

# rural roads

Summer 2013 National Rural Health Association



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## Hope is no longer enough

When traveling by water, going with the mainstream appears to be the easy way. After 30 years of no improvement in rural health access, the mainstream is no longer the way to go.

One of the most important presentations at the National Rural Health Association's 36th Annual Rural Health Conference in May was by Johanna Steenrod of the University of Pennsylvania. She presented a poster about rural health access that mapped authors, concepts and developments graphically.

Graphic renditions of new learning should have new branches leading to new concepts and new authors. The tree of knowledge is a very apt description because it grows and builds upon itself. Rural health access mapping demonstrates no such branching structure.

We have entered a “ready, fire, aim” time period in health care. We are focused on reaction and direct measures, but we fail in action plan research. We should go from “observe” to “reflect” and then “discuss” to generate the concepts and interventions. Next we move to planning and developing measures for accountability. Finally we take action.

Instead of an iterative, reflective process widely shared, we observe:

- Health care costs are high, so we react by focusing on cutting health care costs. But 30 years of cost cutting has not addressed access, and the cuts have devastated rural hospitals and rural health access.
- Health insurance has deficits, so we react to add health insurance. But health insurance is just one of many social determinant reasons for low health access and misdistribution of workforce.
- There are deficits in the primary care workforce, so we react by increasing graduates. But so few enter and stay in primary care that massive expansions fail on making a primary care impact.

Rural areas have the people and resources that they need to make rural health access happen now and for future generations. They can construct better health care delivery and better economics through health care. It is time to move to reflection, discussion, planning and measures specific to rural health access – and action.

Robert C. Bowman, MD

A.T. Still University School of Osteopathic Medicine-Arizona health access researcher

### Write us

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

Send your letter to [editor@NRHArural.org](mailto:editor@NRHArural.org) or *Rural Roads* editor, NRHA, 4501 College Blvd., Leawood, KS 66211.

## Share your story.

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

Contact Lindsey Corey at [editor@NRHArural.org](mailto:editor@NRHArural.org) to share your ideas, innovations and experiences.

Editorial suggestions must not be advertisements.





## Don't let this opportunity pass you by

One of the best things I've done in my 30-year rural health career was to apply to be a Rural Health Fellow. And what an honor it was to be selected to join this elite group of National Rural Health Association members in 2004.

I gained leadership skills, insights and information and most importantly colleagues from across the country who quickly became dear friends and advisers, including Becky Conditt and Jodi Schmidt.

The experience was intense and exciting and continues to influence my work in South Dakota and my volunteer involvement in our wonderful association. Before becoming a fellow and gaining the connections and knowledge that come with the program, it wouldn't have occurred to me to run for NRHA treasurer and later for president.

I strongly encourage you to apply or nominate a colleague to participate in the Rural Health Fellows program. Go to [RuralHealthWeb.org/go/fellows](http://RuralHealthWeb.org/go/fellows) by Aug. 31 to join the 2014 class.

I'm confident I'm a better advocate for rural health thanks to the program, and you will be too.

Sandra Durick  
2013 NRHA president

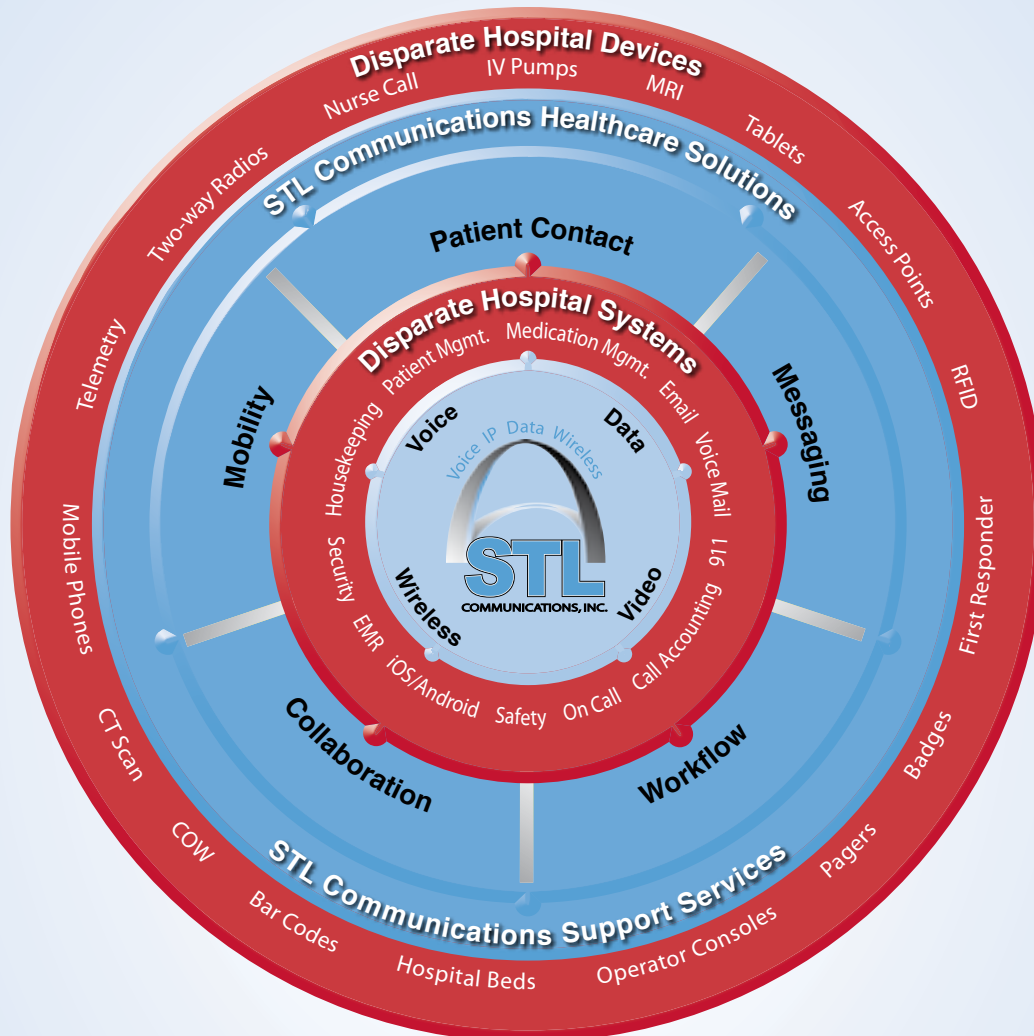
## pit stop

# 5 things I picked up in this issue:

1. A health information exchange system made a catastrophic few days go a little smoother for hospital staff treating tornado victims in Moore, Okla. *page 30*
2. NRHA is exploring international opportunities to increase its impact on rural health beyond borders. *page 63*
3. Experts estimate that one in 10 Native American elders are abused. *page 26*
4. A grateful family donated a cow's auction proceeds to their local hospital to the tune of \$8,000. *page 8*
5. Even one major sunburn can lead to skin cancer. Learn more about prevention and detection in this issue's Street Smarts and Short Cuts. *pages 46 and 69*

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# Rural hospital saves a baby, has a cow

## An Illinois cattleman gives back

By Angela Lutz

Kurtis Davis, MD, was driving home to Carthage, Ill., from a family wedding when he got the call.

Erin Holst, one of his obstetrics patients, was going into premature labor at 32 weeks. She needed to deliver her daughter immediately.

The weather was stormy, so Erin could not be transferred by helicopter to the next-nearest hospital in Peoria, more than 100 miles away. An ambulance would take too long – Erin had HELLP (hemolysis, elevated liver enzymes, and low platelet count) syndrome, a life-threatening complication of pre-eclampsia.

The symptoms of HELLP occurred suddenly, putting Erin's and her daughter's lives at risk. Erin needed medical attention as soon as possible. So Davis sped through the storm to get to Memorial Hospital, Carthage's 18-bed critical access hospital.

"I pulled into the parking lot about 90 miles an hour at 12:01," Davis says, "and we had the baby at 12:03."

Davis and Chris Jones, MD, the physician who was called in that night, delivered Erin and Cody Holst's daughter, Reese, via emergency C-section. The baby girl weighed only 2 pounds 5 ounces.

"It was pretty scary," Erin says. "It happened pretty fast. We didn't really know how it was going to turn out."

Because of its many symptoms, HELLP syndrome can be difficult to diagnose. But the team at Memorial recognized the indicators, and they were able to get Erin and Reese the emergency care they needed. Because of their fast action, Cody credits the hospital staff with saving the lives of his wife and daughter.

"We are extremely blessed to have a facility right here in our community," Cody says. "If we had to travel any further, my wife and child may not be here today."

It was out of this gratitude that Cody, a cattleman, decided to donate the proceeds of a heifer he sold at the annual Sullivan and Son cattle auction to Memorial Hospital. A group of Carthage residents and local businesses pooled their money to purchase the heifer for \$5,500. Several members

of the hospital staff, including Davis and Jones and members of the board, attended the auction.

"We were really honored by that," Davis says of the donation.

Then the generous group of buyers did something that surprised everyone: They donated the cow back to be auctioned off a second time, bringing in an additional \$3,000 for Memorial Hospital.

**"The reason I got into medicine was not for prestige. It was to be part of the community."**

Kurtis Davis, MD

"It helps us to keep doing the things that we do," Davis says. "I came back to a hospital like Carthage that's underserved to do a little bit of everything. Unfortunately a lot of that's kind of gone by the wayside for a lot of smaller hospitals, but Carthage has been able to hang onto that."

The fact that Memorial Hospital has been able to continue offering obstetrics services was vital for Erin and her infant.

"If I would've had to drive to Peoria, neither of us would be here today," Erin says. "So [community hospitals] are extremely important."

According to Davis, one way people can keep hospitals in their communities is to use the services they provide – and if a service is not available, he says patients should request it. Rural physicians know that rural patients don't like to travel, so they will do what they can to keep care local, he says.

*continues on page 11*





*Cody and daughter Reece Holst  
take a break from chores on the  
family farm in rural Illinois.*



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— Brad Anderson  
CFO, Community Memorial Hospital  
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*Cody and Erin Holst donated proceeds from a heifer sold at auction to Memorial Hospital. The cow brought in \$8,000 for the critical access hospital in Carthage, Ill., that the family credits with saving the lives of Erin and their infant daughter Reece.*

“Just ask your local hospital what services they provide,” Davis suggests. “If there’s a big enough need, a lot of hospitals will bring someone in so people don’t have to keep traveling long distances for help.”

**“We are extremely blessed to have a facility right here in our community. If we had to travel any further, my wife and child may not be here today.”**

**Cody Holst**


Though Memorial Hospital provides a variety of specialty services, a lot of nearby hospitals have not been as fortunate. Davis says a rural hospital 15 miles away has “almost completely shut down.” That, he says, is another reason the Holsts’ donation is so valuable: It

raised community awareness and support for Memorial Hospital.

It also reaffirmed Davis’ decision to practice in a rural area. Born and raised in nearby Hammond, he graduated from the rural medical education program at the University of Illinois-Rockford. He always planned to live and work in a rural area, where, he says, you can be a “pillar of the community.”

“The reason I got into medicine was not for prestige,” he says. “It was to be part of the community. You compartmentalize in the big city, and in rural areas you can just be their doctor. The primary care provider takes care of everything they possibly can.”

That has certainly been the case for the Holsts. Davis continues to see Reese, who, at nine months old, is in excellent health and at seven times her birth weight. The Holsts plan to raise their family in Carthage, so he will continue to see her as she grows. He also cares for Erin, Cody and Erin’s grandfather, who is Davis’ veterinarian.

“Everything comes back full circle,” he says. “It’s a dream to come back to an area like this and be continually challenged and not stuck in a rut. I’m always on my toes.” 



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Larry Rhodes, NRHA Rural Health Practitioner of the Year

# Rhodes hits the road to help patients

By John Commins

West Virginia pediatric cardiologist Larry Rhodes, MD, speaks passionately about his work at three community outreach clinics.

“It is always easy to hide under the guise of ‘this is for patient care,’ but the best days of the month, for me, are when I am in my truck driving to one of these clinics,” he says.

