

# rural roads

fall 2015 National Rural Health Association



## It takes a village

Volunteer-run pregnancy support center beats the odds

Greenhouse nurtures confidence in psych patients

Walking 283 miles to save rural hospitals

How rural rivals created an award-winning partnership

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*On the cover: Mark Ward Jr. was born in 2013 after his mother, Dana, sought assistance at the Pregnancy Support Center of Johnson County, Tenn. The all-volunteer organization provides incentives for expectant mothers to make positive lifestyle changes.*

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Jodi Schmidt

## Scoring a rural health touchdown

As football season approaches, I think back to the most important lesson I learned sitting in the stands watching my boys play: When you've had no success going up the middle, it's time for an end run.

Case in point: Medicaid expansion. Consider the significant impact on rural hospitals, despite valiant efforts on the part of many state associations and providers, resulting from continued efforts focused on state legislatures and governors.

Perhaps it's time to look for another option in pursuit of Medicaid expansion?

Innovation is a word inherent in the Affordable Care Act, specifically in the creation of the CMS Innovation Center and the myriad demonstration projects stemming from this most significant change since the inception of Medicare 50 years ago.

Love it or hate it, ACA is designed to test new models of care and build upon those capable of demonstrating success. Is it time to stop beating our heads against the political wall and look to the flexibility and innovation of ACA to expand Medicaid through provider partnerships rather than state governments?

The hard work and stamina of advocates for the rural safety net continue to amaze me. If given the opportunity to put those same talents to work finding new creative solutions to address the needs of our patients caught in the gap between traditional Medicaid and the exchange, there is no limit to what we can achieve.

Sometimes all it takes is that "Hail Mary" play to succeed.


Jodi Schmidt

2015 NRHA president

pit stop

## things I picked up in this issue:

1. Seventy-two percent of students at the nation's smallest medical school in Salina, Kan., are originally from rural areas, meaning they'll likely return to a small town to practice. *page 21*
2. By employing psychiatric patients, a greenhouse in Montana has helped reduce the stigma associated with mental illness. *page 34*
3. Efforts to help rural pregnant women get healthy have dropped the rate of low birth weight in Johnson County, Tenn., from 15.1 percent to 5.3 percent, below the national average of 8 percent. *page 7*
4. A 283-mile walk from Bellhaven, N.C., to Washington, D.C., helped bring attention to rural hospital closures and devastating health care disparities. *page 60*
5. One rural clinic CFO mapped out an eco-friendly expansion with energy-efficient features and no-cost tricks that netted an impressive return on investment. *page 28*



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# It takes a village

Volunteer-run pregnancy support center beats the odds

By Angela Lutz



*Dana Ward and her husband, Mark, take a walk with their son, Mark Jr. The couple is expecting a daughter later this year.*

When Dana Ward learns a woman in her rural community is pregnant, she tells her about the Pregnancy Support Center of Johnson County. Located in Mountain City, Tenn., population 2,504, the center was there for Ward when she and her husband learned they were expecting their son, Mark, in 2013.

“They are some of the most kind and loving ladies ever,” Ward says, recalling her interactions with the center’s all-volunteer staff. “I was pregnant before I had my son, and we lost our baby. I had some anxious feelings about my second pregnancy after what had happened with the first, and I was able to get two ultrasounds there for free to see and hear the heartbeat and know that everything was OK.”

*continues*





Now that Ward is expecting her second child in December, she's visiting the center again – and she says the services it provides are invaluable to women in her rural community.

"Some girls have to drive more than an hour to see the doctor," Ward says. "Sometimes babies are a surprise, and it's good to know there are women in your own county who will help you."

## Resources and guidance

Just like babies, sometimes help arrives without warning. In 2010, Pregnancy Support Center director Samantha Norman knew she had to do something to help expectant mothers in her community. Johnson County had some of the poorest birth outcomes in the state, including the highest rate of low birth weight at 15.1 percent.

A federally designated health professional shortage area, Johnson County has only one hospital and no obstetrics physicians, so women must travel to neighboring communities for prenatal appointments. This can mean more than 84 miles roundtrip on mountainous roads – for many women, an insurmountable barrier to care.

"We needed to do something quickly," Norman says. "We couldn't wait on a doctor to come all the way over here to Mountain City to do our prenatal care."

That's when Norman received a timely gift: A man at the church where her husband is pastor donated a facility for her to open the Pregnancy Support Center, which is funded by community donations and a grant from the March of Dimes Community Program's Tennessee chapter. Initially, the center focused on helping teen mothers, but greater need quickly became apparent.

"We started identifying huge issues in our community," Norman says. "We had women coming in to receive services who were five-, six-, eight-months pregnant and had no prenatal care."

Norman also saw pregnant women struggling with poverty, drug abuse and smoking – and she knew that incentives were needed to prompt behavioral change. That's why the center's Healthy Beginnings program rewards moms-to-be for taking care of their babies and themselves. If women show proof of 10 prenatal



visits, the Pregnancy Support Center gives them a crib and a mattress, as well as a gas card to help cover expenses.

Additionally, each time a woman attends a monthly educational session at the center, she receives a package of diapers and wipes. The sessions follow March of Dimes curriculum and cover everything from the importance of folic acid to breastfeeding.

**“Once they trust you and they know that you love them and care for them right where they are, you see the excitement that they feel when they accomplish something.”**

**Millie Campbell, Pregnancy Support Center volunteer nurse**

According to Lydia Nicholson, who started going to the center after becoming pregnant with her second daughter, London, last April, having a stash of supplies ready when the baby is born is extremely helpful to women in economically depressed Johnson County, where the median household income barely tops \$30,000.

“A lot of people need additional assistance,” Nicholson says. “I was planning on getting pregnant, so it was good additional help for me, but a lot of women are not planning on getting pregnant, and they need a lot of extra resources and guidance. It’s good to have a place where you can go to get the help that you need.”

The stats show that it’s working: Just two years after the Pregnancy Support Center opened, the rate of low birth weight in Johnson County decreased to 5.3 percent, below the national average of 8 percent. And Norman says that number has remained fairly consistent.

## Acceptance and education

Though birth outcomes have improved, one statistic that is nearly four times higher than the national average is the number of pregnant women in Johnson County who smoke. According to Norman, “37 percent of our pregnant women smoke, so we’re working on a program to address that need.”

Pregnancy Support Center ultrasound nurse Millie Campbell plays a vital role in smoking cessation efforts. A labor and delivery nurse, Campbell and her daughter both started volunteering at the center, which is open three days a week, after seeing women struggle with a lack of resources and poor outcomes.

According to Campbell, when women see and hear their baby for the first time, they are more likely to keep their prenatal appointments, eat better and take care of themselves, which includes not smoking, drinking or using drugs.

“I feel like there’s no better time to educate someone on how they need to take care of themselves for the baby than when they’re actually seeing the baby on the screen,” Campbell says. “They see the heart beating, and




*Opposite page, from top: Lydia Nicholson and her daughter Sydney. Nicholson sought care at the Pregnancy Support Center last year when she became pregnant with her second daughter. With help from grant funding, Samantha Norman founded the Pregnancy Support Center in 2010. The center offers many supplies, including discounted, gently used infant clothes and diapers. Above: Millie Campbell provides ultrasounds at the all-volunteer facility.*

you can talk to them then about how this will affect the baby’s lungs, and how this will affect the baby when it’s born. When they’re actually seeing that it’s a living organism there on the screen, it gives them a different perspective on what’s going on.”

In addition to providing education, Norman says the Pregnancy Support Center has been able to affect positive change in the women they serve by “meeting them where they are.”

“You’re not going to force someone to make positive behavioral changes, but we can encourage them and love on them and be a support unit,” she says. “When they do fall, we can help them move forward.”

“Having someone meet them where they are makes them more open to the suggestions and education that you’re providing,” Campbell adds. “Once they trust you and they know that you love them and care for them right where they are, you see the excitement that they feel when they accomplish something.” 

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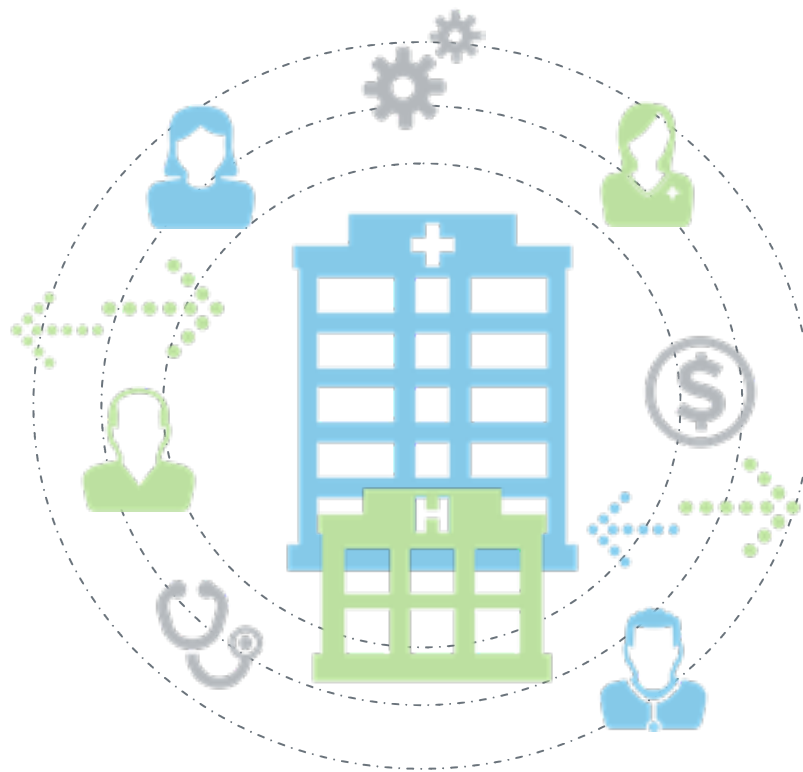
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# From cardboard to concrete

Building a new model for rural hospitals

By Taylor Sisk

*The main entrance of Carolinas HealthCare System's Anson County Hospital, which opened in 2014.*

Since 1954, the 52-bed hospital at 500 Morven Road, on the edge of downtown Wadesboro, N.C., county seat of Anson County, had served the community well.

But the model no longer worked for a rural community with a stagnant population.

For a variety of reasons, the number of people admitted to small, rural hospitals is declining. All those inpatient beds aren't needed. The financial model was no longer viable in Anson.

