communicate more.” As I finish up this article sitting in my desk in Kansas City, I will send a copy to our communications director working at our conference in Florida and copy our CEO in Washington, D.C., and I realize that I will never really know how they felt about the content and flavor of what I’ve written.

Suddenly I find myself longing for a typewriter, a couple sheets or carbon paper and an office right down the hall where I can take my draft and see the reaction on the other person’s face while they are reading it. Hopefully it would be a big smile, a chuckle and a chance to reminisce.

Rob McVay joined NRHA’s staff in 1986. He has served as the association’s chief fiscal officer and director of operations since 2005.

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



Announcing the National Hospital Care Survey sponsored by NCHS / CDC

The National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), is currently launching the **National Hospital Care Survey (NHCS)**. This new survey combines:

- ❖ the **National Hospital Discharge Survey (NHDS)** conducted from 1965-2010, and
- ❖ the **National Hospital Ambulatory Care Survey (NHAMCS)**, conducted since 1992

The new NHCS will continue to collect information on inpatient hospitalizations, as well as visits to emergency (ED) and outpatient (OPD) departments and ambulatory surgery centers (ASC). It will provide a unique research opportunity to study health care utilization across these settings.

A sample of 500 hospitals nationwide is now being recruited for the NHCS. This sample is statistically designed to be nationally representative of non-institutional, nonfederal hospitals in the United States. It is comprised primarily of general and community hospitals of all sizes, including many rural and critical access hospitals. It is of utmost importance to achieve the highest response rate possible, in order for the survey to produce unbiased national statistics on hospital utilization.

Beginning in 2011, participating hospitals are being asked to electronically transmit Uniform Bill (UB)-04 administrative claims (or the same data items in digital format, if they do not file electronic UB-04 claims) for all inpatient discharges. In 2013, data collection will expand to include visits to hospital EDs, OPDs, and hospital-based ambulatory surgery locations, as well as free-standing ambulatory surgery centers. The goal is to establish an annual data collection stream that is minimally invasive and burdensome for participating hospitals, and maximally beneficial for research and health statistics purposes at the national level.

Because rural hospitals are central to the life and economy of rural communities, their participation in the NHCS is critically important to providing a complete picture of hospital use nationwide. Survey participation is voluntary, and there is no penalty for non-participation. However, we hope that the rural hospitals and CAHs that have been specially selected for the NHCS will agree to participate.



For more information about the NHCS see www.cdc.gov/nchs/nhcs.htm. In addition, hospital staff who are Health Information Management (HIM) professionals are eligible to earn **FREE Continuing Education Units** after completing an on-line module. See http://www.cdc.gov/nchs/nhcs/continuing_education.htm.

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Discover Denver

with NRHA member Cari Fouts



Cari Fouts skiing in the Rockies

Cari Fouts has lived in and loved Denver for 20 years. So *Rural Roads* asked the Colorado Rural Health Center's communication and development director to share her favorite spots in and around Denver to help fellow members plan their trips to the National Rural Health Association's 35th Annual Rural Health Conference April 17 through 20.

There's never a dull moment in downtown Denver. Check out Cari's mile-high picks for nightlife, food and fun (in no particular order).

1. The Cruise Room.

This place has excellent mixed drinks in a swanky bar featuring neon pink lights and décor reminiscent of a 1950s cruise ship. Try the Long Island iced tea.



2. Jax Fish House.

This is an excellent place for dinner, featuring a raw bar. Yes, you can get great seafood in Denver!



3. The Tavern. Challenge fellow NRHA members to midnight mini bowling and other games.

4. Rioja. Enjoy amazing food by an award-winning chef, reasonable prices and lovely atmosphere right in Larimer Square. Be sure to make a reservation.

5. 16th Street Mall. There's plenty of fun shopping along a pedestrian outdoor mall. While you're there, hit happy hour at the Rialto Café.



6. El Chapultepec. Don't miss this small, local dive bar with live jazz, right across from Coors Field.

7. Museums. The Denver Museum of Art, Denver National History Museum and the Denver Mint are all downtown and worth a visit.

Photos at right, top to bottom: Inside view of The Cruise Room, courtesy of downandoutindenver.com; inside view of Jax Fish House, courtesy of denver.org; 16th Street Mall, courtesy of denver.com; outside view of El Chapultepec, courtesy of blogs.westward.com

Colorado is home to the most microbrews in the nation.