*continues*



*Larry Rhodes meets with the father of an infant patient in West Virginia.*

Larry Rhodes, MD, interim chair of the West Virginia University (WVU) Department of Pediatrics is a subspecialist who enthusiastically takes his expertise into the field at outreach clinics across the Mountain State.

As director of the WVU Institute for Community and Rural Health, Rhodes also played a key role in a program that has enabled 400 medical students to complete 2,700 weeks of rural health care training in 2012.

For his advocacy of rural health issues and efforts to improve access, Rhodes was named the 2013 Rural Health Practitioner of the Year by the National Rural Health Association.

Rhodes spoke with *HealthLeaders Media* about the challenges and rewards of taking his subspecialty skills to the people.

### Talk about your work with outreach clinics.

**Rhodes:** I do three outreach clinics a month. I'm in Morgantown in the northern part of the state. I go to Parkersburg, which is about two hours away twice a month. And I do a clinic in Beckley, which is about a three-hour drive once a month. Each of our cardiologists do at least one outreach clinic a month. We have almost all areas of the state covered.

There are a couple of reasons why we do it. One is there are a number of children born in these rural communities who have congenital heart disease, and we in Morgantown are the only center in the state that does surgery for kids with congenital heart disease. We have two doctors going to Beckley on Friday and we have 40 patients scheduled. We will keep that many patients from having to drive up here for a follow-up.

**"I pride myself in knowing where almost every patient of mine is from. If I have not been to where they are from I will drive there sometime to find out."**

**Larry Rhodes, NRHA Rural Health Practitioner of the Year**

West Virginia is almost all rural. The biggest town in the state in Charleston, and it's only got 54,000 people. It's a big deal for some families to drive two or three hours and some of the patients are even five hours away. When I go to Beckley I will see patients that maybe have driven an hour and a half to get to the clinic.

I am primarily a pediatrician, but we do the same thing for adults with subspecialty problems. We have a doctor who does an outreach rheumatology clinic in the coal country in the southern part of the state. We have an ophthalmologist and a neurologist who go there too.

### Why are there so few subspecialists venturing to these outreach clinics?

**Rhodes:** It's kind of an ivory tower mentality that 'I am here and they will

come here.’ Frequently when we think about rural health care, we think about primary care physicians, who are the cornerstone to the whole thing and who are very important.

But sometimes the patients with acute, special health care needs are not lost in the shuffle, but we don’t think enough about them at times. We just assume they will come back to the tertiary care center for follow up. I have patients who will cancel a clinic visit because they can’t find the \$50 to put gas in the car.

Or they may find that they can get a ride to an outreach clinic with a neighbor who is willing to drive them a half hour but they are not willing to drive two and a half or three hours and wait for the appointment and drive back.

### Is sending subspecialists into the field a good use of limited resources?

**Rhodes:** That’s true to a degree. You may need to bring the patients into the tertiary care center for the testing and expertise. But the patients I see in these outreach clinics I may be able to see three times before they need to come to Morgantown.

Once every one or two years I may have to bring a patient here, but I can see that patient every six months in their community. I can think of patients I haven’t had to bring to Morgantown in five years. I can go and see the patient as a subspecialist.

The family medicine guy is good at taking care of the patient in between. But they get a little uncomfortable if they are watching the kid with the artificial heart valve. They may have the experience of 20 adults with that problem but what do you say to a 12 year old who has an artificial heart valve in terms of his physical activities? There are certain things we can take to the community that are not necessarily things that they need to come to the tertiary care hospital for.

### Are you urging other subspecialists to do outreach work?

**Rhodes:** I think so, very much. I personally prefer going to the communities because I love it. I love going out and seeing the patients in their home communities. I pride myself in knowing where almost every patient of mine is from. If I have not been to where they are from, I will drive there sometime to find out.

There are always resources issues. If you only have one neurologist in your practice it is a little harder to say ‘go do a clinic once a week somewhere else.’ But it is a great public service. It helps the patients. It helps with compliance. It is very rewarding. I am old enough to realize that what I used to think I was doing for the patient I am really doing for myself.

It is always easy to hide under the guise of ‘this is for patient care,’ but I can tell you the best days of the month for me are when I am in my truck driving to one of these clinics.

### Does clinical outreach make you a better physician?

**Rhodes:** Yes. It forces you to do things sometimes without all the technology. [Like] when I go to a clinic where I don’t have an echo machine or some of the advantages I have here. If I am seeing a patient here and I am a little confused, I can send them for a test. Frequently I can’t do that in outreach clinics. I can arrange a test and have it done the next week, but I can’t just send them out of the office and tell them to ‘go get this test and I will see you.’

“I have said a number of times they will drag me out of this building feet first. I will not retire. I will work until I can’t walk.”

Larry Rhodes, MD

We have taken residents and med students with us to the clinics and they love it. It’s like practicing medicine the way you were taught to practice – using your physical exam abilities, using simple tests like an EKG or an X-ray. It gives you a rapport with your patients.

### How does the outreach experience help you better understand patients’ perspectives?

**Rhodes:** Look at a map of West Virginia and you see there are interstates going through the state and you say there can’t be anyone who lives more than three hours from here.

I have a slide that I use when I talk to medical students about rural health. I can show you the interstates and I will ask ‘how long will that take you to drive?’ and a lot of them will say ‘it’s three hours.’ Well it turns out it’s five hours, because it takes almost an hour and a half to get to the interstate.

You can’t see that on Google Maps, but when you drive out to these places and you realize where these people are coming from, you are not angry when they miss an appointment or when they come 25- or 30-minutes late.

I never refuse to see a person who is late, and I won’t let anyone in my division refuse to see somebody who is late because I have been there. I know where they are

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coming from. It may not be snowing in Morgantown, but an hour from here they may have a foot of snow.

You get mad because a family doesn't get a prescription filled and then you realize that the closest drug store to them is 45 minutes away and it closed at 8 p.m. and they didn't get back from the hospital until 9 p.m. There are things like that that you don't think of if you don't go out and do this type of stuff. It is that type of stuff that makes you appreciate what they are going through.

### Is clinical outreach a good prescription for doctor burnout?

**Rhodes:** It is a great *cure* for burnout. The person, who was my boss who is still in our division, is 73 years old. He still works and he is the one who

started the outreach clinics for pediatric cardiology.

He is not burned out and we will do a clinic together on Friday when I go to Beckley. I have another practitioner in our group who is 71 and another who is 65. They are all cardiologists and none of them are burned out. I have said a number of times they will drag me out of this building feet first. I will not retire. I will work until I can't walk. And part of it is the passion for doing this. 

*John Commins is a senior editor with HealthLeaders Media, where this article originally appeared in May.*

## NRHA honors rural health's finest



NRHA 2013  
award winners

Each year, the National Rural Health Association recognizes outstanding individuals and organizations in the field of rural health who have dedicated their time and talents to improving the health and wellbeing of others.

The 2013 recipients have worked tirelessly to provide innovative programs and services, making rural life healthier and more compassionate. Selected from a record number of nominations, NRHA congratulates the following rural health organizations, professionals and students who were honored at the 36th Annual Rural Health Conference in May.



Charlie Alfero with NRHA president Sandra Durick

### Louis Gorin Award for Outstanding Achievement in Rural Health

Charlie Alfero  
Hidalgo Medical Services Center for Health Innovation  
executive director  
Silver City, N.M.

For more than 30 years, Charlie Alfero has made ambitious contributions to rural health on local, state and national levels.

Under Alfero's leadership Hidalgo Medical Services (HMS) has grown from a single clinic in Lordsburg, N.M., to a 12-site center providing primary

continues on page 20

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medical, dental and mental health services across two rural counties.

In 2011, he became executive director of the newly created HMS Center for Health Innovation, which develops and implements national models for health delivery and payment systems, health professional development and rural health policy.

“Public service is a humbling vocation,” Alfero says. “This award confirms a lifetime of commitment, wonder and awe, not to mention the great people and organizations you get to hang with along the way.”

Alfero is a founding board member of New Mexico Health Connections, a nonprofit health insurance cooperative, and is a past chairperson of NRHA’s Frontier Constituency Group. He has provided consultation to federal agencies including the Centers for Disease Control and National Health Service Corps on the needs and assets of rural communities.

Upon receiving the NRHA award, Charlie offered this advice: “Find mentors and friends. Give back more than you take. Life is short – make it meaningful.”

### **Outstanding Rural Health Organization** Arizona Center for Rural Health Tucson, Ariz.



Arizona Center for Rural Health staff

The Arizona Center for Rural Health strives to improve rural health care services through research and education in a diverse state

containing 22 tribal nations and unique rural health issues along the U.S.-Mexico border.

The center has been instrumental in the initiative to designate Arizona’s rural hospitals as level IV trauma centers.

Staff members show their support for rural health care through active involvement in promotion and access programs, including alliances with rural American Indian reservations.

“The Arizona Center for Rural Health was formed in 2011 and builds upon the rich history of the Rural Health Office at the University of Arizona. Winning

this award helps to validate the new direction our organization has taken, while recognizing our past accomplishments. We are humbled to receive this award, and we will use the recognition to motivate us further,” says Neil MacKinnon, the center’s director.

### **Outstanding Rural Health Program** Alabama Rural Health Leaders Pipeline University of Alabama College of Community Health Sciences Tuscaloosa, Ala.



Alabama Rural Health Leaders staff and students

Alabama Rural Health Leaders Pipeline guides rural students interested in health professions from every county in the state to pursue careers in primary care and return to their rural areas as leaders.

The pipeline offers three programs including one for 11th-graders, another for graduate and medical students and one for college-bound high school graduates from minority populations. The pipeline has also fostered outreach programs to elementary and middle school students that provide age-appropriate information about health careers.

“The University of Alabama Rural Health Leaders Pipeline program personnel are delighted to have NRHA’s validation of their work to engage rural Alabama students in the health professions with high school, college, graduate school and medical school pipeline programs,” says John Wheat, MD, founder and director of the program. “After 20 years, the efforts are bearing fruit with rural health professionals, including more than 50 rural physicians, contributing to the health care, economic development and leadership in rural Alabama.”

### **Rural Health Practitioner of the Year** Larry Rhodes, MD West Virginia University Institute for Community and Rural Health Department of Pediatrics assistant dean, director Morgantown, W.Va.



Larry Rhodes

Larry Rhodes’ calm voice, graying beard and well-worn cowboy boots are familiar to hundreds of parents in rural West Virginia who have a child with heart disease or a congenital heart defect.

He travels the state – from the West Virginia University (WVU) campus in Morgantown to the coalfields of the southern mountains and the river towns of the Ohio Valley – offering outreach clinics for children with cardiovascular issues. He founded

and volunteers each summer at Camp Mountain Heart, a weeklong adventure where his patients and other kids with heart problems participate in fun activities under close medical supervision.



While on the faculty at Children's Hospital of Philadelphia, Rhodes gained national and international acclaim as a foremost expert in pediatric electrophysiology, a specialty generally practiced deep within the walls of a major medical center. To the surprise of his colleagues around the country, Rhodes left Philadelphia in 2005 to rejoin the WVU faculty as chief of pediatric cardiology.

It was his intense connection with the state of West Virginia and Appalachia that drew him back to his childhood roots. His identification with the people of this rural region of the nation created in him the desire to not only provide the highest quality of care for children with heart disease at WVU Children's Hospital, but to make sure this care was available to every child who needed it in the state, wherever they live.

"I am honored to be receiving this award and do so on behalf of an incredibly talented and dedicated staff that works tirelessly to see my dreams to fruition," Rhodes says. "I love living in rural West Virginia and caring for the incredible people who live here."  
*See page 13 for more on Rhodes' work.*

### **Rural Health Quality Award** Gibson Area Hospital and Health Services Gibson City, Ill.



*Gibson Area Hospital staff*

Patient Safety has always been a priority for Gibson Area Hospital and Health Services.

After acknowledging that

medication errors were on the rise, the hospital began implementation of computerized physician order entry medication bar coding to assist with medication verification. They also initiated the process to replace their infusion pumps to smart pump technology that included safety software, helping them achieve and maintain best practice guidelines for patient safety.