What was needed was something entirely new. But the solution wasn't immediately apparent. Some reimagining was in order.

*continues*

“Honestly, I don’t know if we knew what we were getting,” says Denise White, the new Carolinas HealthCare System Anson hospital vice president, chief of nursing and a leader of the team that planned and designed the one-story facility that now shimmers out on the highway.

There was no existing model. So the Carolinas team created one.

**“The premise behind this is that everything you could possibly do is in this flexible space with a center core for all the support you could possibly need.”**

**Denise White, Carolinas HealthCare System Anson hospital vice president and chief of nursing**

“I think this is the way rural health care is going to go,” says Cody Hand, North Carolina Hospital Association governmental affairs vice president, of this facility shaped to meet a community’s needs. “I’m impressed by the innovation.”

It took a system to build Anson County’s new hospital – a hospital system with a lot of resources at its avail.

### A cardboard model

Anson County is home to some 27,000 residents. In 2012, its overall health ranking was 89th of the state’s 100 counties. Nineteen percent of the county’s residents are uninsured.

More than one-third of adults in Anson County are obese. Twenty-seven percent have high blood pressure, 21 percent high cholesterol, and 17 percent suffer from heart disease.

These figures roughly match those of the most underserved of North Carolina’s counties.

In the county’s 2012 community health assessment, 18 percent of those surveyed said a barrier to receiving care was that they had to leave the county for numerous types of care; 14 percent said they had no transportation.

The old hospital, Anson Community, had long been a part of the Carolinas HealthCare System. But Carolinas was, White says, “at a crossroads with what to do in Anson County,” recognizing that to continue to provide health care there, “we’re going to have to do things differently.”



*Chief of nursing Denise White and hospital director Gary Henderson focus on patients’ needs both in and out of the hospital.*

“They came to the board and said, ‘This is what we propose for Anson County,’” says Anna Baucom, Anson County Board of Commissioners chair. “It was a very detailed plan ... They told us it would be innovative and that it would possibly be a model for rural health care in their whole system.”

Without Carolinas stepping up, she says, “I don’t know what would have happened. Because the county simply could not garner the resources to provide anywhere near what we have now.”

“I don’t know the technical term for it,” Baucom says, “but we would have been screwed.”

The overall objective, according to Gary Henderson, the hospital’s administrator, was to improve the county’s health status through a “community-focused care model.”

The first iteration of the new model was fashioned in cardboard – 6,000 pounds of it.

A design team comprised of nurses, physicians, registrars, X-ray technicians and other health care professionals spent five days building, razing and rebuilding a miniature hospital in a warehouse in Charlotte, simulating potential scenarios and designing workflows.

“We literally built this building in that space,” White says.

The doors to the life-size Carolinas HealthCare System Anson, a 43,000-square-foot facility built for \$20 million, opened in July 2014.





*The layout of the new Anson hospital emphasizes communication, patient flow and creating a healing environment.*

## No more walls

The hospital has two physicians, two nurse practitioners and one physician assistant and employs a medical-home approach to care.

A primary goal was to improve patient flow. To that end, an emergency department nurse and physician assistant screen each patient upon arrival to determine the care required.

“When we did an assessment of the legacy facility, there was a tremendous inappropriate utilization of the [emergency department],” White says. “Only 19 percent of this community had a primary care provider, so the primary care provider was the ED. So one of the things we wanted to do was really focus on getting them to the appropriate level of care. We put a lot of work on the front end, on that medical screening exam process.”

There are no walls between the emergency department and primary care. All patient rooms are in one bay, with the staffing stations in the middle.

“The premise behind this is that everything you could possibly do is in this flexible space with a center core for all the support you could possibly need,” White explains.

If a nurse in a primary care room should have a patient experiencing chest pains, “They open the door and say, ‘I need help,’” she says, “and they get an emergency room physician, a respiratory therapist ... We’re one department serving the needs of the patient.”

**“The county simply could not garner the resources to provide anywhere near what we have now. I don’t know the technical term for it. We would have been screwed.”**

**Anna Baucom, Anson County Board of Commissioners chair**

There’s also a behavioral health specialist on staff, and the hospital offers telepsychiatry.

## A ‘healing environment’

A lot of attention was given to the little things.

“We really wanted to put thought into creating a healing environment,” White says.

That translates into soothing color schemes, floors with curve and flow in their design, high ceilings and lights throughout that dim.

There are 15 beds in semi-private rooms. But the hospital averages only two or three inpatients a night,

*continues on page 17*



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with an average stay of 48 to 72 hours, primarily for observation. Acute cases are transported to larger hospitals. There's a helipad out back.

The hospital has a pharmacy and a payment-assistance program that offers, for a small fee, meds donated by pharmaceutical companies.

It provides office space for rotating specialists, with a check-in area and exam rooms. There is also a mobile unit that goes out several times a week to churches, schools, Walmart and elsewhere to offer screenings, diagnostics and education.

Should the community grow, the facility is designed to grow with it: an "expandable hospital," Henderson calls it.



*The new Anson hospital is designed to grow with the community.*

## Transportation and uniformity

As documented in the county's health assessment, transportation was a primary concern.

There's no bus or cab service in Anson County. So the hospital offers van service.

This is particularly helpful with frequent no-show patients. A patient navigator, provided to help coordinate ongoing care and other resources, takes the initiative in scheduling rides.

Another central tenet is removing departments from silos – a concept reinforced by the absence of walls.

Most everyone wears the same uniform. This helps underscore the message that everyone is on the same team.

A great deal of emphasis is placed on skill optimization, "making sure that we give people the ability to practice at the top of their license or their certification," White says, "because that's what people want to do. I get really excited about that. I've been a nurse a long time."

Everyone, including the environmental services staff, is trained in CPR.

And in keeping with its community-focused care model, Henderson said the hospital is developing a

network of community health advocates – in the schools and churches and with the county's major employers – to serve as "tentacles" to better determine the community's needs.

**"The proof will be in the pudding about five years down the road, when we share how we've improved the health status of Anson County."**

Gary Henderson, Carolinas HealthCare System Anson hospital administrator

## The 'right place'

Carolinas HealthCare System Anson transitioned 2,631 patients into primary care in its first year of operation. They would have otherwise been seen in the ED.

"They're at the right place, getting the right care, at the right time," Henderson says.

The hospital's patient navigator has assisted 294 patients, many of whose needs were identified in that upfront screening process.

That process, Henderson says, along with Carolinas' telemedicine services and predictive analysis, are among the reasons the hospital has moved from operating at an average loss of \$7,000 a month in the old facility to breaking even and occasionally showing a profit in this new one.

Commissioner Baucom says she heard criticisms from the community early on, which she attributes to the uncertainty of transition, but is hearing



The Siemens logo is displayed in a bold, teal, sans-serif font. It is positioned in the upper left corner of the advertisement, above a white horizontal bar. The background of the entire advertisement is a photograph of three young girls at an outdoor event, likely a parade. The girl in the center is wearing a purple sun hat and a black top, holding two small American flags and smiling. The girl to her left is wearing a pink visor and a dark polka-dot shirt, also holding a small American flag. The girl to her right is wearing a dark floral dress. In the background, a crowd of people and houses are visible under a clear sky.

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continued from page 17

a plethora of positive things today.

“We’re excited about the fact that this is groundbreaking,” Baucom says. “And so far it’s working well.”

“The proof will be in the pudding about five years down the road, when we share how we’ve improved the health status of Anson County,” Henderson says.

Meanwhile, the county’s health ranking is inching up, from 89th in 2012 to 84th this year.

## A path forward

Anson County created a new model for care, but many rural communities aren’t so lucky.

Fifty-seven rural hospitals have closed since 2010, and 283 more are on the brink of closure.

So the National Rural Health Association advanced a bill in Congress to stabilize and strengthen rural hospitals and put a stop to the closure crisis.

NRHA’s Save Rural Hospitals Act will first provide financial and regulatory relief to improve bottom lines.

It will also offer rural hospitals a new model designation called the community outpatient hospital.


Ask your representatives to co-sponsor NRHA’s legislation to #SaveRural hospitals and patients.

And learn more about our ongoing campaign to stop rural hospital closures on page 73.

Discover how other rural hospitals are thriving in spite of their unique challenges at NRHA’s Rural Health Clinic (Sept. 29-30) and Critical Access Hospital (Sept. 30-Oct. 2) Conferences in Kansas City.

Visit [RuralHealthWeb.org/kc](http://RuralHealthWeb.org/kc) for the full agendas and to register.

But every rural community with an endangered hospital may not have a system such as Carolinas HealthCare to step in.

Asked if something similar could be done without the considerable resources of a hospital system, the Hospital Association’s Cody Hand says, “I know that now that it has been done, it would be easier, because there’s a model. But I don’t know if it would be possible for somebody without the capital that Carolinas has to invest in that sort of location.” 

*This article originally appeared in North Carolina Health News on July 31, 2015, and was made possible by a grant from the Winston-Salem Foundation to examine issues in rural health in North Carolina.*



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# Nation's smallest med school a big deal for rural Kansas

By Angela Lutz



Tyson Wisinger

Tyson Wisinger might have grown up in a rural area, but the newly minted family physician always assumed his medical practice would take him to a larger city.

That all changed when the Fort Hays State University graduate attended medical school at the University of Kansas School of Medicine in Salina.

It didn't take Wisinger long to realize that instead of specializing in surgery, he wanted to practice in his hometown of Phillipsburg, Kan., population 2,541. His wife, Tonya, is also from Phillipsburg, and the young couple looks forward to raising their son in the safe, welcoming community after Wisinger completes a three-year residency in Smoky Hill, Kan., population 7,974.

"I think training in a rural setting let me see what that kind of model looked like, and I fell into my niche that way," Wisinger says. "Training in a rural setting opened my eyes to what rural medicine is really about."

Salina, population 47,846, is the smallest town in the country to host a four-year medical school. With a total of 32 students, the student body is also the nation's smallest. The first class of eight students graduated this May, and dean William Cathcart-Rake, MD, estimates that at least six of them will return to practice in rural Kansas.

This trend is likely to continue. Research shows that physicians are more likely to practice in rural communities if they are originally from a small town – and 72 percent of the students currently attending medical school in Salina are rural Kansas natives. As an additional incentive, students are offered loan forgiveness on a year-by-year basis if they practice in an underserved area after graduation.