Cari Fouts and boyfriend Ryan White at Breckenridge Brewery

Be sure to get samples from these local favorites right in downtown Denver: Breckenridge Brewery, Wynkoop Brewery and the Great Divide Brewery. And make your way to the Wynkoop Brewery basement for Impulse Theater, a fun improv comedy show Thursdays through Saturdays.

Hit the slopes.

The Denver area is known for its outdoor scenery and things to do like skiing, snowshoeing, hiking and biking. During the NRHA conference, Denver may or may not have snow, but you can count on snow in the nearby mountains.

If you have never experienced spring skiing in the Rockies, you're in for a treat! Mid-April is often the best time to go skiing. The weather is warm, and the powder can be incredible. If skiing sounds a little too adventurous, you can always take a drive into the mountains just to take in the beautiful scenery.



Cari Fouts' son Graham and a friend enjoy skiing near Denver.



Tracks in rock at Dinosaur Ridge

Get out of town.

1. Dinosaur Ridge. Take a 20- to- 30-minute drive west from downtown, and you'll find Dinosaur Ridge, where you can see actual dinosaur footprints that remain in the side of the foothills. While you're there, also visit Red Rocks Amphitheatre with beautiful rock formations, good hiking on site and a free museum.

2. Idaho Springs. For a nearby mountain experience that feels faraway, drive up Interstate 70 into the mountains about 45 minutes to the old mining town, Idaho Springs. Be sure to eat at Beau Jo's for the best mountain pie pizza in Colorado. Don't forget to save the thick crust to lather in honey for dessert! And head to Tommyknocker Brewery and Pub for a great microbrew.

3. Resort towns. Vail is amazing to see and experience, but it is by far one of the most expensive places for skiing, shopping and eating. For a memorable experience not as far away and more reasonably priced, try Keystone, Breckenridge or Copper Mountain. On the way to all three resorts, stop off in Silverthorne for outlet mall shopping. Breckenridge has the best shopping for a small, mountain town if you're traveling with people who are looking for something to do while you hit the slopes.

Don't delay.

Join Cari and 900 of your closest rural health colleagues in Denver April 17 through 20. Register for NRHA's 35th Annual Rural Health Conference early at RuralHealthWeb.org/annual to save \$100.

Cari Fouts joined NRHA in 2008.

Be our  friend. Keep in  touch.

Follow NRHA for the latest health reform news, special discount offers and the chance to expand your rural health network.

Members on the move

NRHA member co-authors rural nursing book



Angeline Bushy

Long-time National Rural Health Association member Angeline Bushy, PhD, recently co-authored “The Rural Nurse: Transition to Practice” with Deana Molinari, PhD, Idaho State University College of Nursing associate professor.

The 400-page book provides information about transitioning from an urban-based nursing education or practice to a rural health care environment.

It also details current rural nursing trends and issues and offers solutions in

the form of evidence-based model programs from across the country and around the globe.

Bushy, a registered nurse and University of Central Florida College of Nursing Bert Fish chair and professor, says the book builds on the Institute of Medicine’s recent report on the future of nursing and highlights effective recruitment and retention programs in rural settings.

“Because it’s extremely expensive to recruit nurses into rural areas, we want to be sure that nurses who are hired will stay. Consequently, this edited textbook includes cutting-edge models that will be useful to retain good nurses and ultimately help sustain an effective health care system in rural areas,” she says.

The book highlights locally developed education programs, urban hospital systems’ outreach to rural facilities, universities collaborating with rural businesses, city-based workshops, statewide competencies tracked by employers, and a distance education program customized by rural agencies.

Bushy joined NRHA in 1988 and serves on the association’s Multiracial and Multicultural Health Council.



Sandra Pope

Pope credits NRHA for new appointments

National Rural Health Association board member Sandra Pope was recently appointed to the U.S. Department of Health and Human Services (HHS) Advisory

Committee on Interdisciplinary, Community-Based Linkages (ACICBL) and to the Office of Minority Health’s Region III Health Equity Council.

“My work and involvement with NRHA has provided me many opportunities to learn and grow as a professional and leader in the rural health care arena. Had it not been for my involvement with NRHA, and the support that I receive from the NRHA board and staff, it is doubtful that I would have ever had the opportunity to participate on these national and regional councils,” Pope says. “I have always said, ‘NRHA welcomes you, and you can be as involved in the leadership structure and work of NRHA as you choose to be.’ I am extremely thankful to NRHA for their support and confidence in me.”