"Our development of the medication variance reduction program to reduce medication errors was a priority at our facility to continue to pursue our mission to improve patient safety. We continue with ongoing monitoring of our interventions to evaluate the success of our implementations," says Sylvia Day,

the hospital's quality director.

### **Outstanding Researcher of the Year**

George Pink, PhD  
University of North Carolina Humana distinguished professor  
Chapel Hill, N.C.



*George Pink*

George Pink is a leading health finance researcher who has applied his skills to rural hospitals.

The true importance of his work has been its influence on rural health practitioners and policymakers, particularly through the annual dissemination of the *Critical Access Hospital (CAH) Financial Indicators Report*,

which includes his assessment of relevant benchmarks and peer groupings for CAHs.

Pink has authored multiple textbooks in health care finance, written more than 60 peer-reviewed articles and has made more than 200 academic presentations. He has also co-authored numerous issue briefs and papers designed to make his research accessible to policymakers.

He humbly accepted the Outstanding Researcher award saying, "Thanks to NRHA for recognizing the contribution of the North Carolina Rural Health Research and Policy Analysis Center."

### **President's Award**

Gail Nickerson  
Adventist Health director of clinic services  
Roseville, Calif.



*Gail Nickerson*

NRHA president Sandra Durick selected Gail Nickerson as the winner of the 2013 President's Award.

Nickerson serves on NRHA's board as the Rural Health Clinic Constituency Group chair. She has worked to advance rural health for more than 25 years as a health systems consultant and an outpatient clinic administrator. Nickerson currently serves as

Adventist Health's director of clinic services providing oversight for more than 30 rural health clinics in California, Oregon and Washington.

"Gail is a dedicated advocate for the rural people of California and for our nation," says Derrick Gruen, a colleague at Adventist Health. "She truly wants those underserved and underinsured to not only receive the best health care possible but also to live the greatest quality of life possible."

Nickerson is vice president of the National Association of Rural Health Clinics and the founder and president of the Board of the California Association of Rural Health Clinics. She is also treasurer for the California Rural Health Association.

*continues*

"Gail is both a leader and a pioneer in the field of rural health issues," NRHA CEO Alan Morgan says.

### Volunteer of the Year Award

Bill Sexton

Prairie du Chien Memorial Hospital CEO  
Prairie du Chien, Wis.



Bill Sexton

Bill Sexton has been an integral part of NRHA for more than a decade, including service as president in 2006 and as current board chair

of NRHA Services Corporation (NRHASC), which he helped launch.

Sexton has helped NRHASC work through many of the difficult start-up issues to create a strong and viable for-profit subsidiary that will serve NRHA for years to come.

His trademark good nature and willingness to step up translate into the larger picture of rural health, making him a local, regional and national leader in the health care community, says NRHA CEO Alan Morgan.

"Bill understands that leadership is for the long haul," says Tim Size, Rural Wisconsin Health Cooperative executive director. "Bill is also a model for all NRHA past presidents, as he has continued to be active and committed in both formal and informal roles in support of NRHA and its mission."

### Student Achievement Award

Ian Stormont

University of Wisconsin School of Medicine  
and Public Health  
Madison, Wis.



Ian Stormont with campers

Ian Stormont is changing lives – one camper at a time.

In consultation with the local area health education center, Stormont

created an intertribal and multistate Native Students Health Careers Camp.

"It is vitally important that organizations continue to increase learning and development opportunities for Native youth in rural America," Stormont says.

When funding became a potential roadblock, the third-year med student found alternatives to raise money by assisting with writing grants, meeting with other hospital departments and chasing down donations.

Stormont developed the camp curriculum, enlisted presenters, reserved room space and provided supplies for all of the hands-on activities. He even loaded up a van and drove to and from South Dakota transporting four students from Crazy Horse High School to Wisconsin.

Last July, the first camp boasted 10 campers from two tribes and two states. For six days, the students had opportunities to cast, suture, job shadow, participate in a trauma simulation, tour three colleges, become certified in health care provider CPR and better understand diabetes.

### Student Leadership Award

Erin Locke

University of Kansas School of Medicine  
Wichita, Kan.




Erin Locke in Tanzania

Erin Locke has become a leader and an advocate through her years in medical school at the University of Kansas.

The voting student representative on the Kansas Academy of Family Physicians (KAFP) board of directors, Locke developed an interest in primary care while growing up in small-town WaKeeney, Kan.

While in med school, she added an extra year to earn her master's degree in public health and completed a rotation in rural Plainsville, Kan., and in Tanzania, Africa.

She presented her research on the retention of providers in underserved Kansas at the State Primary Care Offices Annual Meeting and to Kansas Sens. Jerry Moran and Pat Roberts in private meetings on Capitol Hill.

"I am honored to have received this award from NRHA for my research on provider retention and my involvement in the KAFP and other projects that impact rural health," Locke said. 

### Future honorees

The National Rural Health Association will accept nominations for its 2014 Rural Health Awards at [RuralHealthWeb.org](http://RuralHealthWeb.org) beginning in December through Feb. 11.

Winners will be selected by a committee of NRHA members and honored during the 37th Annual Rural Health Conference April 22-25 in Las Vegas. Each student award winner will also receive complimentary conference registration, a one-year NRHA membership and a \$500 award from John Snow Inc.

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# University puts spotlight on elder abuse in Native American communities

By Brandi Jewett



Twenty purple people constructed from cardboard stood guard around Grand Forks, ND. The text on their chests recounts incidents that often remain private. A grandfather verbally abused by his grandson. A grandmother slapped by her daughter.

Those studying the matter can only estimate how many elders are abused in Native American communities.

According to University of North Dakota (UND) professor Jacque Gray, that estimation is one in 10.

“This is often a fear to divulge abuse,” she says. “Many times it is a family that is being abusive.”

Gray is associate director of indigenous programs at the university’s School of Medicine and Health Sciences. She and a small staff are behind the National Indigenous Elder Justice Initiative (NEIJI) based in the University of North Dakota Center for Rural Health.

**“Native Americans typically talk about ‘disrespect,’ not ‘abuse.’”**  
Paula Carter, University of North Dakota professor and National Indigenous Elder Justice Initiative research director

NEIJI aims to establish a resource center for elder abuse, identify and create tribe-specific elder abuse codes and develop culturally appropriate resources for those who may encounter elder abuse situations.

The cardboard cutouts were part of a push to spread awareness about elder abuse. That push also included a webcast to recognize Worldwide Elder Abuse Awareness Day on June 15.

To assist these elderly populations, the initiative needs information from them, but gathering it is not an easy task.

Many elders often don’t think of yelling at them or taking their money as abuse, according to UND professor and initiative research director Paula Carter. Carter is a member of the Turtle Mountain Band of Chippewa.

“Native Americans typically talk about ‘disrespect,’ not ‘abuse,’” she said during the webcast. “In my own family, when my mother was afraid or if something would have been going on, she would never have said ‘I’m being abused,’ but ‘I’m being disrespected.’”

Other abuses aren’t reported out of fear that the caregiver will be taken away and the elder will be placed in a nursing home, according to Carter.

In attempt to gauge how prevalent elder abuse is in Indian Country, Gray and her staff surveyed more than 17,000 elders from 200 tribes in the United States.

The survey couldn’t provide definite numbers but did give them insight into an unmet need.


Less than 1 percent of respondents said they use elder abuse prevention programs, but 13 percent said they would if services were available.

Similar to gathering information, pinpointing the cause of elder abuse isn’t straightforward.

Greed, caregiver stress and feelings of entitlement are just some factors the initiative has identified as leading to elder abuse. John Eagleshield, a community health representative of Standing Rock Nation for 29 years, sees the cause as something even deeper.

“For those that are my kinsmen and tribesmen, you always ask for compassion in case you may say the wrong thing. I’m about to say the wrong thing, but it’s a bias of mine,” he said during the NEIJI webcast. “There is no elder abuse in Indian Country. But there is a lot of elderly abuse.”

The difference between the terms is that elders are thought of as good and wise, living by tradition and passing it on to their children and grandchildren, Eagleshield says. To him, those who are just considered aged and did not live by or pass on tradition are the ones susceptible to abuse. According to Eagleshield, putting emphasis back on tradition could be the key to preventing more abuse – something that could not be accomplished without elders.

“We need elders to step forward,” he says. “There’s a lot of elderly that need their help.” 

*This article originally appeared in the June 23, 2013, Grand Forks Herald.*

## Reporting elder abuse

- Elderly are often reluctant to report abuse due to fear of retaliation, lack of physical and/or cognitive ability to report, or because they don’t want to get the abuser – 90 percent of whom are family members – in trouble.
- Despite the accessibility of Adult Protective Services (APS) in all 50 states, as well as mandatory reporting laws for elder abuse in most states, an overwhelming number of abuse, neglect and exploitation cases go undetected and untreated each year.
- State APS agencies continue to measure an increasing trend in the reporting of elder abuse.
- The New York State Elder Abuse Prevalence Study estimates that for every case known to programs and agencies, 24 are unknown.

For state-specific information and resources, visit [ncea.aoa.gov](http://ncea.aoa.gov) or call 1-800-677-1116.

*Source: National Center on Elder Abuse*



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# Tornado victims benefit from information system that helped doctors quickly access medical records

By Gail Makulowich



*Norman (Okla.) Regional Health System-Porter Campus emergency department following the nearby May 20 tornado.*

Ferocious tornadoes struck Moore, Okla., on May 20 and May 31, destroying buildings and sending many injured victims to emergency departments (EDs).

Moore Medical Center (MMC), destroyed by the May 20 tornado, quickly mobilized to treat incoming patients and transfer them and resident patients to other Norman Regional Health System (NRHS) hospitals in nearby Norman.

"I was the hospitalist on call that night," recalls Brian Yeaman, MD. "The HIE [health information exchange]

didn't come online for me at NRHS until 9 p.m. the night of the storm. I worked traumas in the ED and admitted seven tornado victims – some crush injuries and pneumothorax patients. Something I don't want to see again. And when I got the HIE access, I used it for the second survey on the trauma patients."

The second survey is done when trauma patients have been stabilized and the clinician has time to step back and assess all their current and past medical issues and manage coexisting medical conditions that could complicate their course of recovery. They need quick access to medical records provided by the HIE to do this.



Brian Yeaman

Medical record information from the NRHS HIE, initially funded by Agency for Healthcare Research and Quality (AHRQ), on what medications patients were on and what medical conditions they had was essential in order to provide safe and appropriate care. MMC's electronic health record transfer system also helped ensure accurate transfer of patients' records.

"The inpatients we moved, including several women in labor, required a small status change in

our system. No data was lost," Yeaman says.

Jon White, director of AHRQ's health information technology portfolio, added that "both clinical teams and technology demonstrated their resiliency, as displaced patients were thoughtfully transferred and promptly reunited with their complete electronic medical records."

**"The HIE [health information exchange] was important for Moore citizens that were at home and injured and distributed all over the metro area EDs in making sure the patients' care transition was adequately informed with their medical history."**

Brian Yeaman, Norman Regional Health System chief medical information officer

As chief medical information officer for NRHS and medical director for the HIE, Yeaman says he was gratified to see what a difference the system made in care of tornado victims.

"The HIE was important for Moore citizens cared for at MMC that were at home and injured and distributed all over the metro area EDs in making sure the patients' care transition was adequately informed with their medical history from the HIE," he says.

Fortunately for the tornado victims, MMC is one of 26 hospitals participating in the Oklahoma health information exchange, Secure

Medical Records Transfer Network (SMRTNET), along with 99 clinics and other facilities.

Initially funded by AHRQ, SMRTNET has been recognized by the National eHealth Collaborative as a national health information exchange leader, enabling the exchange of more than 2.7 million patient records across 68 Oklahoma cities. SMRTNET allows medical providers to securely exchange electronic health information among hospitals, physician offices, laboratories, a university, Native American tribe, and public health, mental health and community health centers.