For the state of Kansas, where 89 of 105 counties are wholly or partially designated as federal primary medical care health professional shortage areas, this tiny medical school is definitely a big deal.

"A lot of our patients come from small communities, many of them farming communities," Cathcart-Rake says. "[The students are] well attuned to the health issues that may occur – they've got farm accidents, aging folks, and folks who don't have immediate access to a physician. They're exposed to many of the issues that all providers in rural areas have to deal with."

Wisinger was surprised to discover that rural providers offer such a wide

*continues on page 23*



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William Cathcart-Rake

range of services, including obstetrics and gynecology. In urban areas, he says complex patients are often referred to specialists, but in rural Kansas, family physicians are “taking care of it themselves.”

**“Training in a rural setting opened my eyes to what rural medicine is really about.”**

**Tyson Wisinger**

In addition to common barriers such as access to care, one challenge Wisinger anticipates in his rural practice is “intertwining personal and professional relationships into one” when treating his friends, colleagues and family. But this strong sense of community is also why Wisinger loves living in a small town.

“Rural life is very family-focused and community-driven,” he says. “I feel like if a person is willing, they have the opportunity to make a big difference and a big impact in a lot of people’s lives just through those unique and special relationships.” 

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# Rural rivals create award-winning partnership

## How cooperation cured health centers

By Lauren Donovan



*Sakakawea Medical Center board president Christie Obenauer and chief administrator Darrold Bertsch say the cure for what ailed local health institutions was cooperation. They and Coal Country Community Health Center share NRHA's Outstanding Rural Health Organization honor.*

Two of rural North Dakota's rival health centers have teamed up to learn they feel better together than apart.

Neither the Sakakawea Medical Center in Hazen nor the Coal Country Community Health Center in Beulah was terminally ill, but competition instead of cooperation was weakening their bottom lines.

The diagnosis was obvious enough, but it was the cure that took some doing.

Starting four years ago, the two flagship medical entities began discussing the novel idea of talking to each other.

A fresh, healthy mindset blew in, and in April the two entities received a coveted award from the National Rural Health Association.

NRHA's Outstanding Rural Health Organization award recognized the two as one, though technically

each is still operated separately.

It's where they've come together that's been financially healing and given them the distinction of being the only hospital-clinic combination in the country to do so.

**"If what we do is to benefit the community we can't go wrong."**

*Christie Obenauer, Sakakawea Medical Center board president*

Darrold Bertsch, who started as chief administrator of the Hazen hospital, now splits his time doing the same for the Beulah clinic.

The clinic operates under Health Resources and Services Administration (HRSA) funding guidelines that are tilted toward low-income and underserved populations and require that the top administrator be a clinic employee.

Christie Obenauer, hospital board president, says it took some doing

*continues on page 27*

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Coal Country Community Health Center medical director  
Aaron Garman



Beulah clinic board president DJ Erickson

## Watch and learn

View the health centers' Outstanding Rural Health Organization award acceptance video and many more at [youtube.com/NRHAhealth](https://youtube.com/NRHAhealth).

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to persuade HRSA to go along with sharing the administrator of a critical access hospital, but, after seeing and believing, the agency recently signed an agreement formalizing the arrangement.

"Nobody else is doing this right now. Now, they're seeing that this could be a model," Obenauer adds.

Besides sharing an administrator, the boards of each entity have two mutual members. Talk at the board tables helps avoid expensive redundancies, such as \$500,000 CT scanners each one had at one time, and find ways to be more efficient.

**"There had been a huge left-hand-didn't-know-what-the-right-hand-was-doing effect."**

Aaron Garman, Coal Country Community Health Center  
medical director

"Health care is constantly shape-shifting, and now it's all about prevention. It's cool to be able to do that. No one is on an island. As a community member is diagnosed with something, there's the involvement of more people," Obenauer says.

DJ Erickson, Beulah clinic board president, says the arrangement is not only good for the communities, but it's a relief to step back from the infighting that had characterized relations for so long.

He adds that Bertsch is getting the job done for both entities, and morale has improved.

"Each has a core team of managers, and they're doing the work now that they should have been doing," Erickson says.


Aaron Garman, the clinic's medical director, says the arrangement prevents competition that can be unhealthy, especially when the communities are relatively small.

"There had been a huge left-hand-didn't-know-what-the-right-hand-was-doing effect," Garman says.

Today, the hospital and clinic boards are striving for the benefit of both, sharing resources and training and even bouncing health care providers back and forth as needed, he says.

Bertsch says the result is the hospital and clinic have a much improved cash-on-hand status and have collectively gone from 2.2 percent in the red to 11 percent as a net margin of profitability.

Garman and Obenauer agree wellness for a community is easier now that the gloves are off and hands are clasped.

"If what we do is to benefit the community – if we do that – we can't go wrong," Obenauer says. 

*This article originally appeared in The Bismarck Tribune on April 19, 2015.*

## Green and lean

### Rural clinic undergoes eco-friendly, cost-effective expansion

By Lindsey Corey



*The new Riverside Family Medicine clinic*

Riverside Family Medicine (RFM), a single-provider rural health clinic in southern Louisiana, had outgrown its space.

CFO Marty Bennett was aware of the need for a second nurse practitioner, while concerned about the impact both a new mortgage and an increase in payroll would have on the freestanding clinic.

A self-proclaimed student of green building techniques and technology, Bennett embarked on a quest to design the most eco-friendly and economical practice possible.

"It really was a personal endeavor for me," she says. "What could someone do who has no background in construction? I saw it as an intriguing challenge, and it really became a labor of love."

The goal was to include as many energy-efficient components as possible, while simultaneously requiring each to provide a rigorous return on investment.

"I would have loved to implement solar technology and had the clinic back-feed the electrical grid, but with the prohibitive cost, it really didn't make sense to invest in something that may not even recoup its cost before requiring replacement or repair," Bennett explains.

Instead the design team, made up of Bennett and local contractor/project manager Jim Adams, researched practical technologies themselves.

"We basically web-surfed and read up on the latest and greatest approaches to going green and then sat down and began vetting them for cost effectiveness," Bennett says.

When the list was complete, Adams tapped builder colleague Roy Domangue, an adjunct faculty member in green technology at a nearby university. Domangue volunteered to review the plans by taking them and



*Marty Bennett at the job site for the new eco-friendly clinic*



*The original Riverside Family Medicine clinic*

the RFM team's ideas to the classroom, challenging his students to provide their own suggestions.

"It really allowed us to vet our ideas against someone with over 30 years' industry experience," Bennett says. "As a newbie, you can study and learn a lot, but being able to bounce ideas off someone who has done the work for years was invaluable."

**"I really want other rural health clinics to understand it doesn't take thousands of dollars or expensive consultants to create a beautiful clinic that doesn't cost a fortune to run or build."**

*Marty Bennett, Riverside Family Medicine CFO*

Given the climate in Maurepas, La., population 3,853, keeping the interior cool and reducing air conditioning costs were more of a concern than heating the clinic.

The RFM team determined their best investments would be insulation, galvanized aluminum roofing, double-pane windows, and high-efficiency HVAC, hot water system, and lighting. No-cost efficiencies, such as placing windows high on the walls and limiting the window surface area on the hotter sides of the building, reduce solar heat gain.

"For me, green is a mix of practicality, cost-effectiveness and being a good steward of corporate resources," Bennett says. "I really want other rural health clinics to understand it doesn't take thousands of dollars or expensive consultants to create a beautiful clinic that doesn't cost a fortune to run or build."

### **Here's how RFM went green in 2013:**

**Design:** The clinic features architectural elements, such as a tower over the lobby and intake office, to increase natural lighting. Materials within the building, such as flooring, were chosen for durability and longevity, reducing maintenance and replacement costs.

**Exterior:** The exterior walls were built with 2-by-6-inch framing and blown with rock wool insulation. The exterior was sheathed in omnidirectional strand board, and ¾-inch Styrofoam was applied to the exterior walls to reduce heat conduction through the fiber-cement plank siding. Unpainted galvanized aluminum was used for the clinic roof for its longevity as well as its inherent heat-reflective properties. And 24 inches of loose-fill insulation was blown into the attic.

*continues on page 31*



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**HVAC:** A 16-SEER, two-stage HVAC unit was installed with programmable thermostats. The SEER rating is one of the industry's most efficient, and the two-stage motor allows it to cycle on and off to maintain a constant temperature with a much lower energy expenditure than the older, single-stage units. A gas point-of-service hot water heater was selected to reduce energy consumption by super-heating water on demand, as opposed to constantly maintaining a reservoir of heated water.

## “Grassroots efforts of a small team are nothing new in rural medicine.”

Marty Bennett, Riverside Family Medicine CFO

**Lighting:** LED can fixtures were used instead of either incandescent or those using CFL bulbs. The cans were only used where a more upscale esthetic was desired, such as the lobby and corridors. Utilitarian areas, exam rooms and office spaces were equipped with less expensive four-bulb fluorescents with efficient ballasts.


**Windows:** Since none of the windows in the clinic are operable, the decision was made to go with aluminum-framed, double-paned, low-emissivity windows with factory-applied glazing and thermal break to decrease solar heat.

**Paper:** The clinic switched to electronic health records when Bennett came on board in 2006. And RFM selected an eco-friendly document destruction company for any paper they still use.



Marty Bennett

The final price for the new building came in at \$146 per square foot, and the monthly utility bill for the 4,000-square-foot facility is at or below that of the previous location, which was 1,440 square feet and is now leased by a veterinarian.

“I am beyond thrilled with the results,” Bennett says. “Grassroots efforts of a small team are nothing new in rural medicine. Profit margins in medicine, especially rural primary care, are not that large, and saving every penny counts.” 

## Re-imagining rural

Learn how eco-friendly objectives and other cost-saving initiatives can fit into the budgets and goals of rural clinics and hospitals in sessions on innovative strategies, transformative processes and operational efficiencies at NRHA's Rural Health Clinic (Sept. 29-30) and Critical Access Hospital (Sept. 30-Oct. 2) Conferences in Kansas City.

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And read about how a new rural North Carolina hospital was designed and built to create an accessible and healing environment on page 13.

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## Patients find growth in greenhouse

Initiative nurtures confidence, skills in psychiatric patients

By Candi Helseth



*Patients at Montana State Hospital care for plants at Healing Waters Greenhouse.*

Patients with long-term mental illness are finding that digging in the dirt is truly healing.

At Healing Waters Greenhouse, patients have found that their social skills have improved, their stress has decreased and they have developed skills that will help them function in the work world once they are discharged from Montana State Hospital in Warm Springs.