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

As part of the ACICBL, Pope will help prepare the legislatively mandated 12th Annual Report to the HHS secretary and Congress with an emphasis on training programs. NRHA nominated her for the federal committee.

NRHA also nominated Pope to serve on the regional Health Equity Council to develop an action plan to address health disparities. The councils were recently established by the Office of Minority Health in response to the National Stakeholder Strategy for Achieving Health Equity.

Send your career updates to editor@NRHArural.org.

“NRHA partners with the Office of Minority Health and supports the NPA’s [National Partnership for Action’s] National Stakeholder Strategy for Achieving Health Equity to improve the overall health of our nation,” Pope says. “The work and goals of Region III are closely linked with the goals and strategies of our Multiracial and Multicultural Council.”

She joined NRHA in 1992.

Kelly hopeful about new rural role, university partnership



Ryan Kelly

Ryan Kelly is the newly-appointed executive director of the Mississippi Rural Health Association (MRHA).

Kelly will also continue his duties as external relations director for the University of Southern Mississippi College of Health.

MRHA has not had an executive director for many years, but the association’s partnership with the university helped make it possible, he says.

Kelly says he hopes to increase the Mississippi association’s external funding in 2012 with both increased membership and additional grant support.

“My role is part of a partnership between the university and MRHA,” Kelly says. “We have a very strong body of board members that have worked tirelessly to promote rural health and to support the organization, and I firmly believe that with their constant hard work and dedication, we will be very successful over this next year.”

News briefs

Sebelius to headline NRHA event



Kathleen Sebelius

Kathleen Sebelius, U.S. Department of Health and Human Services secretary, will speak during the National Rural Health Association’s Rural Health Policy Institute scheduled for Jan. 30 through Feb. 1.

Additional members of the Obama administration and Congress will be on the agenda for the 23rd annual education and advocacy conference.

Attracting more than 450 people to Washington, D.C., the Rural Health Policy Institute is the nation’s largest rural advocacy event each year.

“This well-timed conference is the perfect opportunity for rural health advocates to learn about what’s ahead and begin making a difference for rural residents in 2012,” says Maggie Elehwany, NRHA government affairs and policy vice president.”

Attendees will learn firsthand about the development and implementation of health care policy at the federal level and meet with their members of Congress to discuss issues relevant to rural health care quality and access.

Visit RuralHealthWeb.org/pi for the full agenda.

NRHA elects new leadership



Sandra Durick

National Rural Health Association members selected long-time member Sandra Durick 2012 president-elect.

“I am very honored and pleased to serve as president-elect of the National Rural Health Association,” says the South Dakota Office of Rural Health administrator. “In this position, I will work to foster new partnerships to sustain and improve rural health care.”

Durick, who defeated Raymond Christensen, MD, for the position, joined NRHA in 1986. She will assume the duties of NRHA president in 2013. This year’s president is Lance Keilers.

Lisa Kilawee, Avera Rural Health Institute rural health services director, was elected NRHA’s secretary for 2012 and 2013. Kilawee joined NRHA in 1997.

HIT task force tackles new issues

The National Rural Health Association's Rural Health Information Technology (HIT) Task Force met in Washington, D.C., in November.

They discussed regulatory developments involving mobile and wireless devices, workforce issues, security, privacy, quality, health information exchange interoperability, telemedicine and the Federal Communications Commission's Connect America program.

"We are at a critical juncture in the rollout of electronic health records incentive dollars to eligible providers and hospitals, and this meeting highlighted that continuing vigilance is necessary to ensure rural providers are treated fairly and that they take full advantage of the HITECH [Health Information Technology for Economic and Clinical Health] Act," says Brock Slabach, NRHA member services senior vice president. "Meetings like this also help NRHA develop a fine-tuned message as health IT continues to change the landscape of how health care is delivered in rural areas."

NRHA also hosted an emerging policy issue meeting that focused on HIT and long-term care in order to connect with other organizations and help establish NRHA's first policy brief to be used to educate members of Congress. Both meetings are part of NRHA's grant with the Helmsley Charitable Trust to help NRHA contribute to framing future HIT initiatives.

Representatives from telehealth resource centers, academia, long-term care associations, Centers for Medicare and Medicaid Services, Healthcare Information Management Systems Society, the Office of Rural Health Policy, the Office of the National Coordinator for HIT and the Office of Minority Health participated in the NRHA meetings.