These electronic records are housed in a secure data warehouse and were immediately available to SMRTNET's 1,400 provider users as they worked to heal patients hurt by the Oklahoma tornadoes.

For more information on SMRTNET and AHRQ's health information technology program, go to [healthit.ahrq.gov](http://healthit.ahrq.gov). 

*Gail Makulowich is senior editor of the Agency for Healthcare Research and Quality's Research Activities newsletter.*

## Free EHR guidebook for clinicians

The Agency for Healthcare Research and Quality recently published a guidebook to help primary care clinicians connect their patients' electronic health records to a local health information exchange hub and regional health information organization.

The free guide, *Regional Health e-Decisions: A Guide to Connect Health Information Exchange in Primary Care*, is available at [healthit.ahrq.gov/regionalhealthdecisionsguide.pdf](http://healthit.ahrq.gov/regionalhealthdecisionsguide.pdf).





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# Quality project aims to measure, improve care at rural health clinics

By Angela Lutz



*Misty Blevins and John Gale at NRHA's Annual Rural Health Conference*

In a changing health care environment, evaluating and documenting quality is vital. But it's not always easy.

Rural health clinics (RHCs) are the last type of primary care provider that isn't being penalized or incentivized for reporting patient care quality data.

A new quality improvement project involving multiple stakeholders and rural health experts from across the country aims to change that. Spearheaded by the federal Office of Rural Health Policy, the University of Southern Maine Rural Health Research Center and 13 state offices of rural health, the project seeks to establish a set of RHC-specific quality measures that will allow clinics to see where they stand compared to other clinics, enhance what they're doing well, and understand where they have room for improvement.

"You can't improve what you don't measure," says John Gale, research associate at the University of Southern Maine Rural Health Research Center. "It's a standard axiom in the quality improvement world."

With nearly 4,000 locations in 45 states, federally designated RHCs are an important part of the service delivery system in rural communities. Beginning this fall, the RHC quality project will recruit approximately 300 clinics from 13 states to start measuring, documenting and reporting data based on approximately 16 quality improvement measures.

According to Gale, the measures are being established by an expert panel that will ensure the directives are relevant, cost-effective and actionable, not only for RHCs but for third-party policy makers and payers. The panel is considering how each measure relates to a clinic's effectiveness, patient safety, timeliness, patient centeredness and equity.

**"You can't improve what you don't measure."**

**John Gale, University of Southern Maine Rural Health Research Center research associate**

Members of the expert panel include representatives from state offices of rural health, the Colorado Rural Health Center, the National Rural Health Resource Center, the Illinois Critical Access Hospital Network, Central Michigan University, the National Association of Rural Health Clinics and the Office of Rural Health Policy.


"The whole field of health care is moving toward transparency and pay for performance, so we want measures that reflect those dimensions of our changing environment," Gale says. "By virtue of creating these measures, we'll give clinics a starting point by which to make changes. They'll be able to identify areas where they may not do well or they are doing well and how to improve them."

According to Gale, the project's possible challenges include the fact that "clinicians and staff in RHCs wear a lot of hats," which can make data collection difficult. Similarly, staff members at different clinics have expressed concern over public reporting of data, as they may not have enough of any one type of case to report a measure. And, in a smaller system, the influence of one bad case can have a greater impact on overall data than it would in a larger system.

But thanks to early adopters, Gale is confident that the research team will be able to work through these challenges. He hopes the pilot RHCs will lead by example and encourage other clinics to participate in quality reporting.

Going forward, Gale says that a set of benchmarks consistent with the operations of RHCs will allow clinics to learn from each other and “measure and monitor what they do.”

Establishing and reporting quality measures will also allow RHCs to change with the health care environment and continue to fill their vital role in the delivery of rural health care, he says.

“If [clinics] hope to participate in some of the practice transformation initiatives that are being driven by health reform and the ACA (Affordable Care Act), they really have to do this,” Gale says. “It’s very difficult for them to become a provider in an accountable care organization or become a patient-centered medical home unless they collect, monitor, track and work on performance improvement and quality.” 

### Rural health clinic facts

- Nationwide, there are approximately 4,000 rural health clinics (RHCs) in 45 states.
- RHCs are either independent (free-standing) or provider-based (usually hospital-owned).
- RHCs can be gender and age specific as long as the majority of care they provide is primary care.
- RHCs can be public, nonprofit or for-profit.
- RHC practitioners may only provide services covered by Medicare, which limits the services of some specialists.
- RHCs much employ at least one nurse practitioner or physician assistant.
- RHC certification can be critical to providing Medicaid clients access to health care in rural areas.

*Source: Office of Rural Health Policy*

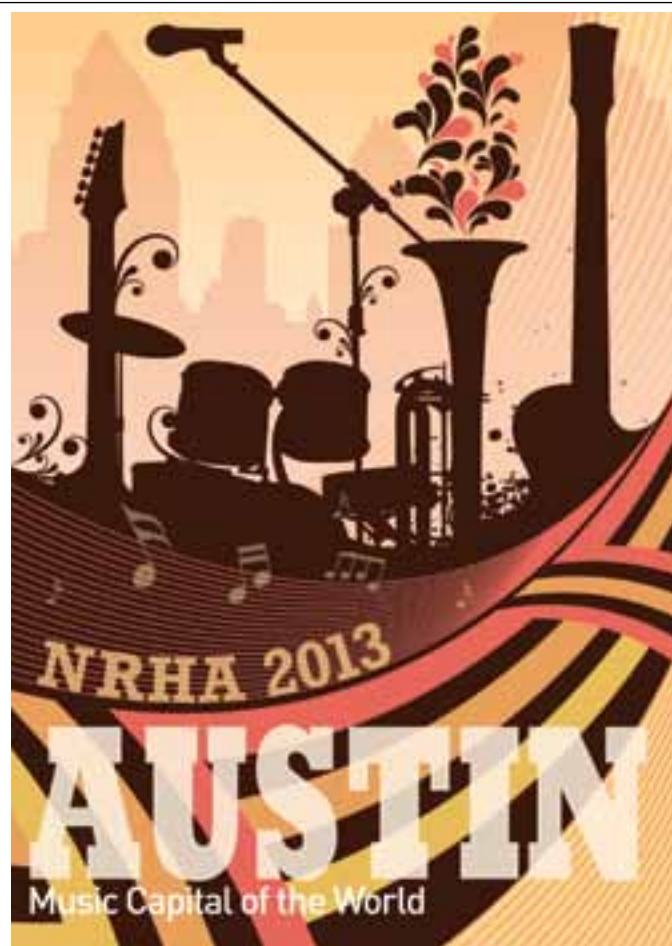
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- quality measures and performance benchmarks for rural health clinics

NRHA’s Critical Access Hospital Conference will follow Oct. 2-4.

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## Reaching out

### VA doc expands telemedicine program for MS patients

By Stephanie Watson



David Omura, a Rural Veterans Telerehabilitation Initiative physical therapist, uses technology to advise a patient.

She prefers not to travel if she doesn't have to – and telemedicine offers an alternative.

#### Accessibility and Affordability

Treating patients remotely via videoconferencing and other electronic technology is at the heart of a growing field known as telemedicine. While it's been around since the 1950s, recent technological advancements have made it more affordable and accessible. One study, published in April 2012 in *Multiple Sclerosis Journal*, found that the ease and convenience of telemedicine reduced medical costs and increased patient satisfaction.

One of telemedicine's advantages is that it allows people with MS to better access quality care.

"There are a lot of issues for people with MS being able to get to the right doctors, particularly in rural areas," says Lisa Skutnik, National MS Society executive vice president of clinical programs.

Travel costs, lack of transportation and insurance that doesn't fully cover out-of-area care can affect access.

**"There are a lot of issues for people with MS being able to get to the right doctors, particularly in rural areas."**

Lisa Skutnik, Multiple Sclerosis Society executive vice president of clinical programs

Michele Wilson, diagnosed with multiple sclerosis (MS) in 1991, had such severe numbness, tingling and pain in her left leg that the 47-year-old spent most nights tossing and turning.

"Sometimes I'd only get an hour or two of sleep," she says.

Her neurologist, Paul Hoffman, MD, examined her, testing for ankle clonus (repetitive muscle contractions), watching as she walked and checking her leg for numbness. He recommended pain relievers and physical therapy, which Wilson says have helped tremendously.

But what sounds like a standard office visit was anything but typical. Wilson was at her primary care doctor's office in Beverly Hills, Fla., while Hoffman communicated via monitor and camera from Gainesville, Fla., more than 50 miles away.

The virtual visit saved Wilson an uncomfortable drive.

"When I'm sitting for that long, when I get out, I can barely walk," she says. "My legs are so stiff."

"Consequently, some people with MS may only see a neurologist once a year or not at all," Skutnik says.

#### Delivering care

Hoffman is the director of the Veterans Rural Health Resource Center-Eastern Region, a division of the U.S. Department of Veterans Affairs Office of Rural Health.

Three years ago, with just five patients, he started the telemedicine program in north Florida which Wilson participated in. Today, the program includes 50 patients at 10 sites across the country.

The program uses monitors – each about the size of a computer screen –

*continues on page 41*

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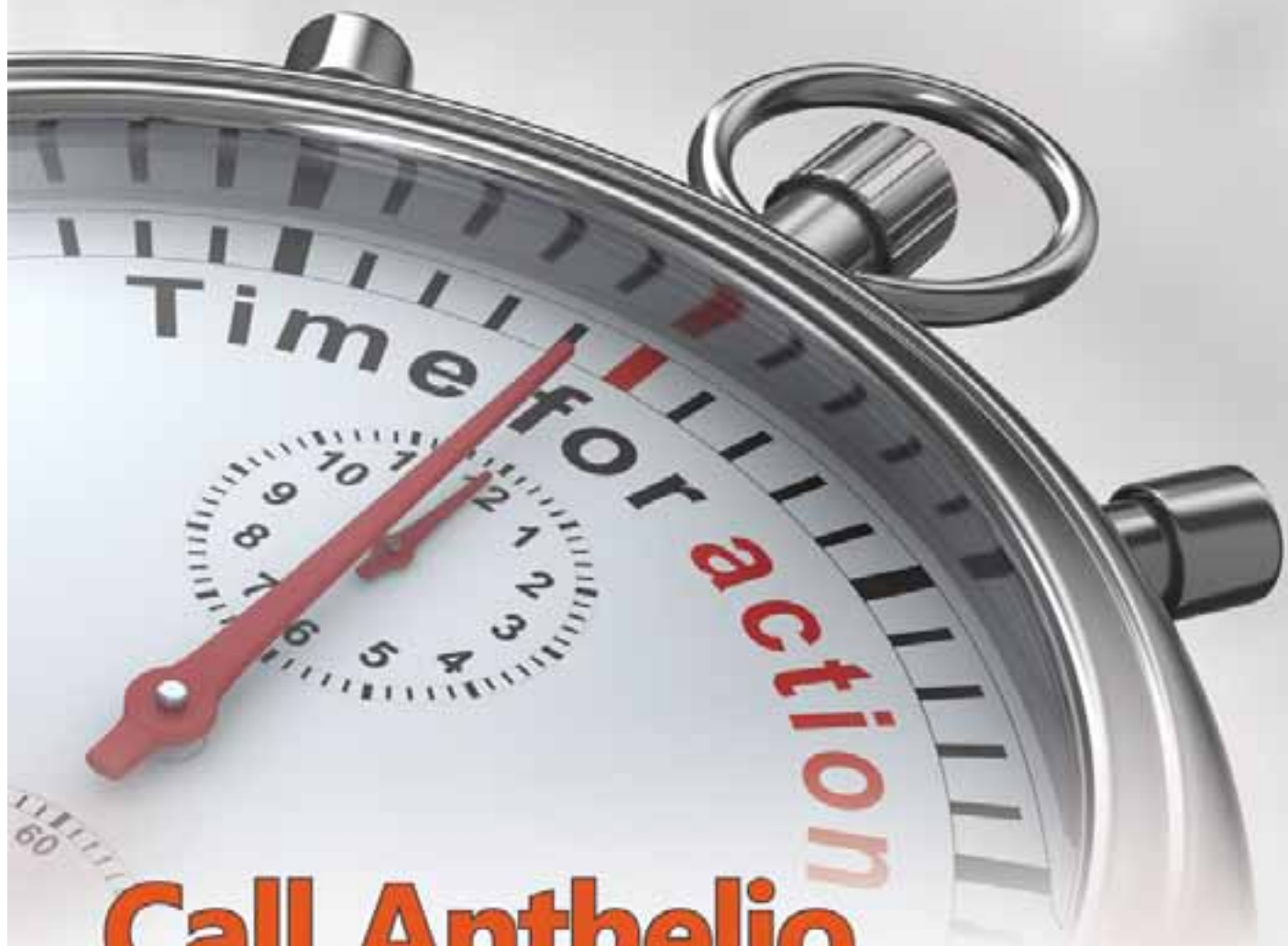
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continued from page 37



Sean McCoy, an exercise physiologist/investigator for the Veterans Rural Health Resource Center-Eastern Region leads a wellness program via televideo.

connected via high-speed Internet.