Rehabilitation department manager Beth Eastman initiated the grant-funded greenhouse project with the dual purpose of providing therapeutic intervention along with actual work experience. Patients grow flowers, vegetables and herbs in the 48-by-24-foot greenhouse erected in early 2013 on the hospital property.

Eastman says it's been amazing to watch how the patients see metaphors between their own lives and what they do in the greenhouse. Even more amazing, she says, is how gardening helps them better cope with

their diseases and circumstances.

"Patients talk about what can grow from consistent care and how the love and attention they put into their plants can carry over into their own lives," Eastman says. "Their self-confidence increases as they see their successes. Working together in the greenhouse improves their social interaction and lessens that tendency to want to isolate themselves. There have been so many 'ah ha' moments where we see a patient healing and being able to understand how this experience contributes to that healing. And the greenhouse atmosphere is very calming and relaxing. That's therapeutic in itself."

Patients also gain work skills they can use when they leave. Five patients are employed full-time at the greenhouse year-round, earning minimum wage. When they aren't involved in plant growth and production, they do research on future crops, business planning and other off-season tasks.

"We want their experience to reflect the real world," says Mindy Gochis, treatment specialist. "Paying them empowers them to have their own income and to exercise some control over it. Our social workers help them develop realistic budgets. Some are paying restitution, some are saving money for discharge, and some have even offered to pay a portion of their



*Healing Waters Greenhouse was built with funds from a grant.*



*Reducing the stigma associated with mental illness has been an unexpected benefit of the greenhouse.*

hospital stay.”

Additional patients participate in a variety of work-related experiences overseen by the patient employees. In addition to growing the plants, work experiences include researching, marketing and advertising, inventory control, sales and other business-related functions. Operating the business empowers patients and makes them feel useful, Gochis says.

“Even failure is a lesson,” she says. “Throwing away that first plant was

**“There have been so many ‘ah ha’ moments where we see a patient healing and being able to understand how this experience contributes to that healing. And the greenhouse atmosphere is very calming and relaxing. That’s therapeutic in itself.”**

**Beth Eastman, Montana State Hospital rehabilitation department manager**

pretty traumatic because they had nurtured it and were so disappointed. But this gave us an opportunity to address failure and the ending of things and how we learn to move on.”


Plants grown at the greenhouse include flowers like petunias and zinnias, herbs including basil, rosemary, chives and cilantro, and landscape plants and houseplants. Patients initially sold their products at the Anaconda Farmers’ Market. At first, Eastman says, patients were nervous about the community’s reaction.

“They didn’t want to identify themselves as being from the State

Hospital,” she says. “But the local people welcomed them, and their self-confidence just soared. They started talking to members of the public about their struggles. The other vendors helped them and treated them as they would any friends. One of the benefits we hadn’t really thought about is the way this has also helped reduce public stigma toward mental illness.”

The Anaconda Garden Club invited patients to sell products at its annual event. And patients researched the possibility of branching out and selling at farmers’ markets in outlying towns, which netted agreements with twice-weekly farmers markets in Butte.

“When people come into the hospital, they are often at the very lowest point in their life,” Eastman says. “If we can just help them experience hope again, they begin to find some joy and pleasure in their lives. Tapping into experiences like gardening can help open those doors again. The greenhouse adds another positive dimension to treatment services we are already providing.”

The greenhouse was funded by a \$141,000 grant from the Montana Mental Health Settlement Trust, created in 2010 to support programs, services and resources for the prevention, treatment and management of serious mental illness in children and adults. 

*This article originally appeared in the Rural Assistance Center’s spring 2014 Rural Monitor at [raconline.org](http://raconline.org).*



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# Free program helps strengthen rural Colorado clinics

By Jami Schumacher



Jennifer Dunn



Michelle Mills

The Healthy Clinic Assessment (HCA) program is helping rural clinics build stronger foundations and focus on quality improvements, according to Jennifer Dunn, director of programs for the Colorado Rural Health Center (CRHC), which runs the HCA.

The voluntary and free process begins with on-site interviews of clinic staff and partners. The HCA looks at basic business operations (telephone protocol, check-in, check-out, visit preparation, accounts receivable and accounts receivable follow-up), compares current clinic operations to industry-accepted best practices, and identifies gaps in operations. At the end of the workday, CRHC staff provide a debriefing about what they have learned. Later, CRHC employees return with findings.

“We put together an action plan on where they need to make improvements and what they are doing well,” explains Michelle Mills, CRHC CEO. “This strengthens the foundation of the clinic and allows them to focus on bigger, greater things like quality improvement, collecting data in disease registries or working on gaining patient-centered medical home status.”

The patient-centered medical home (PCMH) model seeks to replace episodic care with deliberate and coordinated care. The aim is a model that offers more effective, efficient, coordinated and personalized care.

Of the approximately 100 Colorado clinics that have gone through the HCA process, three of them have gained PCMH status through the National Committee for Quality Assurance (NCQA). Yuma District Hospital and Clinics was one of those, despite having little knowledge about PCMHs prior to working with CRHC. Yuma CEO John

Gardner said achieving NCQA’s level 2 medical home certification required considerable work and significant changes to organizational culture.

“This has been a great opportunity for our two clinics,” Gardner says. “I am thankful that CRHC invited us to participate in the project.”

**“It essentially provided us with access to a free consultant. It also provided us with education on best practices. As a rural health clinic, we otherwise would not have had access to this expertise and feedback.”**

*Mendi Choat, Mount San Rafael Hospital Clinic director*

Once the HCA action plan – a report customized to a clinic’s individual needs – has been presented, the clinic decides its next course of action: do nothing with it, execute the plan, seek to gain PCMH certification, or partake in CRHC’s iCare (Improving Communications and Readmissions) program.

“The HCA is just a stepping stone so rural clinics are not quite as worried about just keeping their doors open,” Dunn says.

Mendi Choat, clinic director at the Mount San Rafael Hospital Clinic in Trinidad, Colo., says that the hospital found the HCA so helpful that it has gone through the process several times. They used the first HCA as an



opportunity to set improvement goals for the year.

“One of the primary reasons for undergoing it every year was to see if we had made improvements in the areas identified the prior year,” Choat says.

This allowed the clinic to determine if their new processes were working or if adjustments were needed. The HCA then provided an action plan for the upcoming year.

As a result of the HCA, Choat says there were “opportunities to improve systems and processes in billing and registration.” Specifically, Mount San Rafael Hospital Clinic staff worked on patient flow, scheduling, scripting for registration team members, upfront collections, assignment of billing duties, and educating providers on how to match time spent with patients with their corresponding provider coding levels.

“I would highly recommend this process to another clinic,” Choat says. “It essentially provided us with access to a free consultant. It also provided us with education on best practices. As a rural health clinic, we otherwise would not have had access to this expertise and feedback.”

The HCA supports the Institute for Healthcare Improvement’s Triple Aim for health systems to focus on improving the experience of care, improving the health of populations and reducing per capita costs.

As the focus on reporting for quality and outcomes continues to increase in the health care industry, rural clinics are positioning themselves successfully for the future. CRHC has the goal of having all Colorado rural clinics achieve 90 percent or higher on the HCA, indicating efficient and sound operations.

“Our hope is that the clinics will want to move forward for the betterment of the clinic and the community,” Mills says. [tr](#)

*This article originally appeared in the Rural Assistance Center’s winter 2015 Rural Monitor at [raconline.org](http://raconline.org).*

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# Opioid overdose on the rise in rural

By Alicia Swenson O'Brien, Michele Pray Gibson and Helen Newton



Fred Wells Brason II

The rapid rise of opioid abuse in rural America has earned coverage from *Rolling Stone* to *The Atlantic* and is the subject of multiple documentaries. Although all states have experienced an increase in opioid abuse during the past decade, death and injury from opioid misuse are concentrated in states with large rural populations, such as Kentucky, West Virginia, Alaska and Oklahoma, according to a 2014 study published in the *American Journal of Public Health*.

The rise in overdose deaths from heroin and prescription opioids is an urgent public health crisis, and few substances are more lethal than prescription opiates and heroin, according to former Attorney General Eric Holder. The CDC, in a presentation in February 2011 on "Prescription Drug Overdoses: An Epidemic," estimated the milligram-per-person use of prescription opioids in the United States increased by more than 400 percent from 1997 to 2007.

In 2010, more people died from drug overdose than in motor vehicle accidents. And prescription drug deaths outnumbered those of heroin and cocaine combined, according to the CDC.

**"Research indicates that prescription drug use in rural areas is an embedded part of the culture of the area, with prescription narcotics being commonly prescribed to maintain a steady workflow in heavy labor occupations."**

Dan Mareck, Federal Office of Rural Health Policy chief medical officer

"Some people suggest the marketing of prescription opioids, such as Oxycontin, to relieve pain has been more aggressive in rural communities. Other research indicates that prescription drug use in rural areas is an embedded part of the culture of the area, with prescription narcotics being commonly prescribed to maintain a steady workflow in heavy labor occupations," says Dan Mareck, MD, Federal Office of Rural Health Policy (FORHP) chief medical officer.

To help address the opioid public health crisis, communities are looking into options such as educating the public about opioid overdoses, providing counseling services and medication to prevent overdoses and for treatment, and linking individuals to a medical home.

## A model program

Project Lazarus provides assistance to community groups and clinicians to prevent drug overdoses.

"My nonprofit's premise is a belief that communities are ultimately responsible for their own health, and every drug overdose is preventable," says Fred Wells Brason II, Project Lazarus executive director and founder.

Wells Brason was serving as program director and chaplain for the local hospice in 2004 when he saw a need in his community of Moravian Falls, N.C., population 1,440. So he established Project Lazarus to help prevent opioid drug overdose deaths.

"I became acutely aware of medication issues within the patients and families we were caring for. Local prescribers were beginning to refuse to provide patients much-needed pain relievers while they resided within their home due to constant diversion requiring early refills," Wells Brason says. "My own investigation raised my level of awareness to the local issues



A Project Lazarus forum was held in Wilkes County, N.C., in April, with attendees representing local schools, health care facilities, law enforcement, human services, faith and youth groups and other interested organizations.



The Project Lazarus model includes a wheel, with three core components (the hub) that must always be present, and seven components (the spokes), which can be initiated based on the specific needs of a community.

surrounding prescription medications (mainly overdose) and the crisis our community was in. No community awareness, no solutions, no help, caused me to step up and out to begin to address [the problem]. The people who were dying were our neighbors and friends of all ages.”