Deadline approaches for 2012 rural health awards

The National Rural Health Association is accepting nominations for its 2012 Rural Health Awards through Feb. 8.

Selected rural health organizations, professionals and students will be honored before 900 rural health colleagues during NRHA's 35th Annual Rural Health Conference April 17 through 20 in Denver. Each student award winner will also receive complimentary conference registration, a one-year NRHA membership and a \$500 award from John Snow Inc.

Go to RuralHealthWeb.org for more information and to submit a nomination.

accelerating advocacy

Fight for rural health care safety net continues

The rural health care safety net was endangered by multiple proposals to the Joint Select Committee on Deficit Reduction in the fall.

The proposals called for large modifications to vital rural health programs and even the elimination of important funding designations.

The National Rural Health Association fought to protect rural health care with unprecedented efforts including making early requests to congressional leadership for rural representation on the committee, attending public hearings and regular meetings and contacting committee members.

"NRHA members grassroots letters, emails, phone calls, meetings and other advocacy efforts helped saved rural facilities from catastrophic cuts," says Maggie Elehwany, NRHA

government affairs and policy vice president. "Committee staff indicated that the strong response from rural hospitals, physicians and advocates was influential in protecting these vital facilities. But the fight continues."

The failing of the committee to strike a deal by Nov. 23 means that sequestration, including an across-the-board 2 percent Medicare reimbursement cut, will go into effect January 2013.

NRHA will continue its efforts to reverse cuts to rural facilities and work to continue Medicare extenders set to expire in 2012.

For the latest on federal proposals and changes that impact rural health care, follow NRHA's Rural Health Voices blog at blog.RuralHealthWeb.org.

Meet us at the Mall



Sculptor Lei Yixin in front of
"Stone of Hope"

While you're in D.C. to attend NRHA's Rural Health Policy Institute Jan. 30 through Feb. 1, don't miss the Martin Luther King Jr. Memorial that was dedicated just four months ago on Independence Ave.

Named the "Stone of Hope" – an allusion to King's most famous speech that took place mere steps from this monument – the new memorial is featured alongside historic tributes to other celebrated American leaders.

"Martin Luther King's legacy, both in the history books and now in West Potomac Park, reminds us of the ideas and equality he fought so tirelessly for," says NRHA CEO Alan Morgan. "We at NRHA continue to advocate for health care equality for every American."

For more information on the memorial, visit mlkmemorial.org.

To learn how you can help bring about health care equality to underserved areas, visit RuralHealthWeb.org.

"A right delayed is a right denied."

Martin Luther King Jr.

Off the beaten path



Lucy the Elephant, photo courtesy of the Atlantic City Convention and Visitors Bureau

New Jersey loves Lucy

Lucy the Elephant, beloved local landmark and architectural oddity, stands a full **6 stories** above the Atlantic coastline of Margate City, N.J., population **6,354**.

In **1882**, Lucy's architect, James V. Lafferty, completed his unprecedented **90-ton** project, making it the first example of "zoomorphic architecture." Over the years, Lafferty's elephant enterprise has been home to a restaurant, real estate offices and a hotel. Lucy was even one of the last bars suppressed by Prohibition.

Having been nearly demolished in the late-**1960s**, surviving a significant hurricane in **1944**, and being struck by lightning in July, Lucy would seem to be as lucky as some of her neighbors in Atlantic City. So if your travels lead you to the Jersey shore, don't forget this elephant.

shifting gears

Green winter tips and thermostat tricks

From insulation to additional clothing, these simple steps can be both environmentally-friendly and cost-effective this winter:

- Check for — and repair — window and door "leaks."
- When possible, try adding an extra layer of clothing instead of adjusting your thermostat.
- Close doors to rooms that don't require constant heat.
- For the most efficient furnace, keep it and its filter clean.
- Remember to turn down the thermostat when leaving your home.



National Rural Health Association

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Get smart.

Plan now to attend these NRHA conferences and move to the head of the class.



Rural Health Policy Institute

Jan. 30-Feb. 1
Washington, D.C.

Rural Medical Educators Conference

April 17
Denver

Annual Rural Health Conference

April 17-20
Denver

Rural Quality and Clinical Conference

July 18-20
Seattle

www.RuralHealthWeb.org