“The lines go from the hub site, where the specialty clinic is, to a community-based outpatient facility – the closest medical office these patients can get to,” Hoffman explains.

A trained nurse or physical therapist assists the person with MS in the office, while a neurologist at the specialty clinic directs the exam.

Barbara Giesser, MD, University of California-Los Angeles David Geffen School of Medicine clinical professor of neurology, is also piloting a telemedicine program.

“With very few exceptions, we will be able to do all the parts of the neurologic exam,” she says. “I can see the patient speak and ask questions, and with a little assistance from someone who is with the patient, I can do the salient parts of the exam. I will make recommendations, and the doctor who is seeing the patient locally will be able to implement my recommendations.”

The next phase of Hoffman’s VA program is to determine what other types of MS care, beyond a follow-up exam, doctors can provide remotely.

“Can we treat acute flare-ups? Can we treat infections?” he asks. “Can

we treat wound and bedsore issues? And can we do rehabilitation? Those are some of the questions we will be considering.”

## Future of the field


Skutnik agrees telemedicine holds tremendous promise in treating people with MS.

“I think that there will be a number of places where telemedicine will be used for ongoing MS care,” she says. “It’s been on everyone’s radar screen for the last three or four years.”

Telemedicine programs may eventually expand to assess patients at home – both to monitor their health and to help them adapt their homes to better accommodate their physical needs.

“It potentially has a lot of applications that will simplify the process and save money through the system as a whole,” says Gabriel Pardo, MD, director of the Oklahoma Medical Research Foundation’s Multiple Sclerosis Center of Excellence, where a pilot telemedicine project is being tested.

For now, these doctors exploring the uses of telemedicine say they intend to continue.

“We’re dipping our toe in the telemedicine waters, but hopefully they will expand and grow and flourish,” Giesser says. “Access to care is one of the most important things we do, and this is a great step forward.” 

*This article originally appeared in the winter 2012 issue of Momentum, the National Multiple Sclerosis Society’s magazine.*

# Prescription for rural childhood safety

## Meds should be out of sight, reach

By Shelley Ducker



A new CDC program encourages parents and grandparents to keep medicine “up and away” to protect children.

Every year, more than 60,000 young children – roughly four school busloads of kids each day – end up in emergency rooms after getting into medicine while their parents or caregivers aren’t looking.

And, according to the Centers for Disease Control and Prevention (CDC), this number has increased nationally by 20 percent in recent years.

Unsupervised pediatric medicine ingestions can happen anywhere – spanning rural communities to cities. However, the farther away one is from health care services, the more dangerous these ingestions can be, explains Dan Budnitz, MD, director of the CDC’s Medication Safety Program.

Education about safe medicine storage is crucial for prevention, he adds.

Every 61 seconds an adult calls a poison control center after a child gets into medicine or is given the wrong dose, according to a recent *Safe Kids Worldwide* report. Yet, if urgent care is needed, a child in a rural location is often farther from medical care than a child in an urban location. In fact, the likelihood of seeing an emergency physician drops fivefold in most rural

communities, according to the American Academy of Family Physicians.

“It’s important that health care providers, parents and caregivers nationwide – and especially in rural settings – know what to do if a child gets into medicines or vitamins, as well as the preventative steps they can take,” says Robert Geller, MD, Georgia Poison Center medical director and Grady Memorial Hospital pediatrics chief.

**“Each year one of every 150 2-year-olds ends up in an ED for an unintentional medication overdose, most often after getting into medicine while their parents or caregivers were not looking. A few simple steps – done every time – can protect our children.”**

Dan Budnitz, MD, CDC Medication Safety Program director

If a parent suspects a child has gotten into medication, they should call the poison help line at 1-800-222-1222. Callers should try to have the suspected bottle of medicine on hand so they can inform poison control what the child got into – its dosage strength its dosage strength and how much the child took – to help determine the best course of action.


“Of course, from a poison control perspective, the best action is



prevention,” Geller says.

He says it’s important for health care providers to educate patients about safe medicine storage and to remind them that medicines for adult conditions can be particularly dangerous to children.

A recent study in *Pediatrics* revealed that pediatric exposures to diabetes medications and beta-blockers caused the greatest numbers of emergency department (ED) visits for pediatric poisonings; exposure to opioids and diabetes medications caused the greatest numbers of pediatric hospitalizations. All medications – even those taken daily or multiple times a day – should be put up and away and out of a child’s reach, after each use, Geller emphasizes.

“While it may seem like common knowledge to store medications and vitamins out of the reach of children, each year one of every 150 2-year-olds ends up in an ED for an unintentional medication overdose, most often after getting into medicine while parents or caregivers were not looking,” Budnitz says. “A few simple steps – done every time – can protect our children.” 

*Shelley Ducker is the communications and outreach director at the Consumer Healthcare Products Association, a participating member of the CDC’s PROTECT Initiative.*

## Up and away

Every 61 seconds an adult calls a poison control center after a child gets into medicine or is given the wrong dose. Program this number into your phone, and call if you need help: 1-800-222-1222.

The CDC’s “Up and Away and Out of Sight” campaign makes educational resources – including posters and brochures – available for free to display and share in hospitals, clinics, pharmacies, schools and daycares. Access these materials at [upandaway.org](http://upandaway.org).

Promote safe medicine storage by:

- Reminding patients – especially those with young children or grandchildren – to store medicines in a safe location too high for kids to reach or see.
- Asking expecting mothers and parents with young children to relock the safety caps on medicine bottles and return medicines to the safe storage location after each and every use. Parents should not leave medicines out on a kitchen counter or at a sick child’s bedside.
- Reminding parents and other caregivers that bags or coats that have medicines in them should also be stored out of children’s reach and sight.
- Encouraging parents to teach children about medicine safety, making sure young kids understand that they should never take it by themselves.



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

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- Create a better patient experience through availability of clinical intelligence when and where it is needed





## Facing facts

### Color fades fast, scalpel scars last

By Kacie Fodness



Kacie Fodness

I made quite a few friends that day. Many of them 50 years my senior, we watched hours of “American Pickers” in the waiting room.

I know how fortunate I am. Sure, my doctor had used the word “cancer” after a biopsy, but my form of skin cancer – basal cell carcinoma – was incredibly treatable.

It was also incredibly preventable.

I’ve never been what you’d call “outdoorsy.” Far from it, actually. You couldn’t pay me to go camping or mow a lawn.

I was 24 the first time it happened.

This initial spot – near my ribcage – was more annoying than anything. I ignored it for months, convinced it was nothing to worry about, but as soon as this bump (not unlike a bug bite in appearance) started to bleed, I asked my doctor. He did a biopsy

that same day.

After that, I set up yearly skin checkups. Even the second time I was in denial. I looked at my skin (almost obsessively after my first scare) and found nothing that worried me – a self-proclaimed worrier. But I was wrong; this time a flesh-colored bump on the bridge of my nose that was so harmless-looking it was almost unnoticeable.

**“No one in your family has ever had skin cancer. Hell, your friends and parents used to lay out in the sun for hours with no sunscreen and no problem. Me too. So get checked anyway.”**

Since it was more of a cosmetic concern this time, my doctor cut as little as possible then tested it on site while I waited and watched antiquing programs with people who call themselves antiques. If the edges aren’t clear of the cancerous cells, they’ll try a little more. For me it took six rounds and nearly as many hours and reality TV episodes.

Left untreated, basal cell can have serious complications. Not to mention the many other forms of skin cancer, each much more dangerous and some even life-threatening.

If you’re like me, perhaps you go tanning “just once and a while” for a “healthy glow.” The color is temporary while my new scar is permanent.

If you’re like me, you don’t mind the occasional burn because it “isn’t like I let this happen all the time.”

If you’re like me you wear a daily moisturizer with SPF and use sunscreen 95 percent of the times you should.

No one in your family has ever had skin cancer. Hell, your friends and parents used to lay out in the sun for hours with no sunscreen and no problem.

Me too. So get checked anyway.

It wasn’t painful. Or scary. It was a nuisance and, in the end, I suffered only from vanity. Would that we all were so lucky.

*Kacie Fodness works in administration at Dakota State University in Madison, S.D. She is also an editorial intern for the National Rural Health Association, a jazz musician and doctoral student in literature.*

For more information on how to care for your skin in the sun see Short Cuts and “Get the skin-ny on the sun” on page 69.





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# Beginnings & Passages



*Samuel Johnson*

“When I thought of rural medicine, I thought of one-gas-station towns with miles between houses.”

## Finding my way to rural

By Samuel Johnson, MD

I was born in Nashville and raised in Memphis.

I attended college at Emory University in Atlanta and went to Meharry Medical College for medical school and residency. Originally, my goal was to move back to Memphis and practice family medicine in a suburban area of town. My day would typically be 9-5 allowing me to spend time with family and friends.

When I thought of rural medicine, I thought of one-gas-station towns with miles between houses. My misconceptions were changed when I decided to work with Hanna Ilia, MD, during a rotation in rural medicine. He literally did it all: outpatient clinic with procedures, inpatient and emergency room work. Everybody knew him. I learned a lot from him. I also learned – no matter where you’re from – everyone has the same problems.

It took two steps to bring me to rural health care. The first was the partnership with my residency program and the offering of a rural practice rotation. The next was an invitation to D.C. to speak about the program and what I learned and liked about the rural rotation. While there, I met Cindy Siler and Mary Ann Watson of the Tennessee Rural Partnership. I had no plans to practice in a rural community; I wanted to practice in or near Memphis. But they told me Bolivar was looking for a physician and set me up to talk with Mary Heinzen, Hardeman County Community Health Center CEO. Not too long after I found myself working in Bolivar, population 5,399, about an hour and a half from Memphis.

Since beginning my practice in 2011, I have discovered I do not know everything. The best things about practicing here are that I am able to provide quality care to patients who otherwise would need to travel long distances in this economy to get the care they need, continuity of care, and getting to know my patients and their families.

My advice to clinicians considering rural practice is that you never know what you can do until you are put out on the ledge by yourself. Everything is what you make of it. If you cannot have fun with what you do and enjoy it, then it is not for you.

*Samuel Johnson, MD, is a family practice physician at Hardeman County Community Health Center, a federally qualified health center in Bolivar, Tenn.*

*See the opposite page to learn more about how he began his career there.*

## Recruiting to rural Tennessee

The Tennessee Rural Partnership (TRP) helps clinicians who want to make a difference in rural and underserved communities find a practice site that meets their individual needs.

In addition to matching clinicians with jobs, the nonprofit also administers the Tennessee Residency Stipend

Program which provides clinicians funds to pay off their school debts. In return, recipients agree to practice in an area of need identified by TRP.

To learn more, visit [tnrp.org](http://tnrp.org), and stay tuned for the fall issue of *Rural Roads* magazine.



## Innovative rookies and seasoned professionals share their experiences.

“If at first, you don’t succeed, then try, and try, and try, and try again and again and again.”



Mary Heinzen

### Recruiting the right fit for rural

By Mary Heinzen

I was born in Wisconsin, but moved to rural Tennessee when I was 17.