He further explains, “The current opioid epidemic has five user types: 1) people who use incorrectly, 2) people who use a family member’s or friend’s medicine, 3) accidental users, 4) recreational users, and 5) substance disorder users. A community needs to ask, ‘How do we reach each of these groups?’ and then target education and awareness to them.”

Project Lazarus helps communities nationwide develop awareness, form coalitions, and “create spokes of the wheel,” he says.

“I feel one particular challenge in rural areas is improper disposal,” he says. “There is a mentality of if they paid for it, they hang onto it until they need it again or share it with a friend or family member who needs it.”

Project Lazarus provides materials and services, such as a prescriber’s toolkit for managing chronic pain, naloxone kits, education about proper drug storage and disposal, and recovery services, which seem to be helping.

The nonprofit has had success with reducing opioid overdoses by as much as 69 percent in some communities.

“To change the village, we need to empower the village,” Wells Brason says.

To learn more, visit [projectlazarus.org](http://projectlazarus.org).

## FORHP takes action

In March, U.S. Health and Human Services Secretary Sylvia M. Burwell announced a targeted initiative aimed at reducing prescription opioid- and heroin-related overdose, death and dependence.

And in 2015, Congress provided FORHP funds within the Rural Access Emergency Devices Program (RAEDP) to specifically address opioid overdoses in rural communities through the “purchase of other emergency devices used to rapidly reverse the effects of opioid overdoses.” On Sept. 1, FORHP awarded 18 grantees a total of \$1.8 million. (The grantee list is at [ruralhealth.hrsa.gov](http://ruralhealth.hrsa.gov).) FORHP used lessons learned from the Project Lazarus model, incorporating some of it within the new Rural Opioid Overdose Reversal (ROOR) program.

ROOR’s overall goals are to 1) purchase naloxone and opioid overdose reversal devices and increase the availability in rural areas through strategic placement; 2) train licensed health care professionals and others using the devices to recognize the signs

*continues on page 45*

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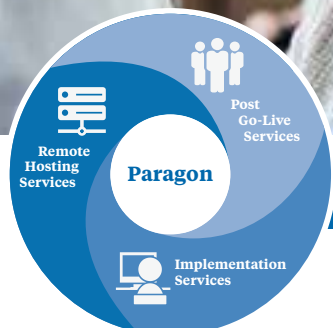
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**MCKESSON**



continued from page 43

of opioid overdose, administer naloxone, administer basic cardiopulmonary life support, report results, and provide appropriate transport to a hospital or clinic for continued care after administration; 3) refer those with a drug dependency to appropriate substance abuse treatment centers where care coordination is provided by a team of providers; and 4) demonstrate improved and measurable health outcomes, including but not limited to reducing opioid overdose morbidity and mortality in rural areas.

“Naloxone has proven to be effective in reversing the effects of opioids,” says FORHP senior health advisor Paul Moore, PharmD. “Faced with the potential outcome of death following an opioid overdose, improving the availability of naloxone could have a significant impact in decreasing the incidence of morbidity and mortality related to opioid overdoses in rural communities.”


FORHP is also funding research to better understand this public health issue. The University of Southern Maine (USM) Rural Health Research Center is currently working on a study, “Catastrophic Consequences: The Rise of Opioid Abuse in Rural Communities.” The project will analyze national data on the prevalence of opioids in rural and urban settings as well as outline state and local efforts to promote prevention and access to treatment.

The Substance Abuse and Mental Health Services Administration presented a recent analysis indicating among heroin users studied, heroin use was often preceded by non-medical pain reliever use. And the CDC found a growing shift in heroin use from urban to rural areas.

“The prevalence rates of non-medical use of pain relievers are higher among vulnerable rural subpopulations such as rural adolescents and young adults compared to urban,” says Jennifer Dunbar Lenardson, USM research associate. “When you think about these higher prevalence rates in combination with the historically low availability of substance abuse treatment facilities, it becomes clear that opioid use is an absolute crisis for our rural towns and communities. We feel the limited resources of rural communities make it

important to document substance abuse trends with recent national data in rural and urban communities and by demographic characteristics.”

FORHP also funded a study by the WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) Rural Health Research Center titled “Supply of Physicians Waivered to Treat Opioid Addiction in Rural America: Policy Options to Remedy Critical Shortages.” The study was completed in 2014 and found that because methadone maintenance clinics are largely non-existent in rural areas, an effective treatment alternative is training physicians in the use of buprenorphine within outpatient practices.

This finding is a key aim of the Drug Addiction Treatment Act of 2000, a federal law that permits physicians to prescribe buprenorphine, which provides office-based accessible care for patients addicted to opioids in rural America. The WWAMI study presented a rural-urban analysis of all 20,604 physicians who as of 2011 had received a Drug Enforcement Administration waiver to prescribe buprenorphine for the treatment of opioid addiction because little is known about the physicians waived to treat opioid addiction. 

*Alicia Swenson O'Brien was formerly a public health analyst with the Federal Office of Rural Health Policy. Michele Pray Gibson and Helen Newton are public health analysts for the Federal Office of Rural Health Policy.*

## Startling statistics for rural residents

Surveys have indicated adolescents in rural areas are more likely to use prescription opioids nonmedically than adolescents in urban areas, as reported in the *American Journal of Public Health*, February 2014.

A 2008 national survey on drug use and health showed 13 percent of rural teens reported nonmedical use of prescription drugs at some point in their lives, compared with 11.5 percent of respondents living in suburban or small metropolitan area counties and 10.3 percent of those living in urban areas, according to the *American Journal on Addictions*, January-February 2009.

Between 1997 and 2003, in rural western Virginia, the medical examiner's office reported a 300 percent increase in the number of deaths in which drugs, including prescription medications, were determined to be related or contributory to cause, according to the *American Journal on Addictions*, January-February 2009.

According to a study in a 2011 CDC *Morbidity and Mortality Weekly Report*, 15- to 24-year-olds died from opioid pain relievers at a higher rate than any other illegal drug. The rate of death for opioids was 3.7 per 100,000 compared to 2.2 per 100,000 for illegal drugs.



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## Rural health leaders meet in Minnesota

The National Rural Health Association's Rural Quality and Clinical Conference and State Rural Health Association Leadership Conference brought rural health professionals and students from across the country to Minneapolis in July.

Quality and performance improvement coordinators, researchers, students, hospital administrators and doctors, physician assistants and nurses practicing on the front lines of rural health gathered to advance quality and clinical care from theory to practice.

"Rural health care is near and dear to my heart, so it was nice to meet others that are like-minded and to learn about their struggles and successes," says Kelly S. McKinnon, a second-year student at the University of Minnesota Duluth Medical School. "As a student, the scholarship I was given was essential to allow me to attend."

Jennifer Lundblad, PhD, president and CEO of Stratis Health, a nonprofit dedicated to health care quality and patient safety, gave the keynote presentation.

"I appreciated the opportunity to help set the stage for dialogue and the learning which occurred throughout NRHA's event," says Lundblad. "The Quality and Clinical Conference seems to attract leaders from across the country who are the most interested in and focused on advancing rural health quality."

"Rural health is at an interesting and exciting juncture, with rapid changes in payment and care delivery, which makes it all the more important and valuable to have the occasion to come together with colleagues for networking and sharing so we can continue to provide the highest quality care to rural residents," Lundblad adds.

Just prior to the Rural Quality and Clinical Conference, more than 40 state rural health associations (SRHAs) were represented at the leadership event, including executive directors, board members and representatives from longstanding and newly developing SRHAs.

With a focus on building and sustaining SRHAs, participants received tools to immediately impact their associations. Presentations ranged from board and membership development to improving communications and financial adherence and guidance.

"The leadership conference was the perfect ending to my rookie year as the executive director for our regional rural health association," says Kim Mohan, New England Rural Health Roundtable executive director. "The excellent content was complemented by valuable networking opportunities that I could not get anywhere other than with NRHA."

As a part of its cooperative agreement with the Federal Office of Rural Health Policy, NRHA provides direct technical assistance to SRHAs.

Plan now for the 2016 SRHA meeting July 12-13 and the 12th annual Rural Quality and Clinical Conference July 13-15 in Oakland, Calif.



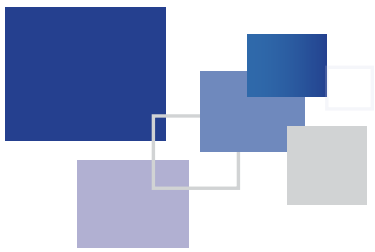


Opposite page: NRHA welcomes Rural Quality and Clinical Conference attendees. Megan Meacham and Ann Ferrero provide an update from the Federal Office of Rural Health Policy. This page, clockwise: Tom Dean, Dave Schmitz and Amy Elizondo catch up during a networking break. Rachel Knutson and Roger Wells talk during a break. Elizondo kicks off the State Rural Health Association Leadership Conference. Leadership Conference attendees. Mayo Clinic staff present on connected care.

## More friendly faces

Continue your trip down Memory Lane or see what you missed with more photos from NRHA's Minnesota events and other NRHA conferences at [facebook.com/ruralhealth](https://facebook.com/ruralhealth) and [flickr.com/nrha](https://flickr.com/nrha).





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Jackson T. Shatraw, M.A., Th.M., CMRP  
Director, Supply Chain, Western Reserve Hospital

## Mobile mission

### Caring for rural veterans at home with telemedicine

By Angela Lutz

Just think of the Volunteers of America (VoA) of North Louisiana telemedicine van as a mobile doctor's office for rural veterans.

The van helps break down a challenge faced by many rural communities: access to care and services. The high-tech, clearly marked vehicle is fitted with a large satellite dish, which ensures broadband access across the organization's predominantly rural 22-county, 22-parish service area in Arkansas, Oklahoma, Texas and Louisiana. This is especially important as more than 36 percent of rural veterans who rely on the U.S. Department of Veterans Affairs (VA) for health care do not have access to the Internet in their home.

Inside the van, patients have access to a registered nurse and a private, soundproofed room, where they are able to connect via telemedicine to VA mental health care providers and VA specialty physicians who are often unavailable in their rural communities, which is consistent with the shortage of providers in rural areas nationwide. When the mobile clinic began visiting rural communities this summer, veterans were eager to utilize the new technology.

"As soon as you press a button, your provider pops up on the screen, and they're able to interact and see how you're doing," says Gary Jaynes, VoA program director. "We've also deployed case managers in each rural area. They're actually going into people's homes, and they're from the communities they serve."

VoA's technology and outreach efforts are funded by the VA Office of Rural Health Rural Veterans Coordination Pilot (RVCP) grant program, which



*The Volunteers of America North Louisiana telemedicine van is outfitted with state-of-the-art technology to bring health care to rural veterans.*

has provided \$10 million in funds to five grantees support rural veterans and their families transitioning from military to civilian life. Located in Shreveport, La., VoA is one of those RVCP grantees selected to each receive \$2 million over a two-year period.

In the mobile clinic's first week of deployment, the technology was already saving lives. According to Jaynes, one of their first patients had such high blood pressure that they immediately sent him to the local emergency department.

"We're seeing people who have not seen a physician in a very, very long time, even though they're eligible for service through VA," Jaynes says. "It's just that much of a problem."

In addition to a lack of providers, one of the main barriers contributing to veterans' inability to access care is transportation. Millions of rural veterans lack reliable options, and Jaynes points out that traveling more than an hour one way to the VA facility in Shreveport can turn going to a doctor's appointment into an all-day endeavor.


In VoA's first year of operation, transportation is the second-most sought-

after service behind medical care. Despite VoA's willingness to, as Jaynes says, do things "old school" and drop veterans off at the front door of the VA facility, he believes telemedicine technology will enable them to provide care for the most patients going forward.

"The telemedicine van is obviously not a panacea, but we want to get people used to the technology so they're more comfortable and can do it at home," Jaynes says. "Telemedicine is going to be the future of health care. You can do it from a smartphone now."

According to Tricia Jowell, VoA community and media relations director, many rural veterans are unfamiliar with the technology, but so far it has been well received. She has also encountered many veterans who aren't aware of the services available to them, such as basic medical screenings, giving VoA's registered nurses the chance to focus on patient education as well.

"The receptiveness of the public has been exciting," Jowell says. "Everybody who sits in [the van] gets a big smile on their face because they see the benefits. It's exciting for them to be able to connect with this new technology."

Jaynes says VoA plans to continue providing services once grant funding ends, and they hope to expand their offerings to include veterans who have already transitioned back to civilian life, as well as those who are trying to age in place. In the meantime, Jowell says VoA is "happy to be part of the solution." 

## Piloting partners

The following organizations received grant funding through Department of Veterans Affairs Rural Veterans Coordination Pilot program, enabling them to support rural veterans and their families as they transition to civilian life.

- Maine Department of Labor, Augusta, Maine
- Nebraska Association of Local Health Directors, Kearney, Neb.
- New Mexico Department of Veteran Services, Albuquerque, N.M.
- Volunteers of America of North Louisiana, Shreveport, La.
- WestCare Washington Inc., Orting, Wash.


Learn more at [ruralhealth.va.gov/coordination-pilot](http://ruralhealth.va.gov/coordination-pilot).



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# Beginnings & Passages



Jennifer and Joshua Niswonger

“I have never looked back and am thankful to be working in a small, rural community where you get to know the patients.”

## Returning to rural Paradise

By Jennifer Niswonger

In 2004, after receiving a job offer over the phone while living in Canada, I moved to Paradise, Calif., to begin a temporary job as an administrative intern with Adventist Health Feather River Hospital.

California was never a place I imagined myself living for a number reasons. I was born and raised in Washington State, where folks tend to look on Californians with suspicion and distrust. Plus, my internship was only supposed to last for 10 weeks, and I was looking for something more long term.

When Paradise was first described to me, there was talk of towering pine trees and majestic oaks. As I ascended into Paradise from the valley floor, I remember asking myself, “Where are all these beautiful trees?” And all of a sudden there they were, towering over me.

As I entered the town, I noticed a population sign informing me there were 26,283 people here. This was the big city to me, having grown up in George, Wash., with a population of 500.

Those 10 weeks, months and then years went by. Paradise won my heart – as did a handsome young man, whom I married in 2006. In 2009, my husband Joshua was accepted at Loma Linda School of Dentistry near Los Angeles, and we found ourselves in the middle of a hectic, crowded, smoggy city. As graduation neared, both of us were anxious to leave the crowds and noise behind for a quieter lifestyle.

Opportunity knocked, and we happily returned to Paradise in 2014, where I oversee four rural health clinics and Joshua sees patients from in and around his hometown.

I have never looked back and am thankful to be working in a small, rural community where you get to know the patients and listen as they talk about their wonderful providers. While not without its challenges, such as obtaining funding and recruiting providers to a rural community, I am grateful to be working with providers and employees towards a common goal of excellence in patient care.

*Jennifer Niswonger is the rural health center director for Adventist Health Feather River Hospital and oversees four rural health clinics with more than 200 employees and 70 providers. Her husband, Joshua Niswonger, DDS, is one of the providers. They love going for walks, motorcycle riding, playing with their dog, Jax, and gardening. Jennifer joined NRHA in 2015.*



Innovative rookies and seasoned professionals share their experiences.

“Everything opened up, and rural health care became my passion.”



Joanie Perkins

## Clinic manager touts rural quality of life

By Joanie Perkins

Working in a rural health care environment was not something I set out to do when I started my career.

In 1998 I was working in a mid-sized town north of Indianapolis when I got the call for an interview to manage four rural health clinics (RHCs) for a large hospital in Indy. These clinics were located in one of the poorest counties in the state and were deemed health professional shortage areas.

Not knowing what I was getting into, I accepted the job. Shortly afterward, I realized I had quite a bit to learn, so I followed the National Rural Health Association and National Association of Rural Health Clinics' conferences around for a year soaking up as much information as I could.

Once I felt qualified to handle the intricacies of rural health clinic compliance and billing issues, I just seemed to find my niche; everything opened up, and rural health care became my passion.

My initial experience with rural clinics was managing four of them. After about six years of that, I moved on to a larger organization and managed 10 clinics, six of them RHCs.

Funnily enough, I met my current executive director, Billy Marlow, at an NRHA conference in St. Louis, where I was

doing a breakout session on RHCs. He said I had to come to Ruleville. Now Ruleville, Miss., (population 2,874) is a little smaller than anywhere I'd ever lived before, and my family thought I was crazy, but I made the move anyway to join the management team of North Sunflower Medical Center, a critical access hospital in the Mississippi Delta. I've never looked back.

Working in a smaller environment gives me some advantages I didn't have in urban America. If an idea fails, or I don't get the outcomes I predicted, I can pick myself back up and try again without 10 committee meetings about what went wrong. I get the privilege of working with my friends and neighbors and knowing the name of every person that lives on my street. I wasn't born in a small town, but I love it, and I think it has added a lot of quality to my life.

*Joanie Perkins has worked in health care management for the past 27 years, the last 15 in rural health clinics and critical access hospitals. She is chief of network development for North Sunflower Medical Center, a critical access hospital in the Mississippi Delta, does consulting work for rural facilities and has presented at multiple NRHA conferences. She joined NRHA in 2005.*

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## Why I walked

### Student joins advocates on 283-mile march to save rural hospitals

By Devon Geary



*A diverse group of rural health care advocates walked from Bellhaven, N.C., to Washington, D.C., for two weeks in June.*

Through pouring rain and blistering heat, our diverse collective of walkers traversed hundreds of miles from Belhaven, N.C., to Washington, D.C., to bring attention to the alarming rate of rural hospital closures and the nation's devastating health care disparities.

The walk ended with a rally for rural health care on the lawn of the U.S. Capitol in June. Each of the 283 miles we walked represented one of the 283 rural American hospitals in danger of closing.

As we trekked across the states, our group shrank and grew; we were

college students and children, a bishop and a hospital CEO, social justice organizers and farmers – individuals joined together by devastating stories of inaccessible health care. In North Carolina, a 16-year-old girl bled to death in front of her parents before help arrived. In Texas, a baby girl choked to death on a grape in her mother's arms.

My own reasons for flying across the country to walk stemmed from my previous summer experience. I lived in Tutwiler, Miss., while working for the Emmett Till Interpretive Center. Tutwiler, population 3,543, has one small clinic with limited hours: open until 5 p.m. most weekdays and closed on weekends. In an emergency, outside the scope of available patient services or after



*Bellhaven, N.C., Mayor Adam O'Neal speaks during in the Save Rural Hospitals rally at the culmination of the 283-mile walk. This was his second walk to Washington to bring attention to the rural hospital closure crisis.*

the clinic's doors close, residents must drive – if they have access to a vehicle – to hospitals in Clarksdale, Charleston or Ruleville, 20 to 30 minutes away. While clinics are sprinkled across the Delta, hospitals are scarce.

One of the gentlemen I lived with that summer, a Mississippi State University student who grew up in Greenwood, Miss., had a grandmother who was battling cancer. She endured countless, long and painful car rides to and from treatment and suffered from intense pain between trips for care and medication. The impact of the current lack of health care access in the Mississippi Delta, let alone further devastation that would be caused by any loss of these rural hospitals, was starkly apparent; so I signed up to walk with strangers – differing in political stance, age, religious beliefs, reasons for joining the walk – for two weeks. It was an experience I will never forget.

As the temperature climbed, we swatted flies from each other's backs. Enlivening our tired, blistered feet, we sang songs to embolden us, such as "This Little Light of Mine" and "Keep Your Eyes on the Prize," sung by those who had fought this fight before.

**"We were college students and children, a bishop and a hospital CEO, social justice organizers and farmers - individuals joined together by devastating stories of inaccessible health care."**

We began our journey in rural North Carolina, where a mother lost her life waiting for emergency care to arrive just seven days after the local hospital shut its doors. The closure of that hospital, Pungo Medical Center, multiplied the time separating its residents from preventative and critical emergency health services.

In Bellhaven, population 27,810, residents live with the fearful reality

*continues*

*continued*



*Devon Geary*



*Many of the walkers had little in common other than a desire to save rural hospitals and communities.*

that care would likely arrive too late for their children, parents, siblings, neighbors, friends. Preventative care, once easily accessible and nearby – encouraging more frequent check-ups and a healthy community – is now gone.

Anxiety replaces security; uncertainty supplants wellbeing. This is the reality invading towns and communities nationwide.

**“Enlivening our tired, blistered feet, we sang songs to embolden us, songs sung by those who had fought this fight before.”**

A bill introduced this summer, the Save Rural Hospitals Act, would help stabilize rural hospitals by providing new funds, stopping Medicare cuts, and creating a path forward with the development of new rural health models for struggling rural hospitals.