I worked in major cities until I decided to come back to a rural area in 1995. A family member told me there was an opening in my old hometown to direct the Hardeman County Community Health Center (HCCHC), a small nonprofit. The job description and some research into community health centers made me realize it was a chance to continue my mission to help improve the lives of those in need.

HCCHC was only three years old when I arrived. It has been wonderful to see the business grow the last 18 years. I truly believe in the mission of community health centers, and have never regretted my decision to work here.

Recruiting and retaining physicians and other providers has been one of the most challenging aspects of my job. It’s not easy to find physicians who want to move into small towns. Often there are few or no specialists in these small towns to refer patients to when they need medical care beyond the primary care clinics. Many of the patients who use community health centers have low incomes or do not have health insurance, and most specialists and medical facilities which provide diagnostic medical tests (Xrays, mammograms) they may need are reluctant to take patients who cannot afford to pay their normal fees. Of course, as a nonprofit business with a tight budget, it’s also impossible to offer physicians the salaries that large hospital systems or for-profit businesses can. It takes a special provider to take on the challenges of practicing in rural clinics like ours, and to do that for a number of years.

We did not have an opening when the Tennessee Rural Partnership (TRP) indicated they knew of a physician completing his residency who wanted to work near Memphis. But in a medically underserved area, we had to check that out. Fortunately, Samuel Johnson, MD, wanted to be involved in the practice incentive program that was available through TRP. We met with Dr. Johnson, and liked him immediately and knew he’d fit in well with our patients and our organization, and the local hospital agreed to help some financially to make our offer more attractive to him.

I had been working with TRP’s staff to help us recruit a physician since TRP started in 2006, and the employees have become not only colleagues but friends. They’d connected us to various prospects over the years, and we interviewed all who were willing to interview with us. However, it was not until 2011 that we were able to close the deal with a physician referral from TRP.

My motto has been: If at first, you don’t succeed, then try, and try, and try, and try again and again and again.

The need at community health centers is great, and our patients will be rewarding to work with once you find someone who agrees with your mission and wants to be part of it. It’s important to be grateful for the time these good clinicians stay with you (even if just for a few years) and keep working on honing your recruitment and retention efforts.

*Mary Heinzen is CEO at Hardeman County Community Health Center in Bolivar, Tenn. See the opposite page for more on Samuel Johnson’s journey to her federally qualified health center.*

*Are you relatively new to rural health or looking back on years of serving rural America?  
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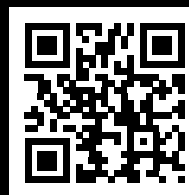
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## Rural health leaders race to Kentucky

The National Rural Health Association's 36th Annual Rural Health Conference brought more than 900 rural health professionals and students to Louisville, Ky., to represent rural, start a flash mob and participate in more than 65 diverse educational sessions.

"One of the best things about NRHA is the people it brings together," says 2013 NRHA president Sandra Durick. "And this year's Annual Conference was no exception."

Comedian Brad Montgomery kicked off the May event with a session on happiness in the workplace and got the crowd to their feet for a surprise dance number.

"It's safe to say that was the first-ever rural health flash mob," joked NRHA CEO Alan Morgan.

Attendees had the opportunity to hear updates from and ask questions of insiders at the Office of Rural Health Policy, Veterans Administration, Centers for Medicare and Medicaid Services and more.

An impromptu hat auction at Durick's derby-themed reception raised more than \$500 for NRHA's Rural Health Foundation. And NRHA announced the 2013 Rural Health Award recipients at a banquet in their honor.

Join experts and colleagues from across the country next year for the 37th Annual Rural Health Conference, the nation's largest gathering of rural health leaders, April 22-25 and for the Rural Medical Educators Conference April 22 in Las Vegas.



*NRHA members Gregg Kishaba, Sally Buck and Scott Daniels enjoy the opening session of the 36th Annual Rural Health Conference. Above: Leticia Manning, Office of Rural Health Policy public health analyst, presents on the value of rural health networks. Left: Veterans Affairs Homeless Veterans Initiative representatives Sam Salkin and Brian Hawthorne share information with University of Alabama Rural Medical Scholars Justin Vines and Brittney Anderson during a conference break in the exhibit hall.*



*Clockwise: Jenna Kennedy Sloan provides a medical student's perspective during NRHA's Rural Medical Educators Conference, just prior to the Annual Conference. NRHA CEO Alan Morgan serves as auctioneer and model during an impromptu hat auction to raise funds for the Rural Health Foundation. Members turned their trip to the conference into a chance to see the Kentucky Derby, just days before the NRHA event. University of Central Florida Rural Health Research Group director Judith Ortiz talks with Office of Rural Health Policy associate administrator Tom Morris during a break between sessions. NRHA member Hilda Heady and NRHA staff member Amy Elizondo enjoy a derby-themed reception. Sandra Durick surprises Gail Nickerson with the President's Award.*

## More friendly faces

Continue your trip down Memory Lane or see what you missed with more photos from the 36th Annual Rural Health Conference and other NRHA events at [flickr.com/nrha](http://flickr.com/nrha). And learn more about the Rural Health Awards recipients on page 17.

# It's not just about the survey...



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# Why Austin is awesome... and weird

## with NRHA member Dave Pearson

Side trip



Dave Pearson



Austin, Texas, is known as the Live Music Capital of the World.

Austin is the greatest city in the world!

Well, at least in Central Texas, and there is no shortage of things to see and do.

With a population of nearly 850,000, Austin has become the 11th most populous city in the country, and its unique blend of Texas history, high-tech economy, vibrant arts and music culture and general 'weirdness' has made it the most eclectic and trendy city in the state.

Here are a few of the best spots to eat, people-watch and exercise in and around the Austin area:

### Music scene

Austin is a music lover's paradise.

The **Austin City Limits Music Festival** is one of the largest music events in the country and coincides with the National Rural Health Association's early October conferences.

Stay for '80s favorites Depeche Mode and The Cure as well as MUSE, Kings of Leon and 100 other acts. The music scene will be full-tilt in the days leading up to this non-stop concert in Zilker Park.

### Downtown dining

Check out these tried and true local favorites (including mine) near the NRHA conference, certain to please everyone's palette:

- **Dave's fave: Shady Grove** serves up Austin-inspired home-cooking and cocktails.
- **Maudie's Café** has been a tradition in Austin since the early '50s, serving the best home-style cooking around. This is Tex-Mex Heaven.

### Everything's bigger in Texas

Join rural health colleagues and national experts for the National Rural Health Association's fastest-growing conferences in Austin Texas.

Plan now to connect and collaborate at the Rural Health Clinic (Oct. 1-2) and Critical Access Hospital (Oct. 2-4) Conferences. And take what you learn home to improve care right away.

Go to [RuralHealthWeb.org/austin](http://RuralHealthWeb.org/austin) for event details and discounts.

- **Hopdoddy Burger Bar** is a casual spot that supports local ranchers and farmers.
- Also check out **Roaring Fork** and **Moonshine**.

## Destination dining

For those who enjoy taking in the scenery and are willing to venture just outside of weird, there are a few places around town that are known as much for their food and drinks as their location.

- **Dave's fave:** From the multilevel decks of **The Oasis** nestled into the hillside hundreds of feet above Lake Travis, you can sip a margarita as the sun descends behind the hills on the opposite shores.
- On the grounds of the Mandola Estate in Driftwood, Texas, you'll feel like you have been transported to the Italian countryside while dining at **Trattoria Lisina**, and it's only a 20-minute drive.
- The **Salt Lick BBQ**, also in Driftwood, is a famous barbecue spot with lots of Texas Hill Country hospitality.



The Tavern

## Go west

The 6th and Lamar area is the epicenter for Austin's new urban renaissance. Nerd culture, vinyl records and organic food collide in this walkable shopping and entertainment district just west of downtown.

**Book People** is one of the largest and best independent bookstores you're likely to find these days.

Be sure and pick up your very own "Keep Austin weird" T-shirt here.

The **Whole Foods headquarters** is near the original store and over 80,000 square feet. Stop in for a made-to-order healthy bite.

**Waterloo Records** is a real record store with the best selection of music you'll find anywhere.

What can I say? I like Mexican food. A lot. And the chain's original **El Arroyo** is a historical Austin landmark with daily happy hour specials.

**Dave's fave: The Tavern** has traditional pub grub, plus a 50-bottle craft-style beer selection.

## Hikes and bikes

The **Austin Hike and Bike Trail** spans the length of Lady Bird Lake, the segment of the Colorado River that runs through downtown Austin. This is an amazingly friendly place to take a run or walk, and early October has some of the best weather that Texas has to offer.



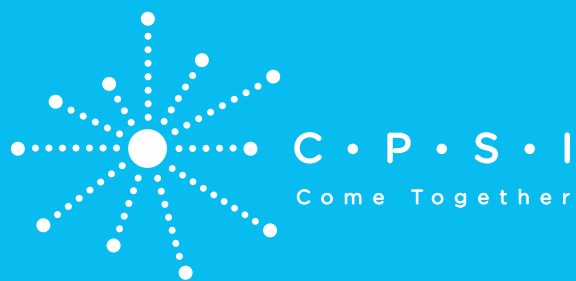
Austin Hike and Bike Trail

If you prefer to wheel your way around downtown, the **Bicycle Sport Shop** has one of the largest selections.

Want to go cross country? Make your way over to the **Barton Creek Greenbelt**, a stunning natural preserve just south and a bit west of downtown. [!\[\]\(5d954b3e270654ad8ab0d5913161c03c\_img.jpg\)](#)

*Dave Pearson is president and CEO of the Texas Organization of Rural and Community Hospitals in Austin. He joined the National Rural Health Association in 2007.*





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## Members on the move

### KRHA names first executive director



*Tina McCormick*

The Kentucky Rural Health Association (KRHA) recently introduced the first executive director in its 14-year history.

Thomasina (Tina) McCormick, who has more than 20 years of rural health experience, began leading KRHA and its nearly 400 members in May.

“As the new face of KRHA, I am eager to prove that our mission is vital to the rural communities we serve,” McCormick says. “With over two decades in the public health environment and having

grown up in rural Western Kentucky, I know the importance of access to quality health care.”

She recently was elected as a Kentucky delegate to the American Public Health Association. Prior to her KRHA role, McCormick was interim public health director for the Marshall County Health Department and worked for two other health departments.

“KRHA has a mission of advocating for equitable distribution of health care resources and improving access to care in an effort to enhance the health status of rural Kentuckians,” says David A. Gross, president of the Kentucky Rural Health Association and administrative director for education and research at St. Claire Regional Medical Center. “We are confident that Tina’s enthusiasm and vast rural health experience will help KRHA meet that mission by significantly increasing the association’s impact and level of activity.”

Among other things, that will include providing leadership and creativity in developing program, organizational and financial plans on behalf of the association and carrying out plans and policies authorized by the board of directors; advocating for rural interests on state and federal health care issues; growing and developing KRHA’s membership; and serving as the association’s spokesperson.

“I want to engage and connect with our current members to utilize the experience and expertise we already have to move us forward. I expect to plan additional activities that give our members something back for being a part of this association.”



*Benjamin Anderson*

### Member leads another Kansas hospital

National Rural Health Association member Benjamin Anderson recently relocated to Lakin, Kan., to lead Kearny County Hospital, including its hospital, clinic and skilled nursing facility.

Prior to the move, Anderson served as CEO of Ashland (Kan.) Health Center for four and a half years where he implemented a mission-focused medicine model.

“Managing the change we are experiencing in our industry is a constant battle, but thanks to NRHA, we fight this fight with an arsenal of support behind us,” Anderson says. “NRHA’s Brock Slabach and Alan Morgan have both been tremendous resources for me. I call on them often for guidance and advocacy.”

He joined NRHA in 2012.

### Past presidents starts consulting company



*Lance Keilers*

2012 National Rural Health Association president Lance Keilers recently started Connected Healthcare Solutions, a rural health consulting company based in Missouri.

The firm specializes in critical access hospital (CAH) operations, hospital administration, physician practice management, rural health clinics and physician and staff recruitment.



“My passion is rural, and I have had the opportunity to network with NRHA members and have seen firsthand the positive impact that rural health care has on small communities,” Keilers says. “Our rural health care system is under the greatest pressure in many years, and it is important that NRHA members stay engaged to fight so that people that choose to live in rural areas will continue to have access to quality health care close to home.”

He had served as administrator of Ballinger Memorial Hospital, a 25-bed CAH in Texas, for 14 years. Keilers joined NRHA in 1999.

## NRHA fellow earns doctoral degree



Cristina Miller

Cristina Miller, PhD, recently received her doctoral degree in economics from the University of Illinois-Chicago and started a full-time position as an agricultural economist with the U.S. Department of Agriculture Economic

Research Service.

Miller, a 2013 National Rural Health Association Rural Health Fellow, is passionate about her research on rural access to health care and farm and rural household wellbeing.

“I am thrilled to be a Rural Health Fellow,” she says. “It is such an honor to have been selected. Having the opportunity to spend time with the other fellows, learn more about what they do and hear firsthand about rural access to health care in their areas has been a truly enlightening experience for me. These fellows are an amazing group of people who work hard every day to provide health care, share knowledge and support their rural communities.”

Miller joined NRHA in 2012 and volunteered at NRHA’s Critical Access Hospital Conference last year.



Val Schott

## Longtime member changes roles

Former National Rural Health Association president and longtime member Val Schott is now the Rural Community Hospitals of America (RCHA) business development senior vice president.

Schott works to find rural hospitals for potential management by the firm, which currently manages 12 hospitals in five states.

“NRHA provides both background and grounding for anyone working in rural health and continually reminds us of why we work in this arena: improved health and wellbeing for rural people,” Schott says. “My years in NRHA have contributed substantially to my career in rural health by keeping me grounded as to our purpose and providing so many relationships that I have relied on in my past endeavors. I look forward to continuing these relationships as I start this new endeavor.”

Prior to his RCHA position, Schott was CEO for the Oklahoma Health Information Exchange Trust after working for the Oklahoma Office of Rural Health for nearly 20 years.

Schott joined NRHA in 1992 and served as president in 2002.

## NRHA news

### NRHA goes global, and you’re invited

The National Rural Health Association is extending its reach to further provide leadership on rural health issues by fostering international rural health connections and travel for members.

“I’m very excited to see NRHA expanding its activities internationally,” says H.D. Cannington, NRHA’s International Rural Health Task Force (IRHTF) chair and a rural Georgia hospital and health clinic CEO. “This effort not only allows us to learn about innovative approaches to rural health care delivery, but it also provides our membership with new opportunities for personal and professional development.”

The association’s new task force is embarking on its first international experience to set the foundation for collaboration. This trip is in the initial planning stage, so NRHA is determining how many people are interested and in what countries.

Efforts will be organized around three main areas where applicable:

*continues*

continued

public health assessment, facility management and consultation and policy management.

IRHTF trips will include on-site visits with rural health professionals, opportunities to experience firsthand the barriers to care for the rural population and time to collaborate on best practices for rural care with foreign counterparts.

To join the cause and learn about rates and destinations being considered, including Australia, England, Peru and Middle Eastern countries, visit [RuralHealthWeb.org/go/international](http://RuralHealthWeb.org/go/international) or email [international@NRHArural.org](mailto:international@NRHArural.org).

## Rural Training Track program helps develop new sites

The National Rural Health Association's Rural Training Track Technical Assistance Program (RTT TAP) continues to support RTTs and future rural physicians.

During NRHA's 36th Annual Rural Health Conference in May, 18 medical students from across the country participated in a focus group led by RTT TAP to discuss ways to increase awareness of RTT residency opportunities and to increase interest in rural training and practice.

"This program has brought together collective expertise to support and promote existing and new rural training tracks in meeting their mission of producing the physicians rural America so desperately needs," says Dave Schmitz, MD, RTT TAP assistant project director.

NRHA's RTT program has provided technical assistance to five new RTT programs which recently received accreditation. The newly accredited programs are located in Blackstone, Va.; Magnolia, Ark.; Redding, Calif.; Hood River, Ore.; and Silver City, N.M.

## Join journal editorial board

The National Rural Health Association is accepting applications and nominations for *Journal of Rural Health* editorial board positions.

"Serving on our editorial board is great way for rural health scholars to become more involved with NRHA, connect with fellow researchers and further contribute to our journal," says Ty Borders, PhD, journal editor.

Responsibilities include reviewing manuscripts, recruiting reviewers, setting editorial content guidelines and soliciting manuscripts to be published in the peer-reviewed journal.

Candidates must have significant rural health experience and an established record of publications. Professional and disciplinary backgrounds will also be considered to ensure the board reflects the diversity

of the rural health field.

Terms for open positions begin Jan. 1, and board members serve three-year terms.

The editorial board meets once a year in conjunction with NRHA's Annual Rural Health Conference and via teleconference each quarter. Members pay their own travel and lodging expenses for the annual meeting.

Apply or nominate a board member at [RuralHealthWeb.org/go/journal](http://RuralHealthWeb.org/go/journal) by Sept. 30.

## Apply now to become a Rural Health Fellow

Applications for the National Rural Health Association's Rural Health Fellows program are due soon.

The program aims to educate, develop and inspire a networked community of rural health leaders who will step forward to serve key positions in the association, affiliated rural health advocacy groups and local and state legislative bodies.

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

"It was a wonderful experience that provided me with a better understanding of NRHA as well as rural health," says Sally Buck, 2011 NRHA fellow and National Rural Health Resource Center associate director.

Apply at [RuralHealthWeb.org/go/fellows](http://RuralHealthWeb.org/go/fellows) by Aug. 31 to be considered for the 2014 fellows class.

## Scholarships, discounts available for NRHA conference

The National Rural Health Association's Rural Multiracial and Multicultural Health Conference will be Dec. 3-5 in San Antonio, Texas.

"People often ask me if there are opportunities to hear about what others are doing in their communities to address minority health issues," says Sandra Pope,

West Virginia Area Health Education Center director. “This conference is the perfect venue for learning about and sharing successful projects and initiatives that can be replicated in your community.”

This will be the 19th year for nation’s only conference focusing on eliminating health disparities and improving access to quality health care services for rural underserved populations.

Attendees will gain valuable insight on border, oral and behavioral health, health literacy and health disparities, grant writing and leadership skills.

“One of our goals to increase awareness of grassroots efforts to improve the health of our minority populations,” Pope says. “Join us in this important educational, networking and advocacy event to make your voice louder.”

Visit [RuralHealthWeb.org/mm](http://RuralHealthWeb.org/mm) to register early and save or to apply for scholarships beginning Aug. 15.

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

## NRHA receives recognition

The National Rural Health Association recently received the 2013 Kansas City Award for Health and Welfare.

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

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

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

## Task force meets with feds, creates compendium

Earlier this month, 12 members of the National Rural Health Association’s Nation Rural Task Force (NRTF) members convened in Washington, D.C., where they met with Health Resources and Services Administration and Veterans Health Administration leaders to discuss rural work force issues.

“This was not just another meeting,” explains Carol Miller, task force co-chair. “For a day and a half, rural and frontier community health center leaders met with staff from the National Association of Community Health Centers and the National Rural Health Association. After being briefed by key federal policy leaders and representatives of national organizations, open and lively discussions were held with the presenters.

“Members come prepared to dig in and work at this meeting every year.

We brainstormed ideas for tackling current, unique challenges and changes faced by rural and frontier community health center in the rapidly changing health delivery environment and generated ideas for best navigating the new world of health coverage beginning Jan. 1.”

NRTF also recently published its latest compendium of best practices.

In the booklet, “Innovations to strengthen rural health care: Technologies, quality improvement, collaborations and training” the task force highlights best practices from hospitals, area health education centers and community health centers.

The latest compendium and other NRTF materials are available on NRHA’s website at [RuralHealthWeb.org](http://RuralHealthWeb.org) under the “Networking and Programs” tab.

## Rural clinic, hospital conferences coming in October

Join national experts and colleagues for the National Rural Health Association’s Rural Health Clinic and Critical Access Hospital Conferences Oct. 1-4 in Austin, Texas.

Mark Drabenstott, PhD, will give the keynote address. Recognized as a thought leader on regional development, Drabenstott served chairman of the world’s premier forum on regional policy, the Organization for Economic Co-Operation and Development’s Territorial Development Policy Committee from 2006 to 2010.

He previously served as director of the Rural Policy Research Institute’s Center for Regional Competitiveness. Drabenstott also spent 25 years at the Federal Reserve Bank of Kansas City, where he served as vice president, led the creation of the Fed’s Center for the Study of Rural America and provided monetary policy advice to the Federal Open Market Committee.

Take advantage of discounted early registration rates at [RuralHealthWeb.org](http://RuralHealthWeb.org) today, and get a local member’s advice on experiencing Austin on page 58.

*continues*

Send your career updates to [editor@NRHArural.org](mailto:editor@NRHArural.org).



continued

## NRHA brings border health experts together

The National Rural Health Association's Border Health Initiative aims to create a partnership for addressing health care access needs in rural areas along the U.S.-Mexico border.

Partners from the U.S.-Mexico Border Health Commission, state Offices of Border Health, the federal Office of Rural Health Policy and NRHA leadership attended NRHA's latest annual border health meeting in June in D.C.

Attendees heard updates on current efforts from all partners, formulated steps to advance efforts in the next year and established new priorities for NRHA.

"This initiative is a great opportunity for all individuals and organizations working along the U.S.-Mexico border to share challenges and opportunities in order to improve access to health care," says Gaby Boscan, NRHA's program services manager.

This NRHA initiative, which formally began in 2008, has helped highlight best practices and issues along the rural and underserved areas of the U.S.-Mexico border, developed a policy paper on border health and increased the number of sessions focused on border health at NRHA conferences.

Learn more at NRHA's Rural Multicultural and Multiracial Health Conference Dec. 3-5 in San Antonio, Texas.

## State association leaders gather in Chicago

Forty people attended the National Rural Health Association's Skill Building Workshop in July in Chicago.

And 34 state rural health associations (SRHAs) were represented at the annual networking event created for them.

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

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

As a part of its cooperative agreement with the Office of Rural Health Policy, NRHA provides direct technical assistance to state rural health associations.

## Lights, camera, action: NRHA kicks off photo, video contests

Based on the success of the National Rural Health Association's first photo contest in 2012, the Communications Committee is adding a video category to this year's Rural Lens competition.

NRHA is accepting photos in three categories – community outreach, people and landscape – and rural health-relevant videos through Aug. 15.

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

NRHA Facebook fans will select their favorite photos and videos throughout September. The winner in each category will have their image featured in *Rural Roads* magazine.

Visit [RuralHealthWeb.org](http://RuralHealthWeb.org) for contest rules.



NRHA 2012 Rural Lens finalist

## accelerating advocacy

### NRHA invited to White House for mental health discussion

The National Rural Health Association was invited to participate in the National Mental Health Conference with President Barack Obama and Vice President Joe Biden at the White House in June.

In addition to NRHA, the event brought together stakeholders from throughout the country, including mental health advocates, educators, health care providers, faith leaders, members of Congress, representatives from local governments and individuals who have struggled with mental health problems.

“NRHA applauds the Administration’s renewed focus on mental health, specifically in rural communities, and remains committed to increasing the access to and utilization of mental health services in all rural areas,” says NRHA CEO Alan Morgan.

According to recent studies, rural America is disproportionately impacted by mental health conditions with higher levels of depression, domestic violence and child abuse than their urban counterparts.

Rural residents also face distinct challenges in accessing mental health services including physical, cultural and financial barriers. As a result, they tend to seek mental health services later, have greater symptoms and require more intensive treatment.