While the bipartisan legislation lessens the blow of rural hospital closures by helping them keep their doors open, it still leaves many rural residents entirely uninsured.

We need hospitals, but we also need the health insurance that affords every parent, every child, every person their right to avoid this costly last resort. Health is not merely the absence of disease; it is the opportunity to live a full and meaningful life.

Our intergenerational, multicultural, bipartisan walkers came together because we believe in an America where treatment does not depend on your race, gender, region, income or community. We believe in health care, not as a for-profit business commodity, but as a foundation for the beloved community.

Rejecting Medicaid funds means restricting preventative care. Denying health care is placing profit over people and party politics over constituents.

The population of rural communities are typically older and poorer, with higher incidences of chronic disease. Medicaid expansion is crucial to ensuring





*Clockwise: Small-town mayor Adam O'Neal and civil rights activist Bob Zellner lead the walk to Washington. The march raised awareness in rural communities along the way. The two-week journey began in rural North Carolina, where a mother lost her life waiting for emergency care. National Rural Health Association government affairs and policy vice president Maggie Elehwany speaks at the Capitol Hill rally.*

quality, consistent health care treatment for these citizens, individuals who are our neighbors, the people who made your food today, built your home, cleaned your office and cared for your children.

Denying access to health care is a moral issue. Denying health care to individuals just because they are part of the working poor is equivalent to telling those individuals that their lives do not matter. I believe in disregarding personal and political differences for the sake of providing crucial health services to all, especially the most vulnerable among us our uninsured brothers and sisters.

**“Anxiety replaces security; uncertainty supplants wellbeing. This is the reality invading towns and communities nationwide.”**

Are we going to be a country where the little boy in Tutwiler, Miss., and the little girl in Harlem, N.Y. have the same access to health care as the little boys and little girls in our wealthiest communities?

Hopefully one day – due to initiatives that place people over profit, personal over political values – we’ll be able to say that we do. 🇺🇸

*Devon Geary is fellow at the Bending the Arc initiative in Seattle and a graduate student in political communication at the University of Washington.*

## Join the journey

The Walk to Save Rural Hospitals may be over, but the campaign continues.

Learn more about the Save Rural Hospitals Act and how you can help on page 73 and at [RuralHealthWeb.org](http://RuralHealthWeb.org).

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# Follow the beat to KC's historic 18th and Vine Jazz District and beyond

Side trip



American Jazz Museum exhibit, courtesy of the American Jazz Museum

## Jazzed to be in Kansas City

Join experts and colleagues in Kansas City for the National Rural Health Association's Rural Health Clinic (Sept. 29-30) and Critical Access Hospital (Sept. 30-Oct. 2) Conferences.

Discover why these educational and networking events are NRHA's fastest-growing conferences. Go to [RuralHealthWeb.org/kc](http://RuralHealthWeb.org/kc) today to register and save.

From world-class performances to award-winning venues, Kansas City has remained a hotbed for improvisational jazz since the 1930s.

From the historic 18th and Vine Jazz District to any of the many tucked-away clubs sprinkled across the city, you're always a stone's throw from the swing.

A frequent stop for visiting celebrities and dignitaries, the American Jazz Museum is what *The New York Times* called "an interactive paradise," with its listening stations, touch-screen adventures and custom-mixing soundboards. Check out Charlie Parker's saxophone, a gift to the museum from former president Bill Clinton.

Just down the block, the Negro Leagues Baseball Museum chronicles the stars and stories of America's favorite pastime from the leagues' origin after the Civil War to their demise in the 1960s.



*The Blue Room, courtesy of the American Jazz Museum*



*Top to bottom: The Green Lady Lounge via [tripadvisor.com](http://tripadvisor.com). The Mutual Musicians Foundation via [kcjazzlark.com](http://kcjazzlark.com). The Majestic Steakhouse via [tripadvisor.com](http://tripadvisor.com)*

Sample KC's signature sound at the district's acclaimed jazz club, the Blue Room, recognized as a top jazz destination by *Downbeat* magazine.

Jazz: A Louisiana Kitchen and BB's Lawnside BBQ are two no-frills venues known just as much for their indulgent cuisine as their distinct flavors of New Orleans and KC jazz.

The Phoenix Jazz Club, Green Lady Lounge, Broadway Jazz Club, Majestic Restaurant, 12 Baltimore at Hotel Phillips, Chaz on the Plaza, Café Trio, Gaslight Grill and Kansas City Juke House are also keeping the spirit alive in the modern age.

Night owls are in for a real treat at the Mutual Musicians Foundation, where the late-night party is hopping until 5 a.m. Have an instrument of your own? Bring it and join in. After all, this is where the jam session was invented.

And while Kansas City is famous for its jazz, it's also being recognized as the place to be for other musicians and performing artists. Learn more on page 75.



## Members on the move

### Former Rural Health Fellow to focus on rural wellbeing



Jarod Giger

After serving as an assistant professor at the University of South Dakota for five years, Jarod Giger, PhD, accepted a position as an assistant professor at the University of Kentucky College of Social Work in July.

In his new position, Giger's responsibilities include research, teaching and service, with a primary focus on rural and frontier populations and subjective wellbeing among rural children.

"The National Rural Health Association remains instrumental in my professional development," Giger says. "As a [former] Rural Health Fellow, I receive regular updates on local, state and federal issues impacting, positively or negatively, rural communities. The information allows me to stay abreast of new issues and opportunities within the rural health arena. NRHA continues to champion rural health initiatives with vigor. The energy keeps me going."

Giger joined NRHA in 2011, was a 2012 NRHA Rural Health Fellow and serves on the *Journal of Rural Health* editorial board.

### Statistician honored for contributions to rural research

James Leeper, PhD, University of Alabama College of Community Health Sciences community and rural medicine professor, was recently selected as a Fellow of the American Statistical Association.

According to the university, Leeper was recognized for "continuous contributions of statistical knowledge to the medical and public health research communities; for outstanding mentorship and teaching of medical, other health sciences, and graduate students; and for service to the statistics profession through exceptional leadership as an applied statistician in public health and medicine."

"This recognition is a great honor after 38 years of teaching biostatistics courses, serving on 200 PhD dissertation committees and publishing over 100 papers dealing with statistical methodology and applications,"



James Leeper

Leeper says. "The National Rural Health Association has provided a forum for being involved in rural medical education and opportunities for presenting results of evaluations of our rural-based programs."

Leeper joined NRHA in 2005.

### Member recognized as professional of the year



Gail Nickerson

Longtime rural health professional Gail Nickerson was recently recognized as the professional of the year in clinical health care services by Strathmore's "Who's Who," a publication that

lists thousands of successful individuals in a variety of fields from medicine to government.

Nickerson serves as director of rural health services at Adventist Health in Roseville, Calif., providing oversight



for more than 50 rural health clinics in California, Oregon and Washington.

“I have been doing this work for 30 years now and am always very grateful to be recognized for my efforts,” Nickerson says. “NRHA has been a wonderful connection for me. Continuation and expansion of rural health services is my main work mission, and I have gotten to spend lots of good time with people through NRHA who share my mission all over our country.”

Nickerson joined the association in 2007.

## Member looks forward to ‘dynamic time’ in new role



Sally Trnka

Sally Trnka recently accepted a position as executive director of the Northern Minnesota Network, a nonprofit organization providing health information technology systems, resources and support.

The network is comprised of federally qualified health centers and migrant health centers across four states. Trnka is responsible for guiding current strategic goals and positioning the organization to be successful going forward.

She previously served as director of network development for Western Healthcare Alliance and the California Critical Access Hospital Network, as well as executive director of N2N Strategies.

“The knowledge and support that I have gained from the staff, leadership and members of the National Rural Health Association has been invaluable in my growth as a professional in rural health care,” Trnka says. “Many of my mentors are active NRHA members, and the

knowledge I have gained through participating in webinars, conferences and through one-on-one interactions undoubtedly has positioned me to be successful in my new role. I look forward to continuing to partner with NRHA as we move through this exciting, dynamic time in health care.”

Trnka joined NRHA in 2009.

## Rural health advocate ready to tackle new challenges



Roger Wells

After serving on the Nebraska Rural Health Advisory Commission since 2003, Roger Wells, a physician assistant at Howard County Medical Center in St. Paul, Neb., was reappointed to his position this year.

In this role, Wells works with other rural health advocates to evaluate the status of rural health in his state and find solutions to pressing issues.

Wells also serves on the National Rural Health Association’s Rural Health Congress, helping to develop policy for the organization and representing NRHA in meetings with CMS.

“With this experience, I am ready to take on the far-reaching rural limitations in all areas of rural health, including population density issues, EMS shortages, legislative restrictions on mid-level providers and the ever-racing telehealth restrictions due to lack of broadband,” Wells says. “Only with a team of providers and educators can we step forward, trying to identify limitations and utilize resources to our best advantage. I look forward to this year’s team of bright energetic members taking on new challenges with positive outcomes expected.”

Wells joined NRHA in 2013.

## NRHA members make community hospitals list

Each year, the *Becker’s Hospital Review* editorial team selects “100 Great Community Hospitals” based on rankings and awards from several independent organizations.

*Becker’s* defines a community hospital as a hospital with fewer than 550 beds and that has minimal teaching programs. Some are found in rural towns that serve as the only hospitals in their communities, while others are located in suburban areas.

*continues*

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

continued

Becker's named the following National Rural Health Association member hospitals to its 2015 list:

- Avera Holy Family Hospital, Estherville, Iowa
- Brodstone Memorial Hospital, Superior, Neb.
- Elizabethtown (N.Y.) Community Hospital
- Fairview Hospital, Great Barrington, Mass.
- Fort Madison (Iowa) Community Hospital
- Grant Regional Health Center, Lancaster, Wis.
- Hudson (Wis.) Hospital
- Mount Desert Island Hospital, Bar Island, Maine
- Redington-Fairview General Hospital, Skowhegan, Maine
- Tanner Medical Center, Villa Rica, Ga.

Whether independent or part of a larger health system, the hospitals on this list have continually worked to provide high-quality care.

## NRHA member organizations among nation's 'most wired' hospitals

Each year, the American Hospital Association's *Hospitals & Health Networks* conducts a survey to determine which hospitals across the nation are the "most wired." The survey measures IT adoption in U.S. hospitals and health systems, and data is used to determine industry standards for measuring IT adoption.