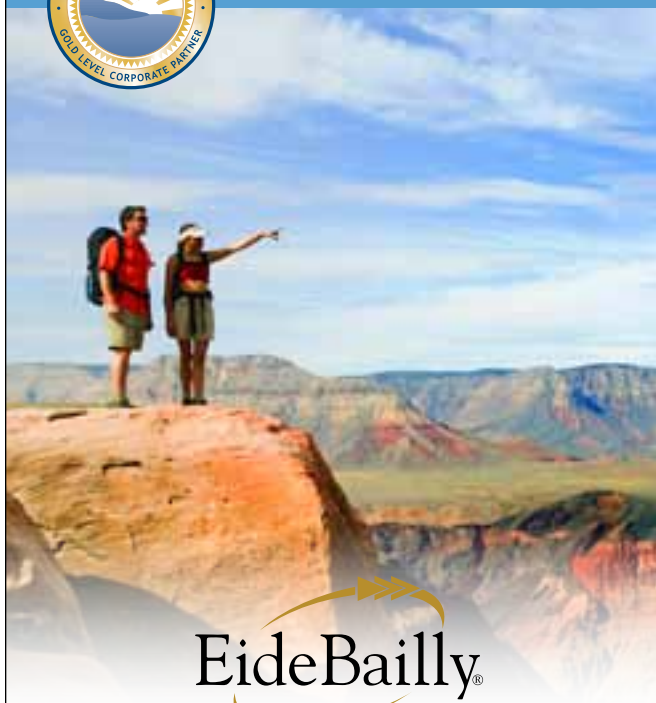
Of the 3,800 mental health professional shortage areas in the United States, more than 85 percent are located in a rural part of the country.

“Tremendous workforce shortages in rural America compound an already complex problem,” says Maggie Elehwany, NRHA government affairs vice president. “We must ensure rural Americans have access to the care they need. NRHA fully supports recruiting and retaining mental health providers and strengthening telepsychiatry.”

NRHA continues to work toward advancing federal legislation and funding to improve mental health access and services. Visit [RuralHealthWeb.org](http://RuralHealthWeb.org) for details.



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# Get the *skin-ny* on the sun

Let's face it. For so many of us, summer means fun in the sun.

Often imprisoned by winter's harsh winds and spring's showers, by the time summer rolls around, we're ready for the great outdoors. But did you know that even one bad sunburn can cause skin cancer?

Here are a few tips on how to protect yourself from the sun:

- Wear sunscreen, wear it thick, and wear it every time. Experts recommend you apply a sunscreen of at least SPF 15 (with broad-spectrum protection) every two hours, more if swimming or sweating. It is also important to apply it long before you first go outside.
- Places often missed by well-intentioned sunscreen wearers include your lips (most lip care products

now contain SPF), the part line in your hair and your ears.

- According to the Skin Cancer Foundation, it is best to avoid the sun from 10 a.m. to 4 p.m. When this isn't possible, wear hats and clothing made of tightly woven materials, and seek shade. And who doesn't need an excuse to buy sunglasses?
- If you find yourself with a sunburn, go inside right away. Drink plenty of water and apply aloe or other topical treatments. Adults can also take ibuprofen to reduce swelling and pain. Seek medical attention if you develop chills or a prolonged fever.

*See page 46 for one young woman's personal account of her skin cancer treatments.*

## Off the beaten path

### Of “irresistible speculation” and unexplainable phenomena

When driving near Death Valley Junction, Calif., population **4** (according to the city limit sign), you are likely encounter what has come to be known as a “dry lake.”

Rocks, dubbed “sailing stones,” made of syenite and dolomite create tracks on this playa surface likened to Saturn's moon “Titan.” But the most mysterious part is that no one — not trained NASA scientists or one of Death Valley's **four** residents — has ever seen these rocks move, despite the fact the tracks, and the rocks that continue to create them, have been visible since before the **1940s**.

These rocks, which according to NASA reports “glide across a mirror flat landscape, leaving behind a tangle of trails” are visible on the cracked surface of Racetrack Playa. The report goes on to note that “some rocks travel in pairs, their **two** tracks so perfectly in sync along straight stretches and around curves that they seem made by a car.” Yet even NASA researchers and university students have never actually witnessed the rocks in motion, making the region a subject of “irresistible speculation.”

Think you'll be the **first**? This one's truly “off the beaten path” and a visit here, though possible, is unlikely. The terrain is as dangerous as it is mysterious and requires clearance to travel a “**28**-mile rough gravel road” from the nearest town.

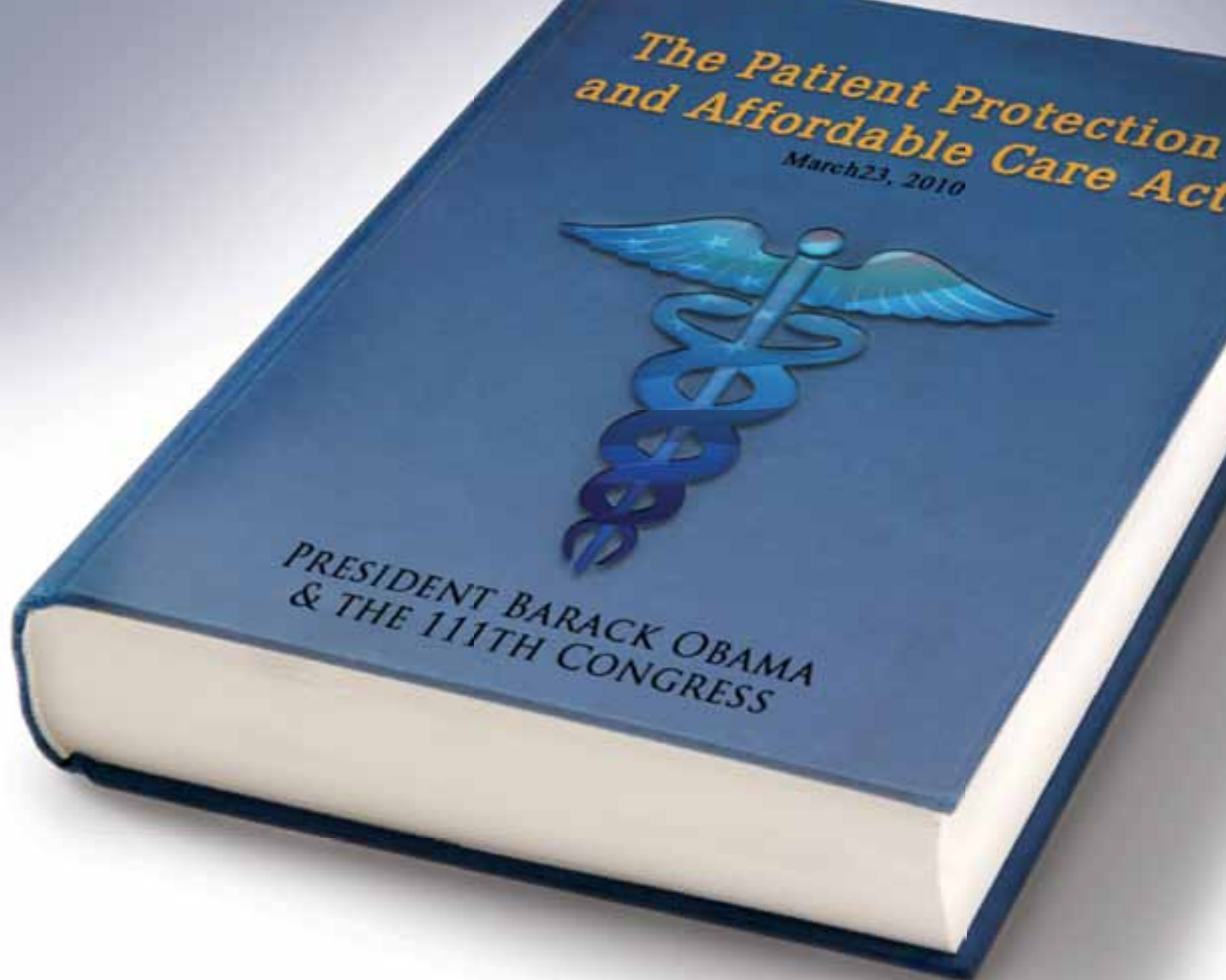
## shifting gears

### Eco on the line



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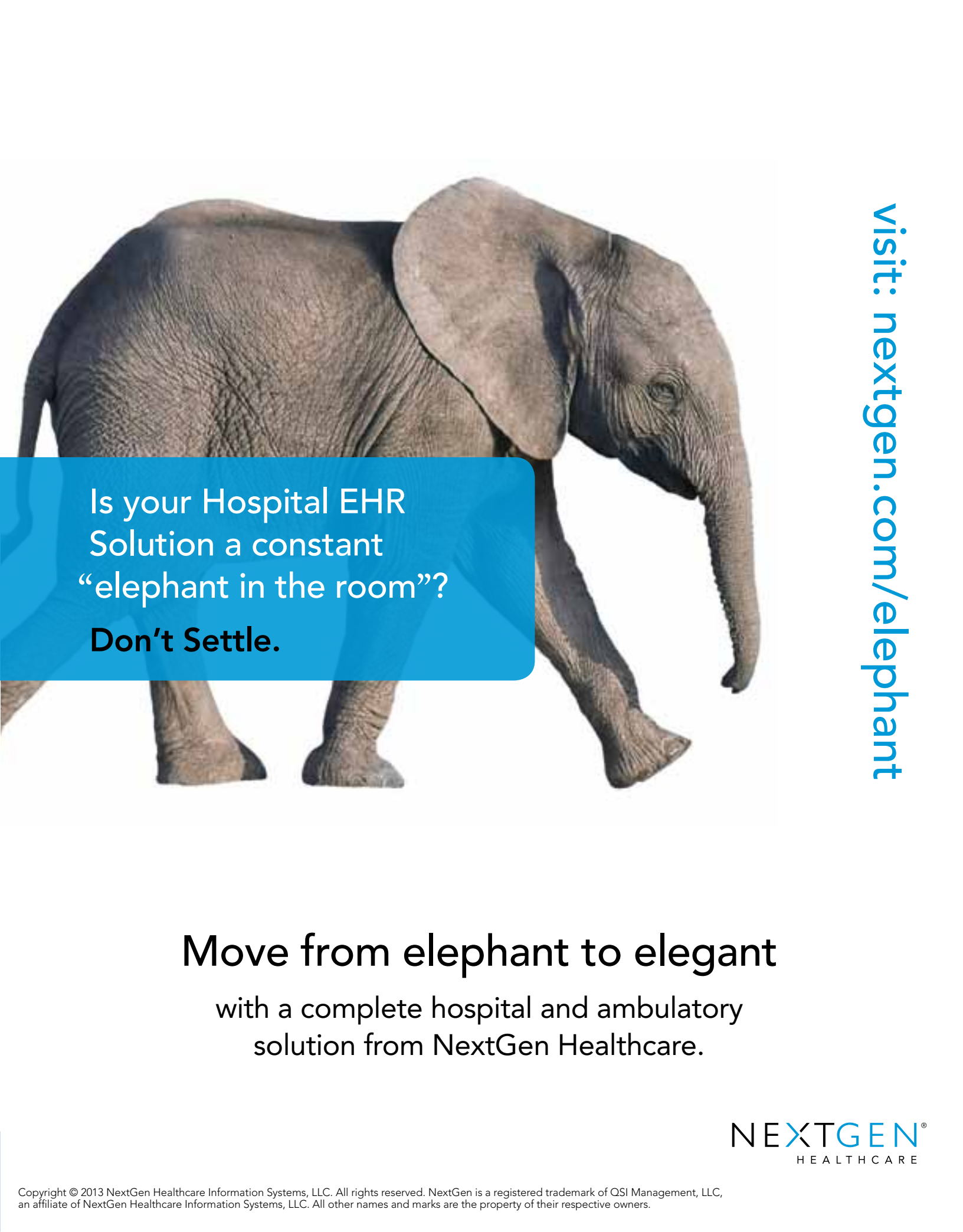


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Set up a video chat. Or schedule a brief get-to-know-you intro at the Critical Access Hospital and Rural Health Clinic Conferences on October 1-4 in Austin, TX, by calling Mike Milligan, President, Legato Healthcare Marketing at 920.544.8102.

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