The 2015 Most Wired Hospitals list includes the following National Rural Health Association members:

### Most wired hospitals (overall):

- Abraham Lincoln Memorial Hospital, Lincoln, Ill.
- Cibola General Hospital, Grants, N.M.
- Citizens Memorial Hospital, Bolivar, Mo.
- Crawford Memorial Hospital, Robinson, Ill.
- Grundy County Memorial Hospital, Grundy Center, Iowa
- Harrisburg (Ill.) Medical Center
- Kalkaska (Mich.) Memorial Health Center
- Mason General Hospital, Shelton, Wash.
- Othello (Wash.) Community Hospital
- Pullman (Wash.) Regional Hospital
- Tri-State Memorial Hospital, Clarkston, Wash.

### Small and rural wired hospitals:

- Boone County Health Center, Albion, Neb.
- Carroll County Memorial Hospital, Carrollton, Mo.
- Chadron (Neb.) Community Hospital and Health Services

- Charles A. Dean Memorial Hospital, Greenville, Maine
- Fort Madison (Iowa) Community Hospital
- Indiana University Health Blackford Hospital, Hartford City, Ind.
- Lake Chelan Community Hospital, Chelan, Wash.
- Otsego Memorial Hospital, Gaylord, Mich.

### Most improved wired hospitals:

- Aroostook Medical Center, Presque Isle, Maine
- Faith Regional Health Services, Norfolk, Neb.
- Winona (Minn.) Health

## NRHA news

### NRHA council expands focus, seeks conference submissions

The National Rural Health Association is pleased to announce the reformation of the Health Equity Council and Conference, formerly the Multiracial and Multicultural Council and Conference, to highlight issues related to rural and underserved LGBTQ, veteran and homeless populations in addition to the many cultural minority populations the council has advocated on behalf of for years.

The Health Equity Council's mission is to promote and enhance physical and mental wellbeing for rural and frontier underserved populations through national leadership, representation and advocacy for accessible, affordable, high quality health services that result in an improved quality of life.

"We are excited for this new chapter and to continue our efforts of advocating for all underserved populations living in rural America and assuring their access to care," says Eron Manusov, MD, Health Equity Council chair.

NRHA's Health Equity Council members are:

**Shantay Davies**, Fresno Pacific University health care administration student

**David Denali**, PhD, A.T. Still University assistant professor

**Robert Guerrero**, Arizona Office of Border Health chief

**Sterling Haws**, University of  
Miami medical student

**Angela Jukkala**, PhD, University  
of Alabama-Birmingham School  
of Nursing associate professor

**Susan Kunz**, Mariposa  
Community Health Center chief  
of health and wellness

**Eron Manusov**, MD, University  
of Texas-Rio Grande Valley  
School of Medicine assistant  
dean and professor

**Ileana Ponce-Gonzalez**, MD,  
Migrant Clinician Network  
senior advisor for scientific and  
strategic planning

**Jan Probst**, PhD, University of  
South Carolina Rural Health  
Research Center director

**Mary-Katherine Smith**, PhD,  
A.T. Still University chair and  
associate professor

**Julie St. John**, DrPH, Texas Tech  
University Health Science  
Center assistant director

**Pat Talbert**, MD, Center for  
Professional Academic  
Consulting president and CEO

**Craig Wesley**, National MS Society  
senior manager of diversity and  
community outreach

NRHA's Health Equity Conference  
will be May 10, just before  
NRHA's 39th Annual Rural Health  
Conference, in Minneapolis.

This 21st annual conference is  
designed for those who are dedicated  
to bringing quality health care and  
services to underserved and often  
underrepresented portions of the  
rural population.

Submit session proposals at  
[Ruralhealthweb.org/equity](http://Ruralhealthweb.org/equity) by Oct. 15.



## Donor corner

Tom Dean, MD, has given generously to the National Rural Health Association's Rural Health Foundation each year since it was established in 2012.

Dean, a part-time rural physician in Wessington Springs, S.D., joined NRHA in 1985 and served as NRHA president in 1990.

**Rural Roads:** Why is rural health important to you?

**Tom Dean:** In a town of 900 about 125 miles from the nearest full-service referral center and 55 miles from a community hospital, our local critical access hospital does a good job, but if it were not for the advocacy provided by NRHA and others I am confident it would not be here.

Rural residents represent a minority with unique needs, needs that are all too easily overlooked in a political process dominated by urban interests.

For me the opportunity to practice in a small community where I know most of the people and have a fairly good idea of what kinds of stresses they are facing — even if they do not tell me — makes the practice of medicine easier and more effective. Even though the isolation adds some stresses, it also offers a degree of flexibility often not found in urban environments. All this leads to personal satisfaction, which is all too often missing in a world of bureaucratic structures and fragmented care.

**Rural Roads:** Why do you support the foundation?

**Dean:** The focus of the foundation is supporting the development of new leaders. In my view there is nothing more important for the development and stabilization of rural community services than local leadership.

For leadership to evolve and have its full impact, it needs to be nurtured. In my view that is the vital role played by NRHA's foundation.

**Rural Roads:** Why do you donate?

**Dean:** Contributions to the foundation are truly an investment in the future, and I would strongly encourage everyone reading this to consider a generous donation.

If rural health services are to be stabilized and organized in a way that effectively serves rural folks, we need to invest in the development of local leaders. The talent is there, but in many cases it needs to be encouraged and helped to develop the necessary technical skills. This foundation is beginning to have an impact, but to reach its potential it needs substantially more resources.

*NRHA thanks Tom Dean for his ongoing contributions to the Rural Health Foundation.*

*For more information and to join in helping to build a permanent endowment for rural leaders, visit [RuralHealthWeb.org/donate](http://RuralHealthWeb.org/donate). Donations are tax-deductible.*

caring for the future of rural America



## NRHA leads community health worker trainings

The National Rural Health Association hosted two community health worker trainings in June in McAllen, Texas.

NRHA collaborated with facilitators and trainers from the Texas A&M University Health Science Center School of Public Health to develop the agenda. The Texas State Office of Border Health also assisted with promoting the trainings. Eighty community health workers participated in the trainings over two days.

NRHA has trained more than 350 community health workers since 2012. The next training will be in the summer of 2016 in El Paso, Texas.

“NRHA is excited to continue to train community health workers along the U.S.-Mexico border and continue to highlight how integral they are to our health care system,” says Gabriela Boscan, NRHA program services manager.

## Journal seeks editorial board members

The *Journal of Rural Health*, the National Rural Health Association’s quarterly research publication, is seeking nominations for its editorial board.

The academic journal serves to advance professional practice, research, theory development and public policy by serving as a medium for communication among health scientists and professionals.

Candidates must have significant rural health experience and an established record of publication.

Terms for open positions begin Jan. 1, and board members serve three-year terms. Duties include selecting editorial content, soliciting manuscripts, reviewing manuscripts and recruiting reviewers.

The editorial board meets once annually in conjunction with NRHA’s Annual Rural Health Conference and via teleconference each quarter.

Applications will be accepted at [RuralHealthWeb.org](http://RuralHealthWeb.org) through Oct. 15.

## NRHA voting begins in November

Voting for the National Rural Health Association’s volunteer leadership positions will occur in November.

“Your vote is an important member benefit and helps determine who will provide the leadership for our organization as we work to improve health care in rural America,” says NRHA CEO Alan Morgan.

The ballot for NRHA’s new 2016 officers, including president-elect and treasurer, will be delivered by email to all NRHA members.

## NRHA hosts 9th border health meeting

The National Rural Health Association led its ninth Border Health Initiative meeting in June in Washington, D.C.

Representatives from the U.S.-Mexico Border Health Commission, the Federal Office of Rural Health Policy and border health partners participated in the two-day meeting to provide updates and perspectives on the status of these rural communities.

Through this initiative, NRHA hopes to further the efforts currently in progress by other entities to develop new and lasting partnerships and aid rural communities along the border, explains Gabriela Boscan, NRHA program services manager.

## Award nominations accepted soon

Rosemary McKenzie’s passion for rural health care and dedication to multicultural and multiracial populations were unparalleled.

She served as the National Rural Health Association’s minority liaison and program services manager for 27 years. She died in 2011 due to complications from pancreatic cancer.

To carry on McKenzie’s legacy and honor her memory, NRHA established the Rosemary McKenzie Legacy Award to be presented annually during the Health Equity Conference.

Nominations for the award will be accepted Oct. 1-Dec. 10 at [RuralHealthWeb.org/equity](http://RuralHealthWeb.org/equity).

Tax-deductible contributions to help fund the award and scholarship may be sent to NRHA honoring Rosemary, 4501 College Blvd. #225, Leawood, Kan., 66211.

## accelerating advocacy

### NRHA endorses Save Rural Hospitals Act, applauds grassroots efforts

The National Rural Health Association advanced a bill to stop the impending flood of rural hospital closures and provide needed access to care for rural Americans.

We've heard your concerns and collaborated to develop legislation for Congress to make your voice louder.

Introduced by U.S. Reps. Sam Graves (R-Mo.) and Dave Loebsack (D-Iowa) in late July, the Save Rural Hospitals Act (H.R. 3225) will provide rural hospitals with financial and regulatory relief to allow them to stay open and care for rural residents.

Fifty-seven rural hospitals have closed since 2010, and 283 more are on the brink of closure, risking access to much-needed health care for more than 700,000 Americans.

"NRHA has led the fight to stop rural hospital closures across the nation," says Jodi Schmidt, 2015 NRHA president. "We're calling on Congress to pass this comprehensive legislation to save rural hospitals and patients and to provide a pathway to the future for rural health."

This monumental legislation will stabilize and strengthen rural hospitals by:

1. Stopping the many cuts in Medicare that rural hospitals have endured for years;
2. Providing rural hospitals with new funding so they can provide quality primary care to rural patients across the nation; and
3. Creating a path forward for struggling rural hospitals by allowing them to provide care that makes sense in their communities and receive fair reimbursement for emergency room and primary care.

While numbers are important and data help illustrate a need, it is your personal stories of how these cuts affect your facility or how a hospital closure will devastate the local community that really make an impact.

NRHA thanks you for sharing what it's like in your small town.

Thank you for telling Congress that rural hospitals are the place where you received excellent care when you were most in need, where you were born, where your parents brought you when you had to get your appendix removed, and where your grandmother was well cared for in her final days.

Rural hospitals are cornerstones of their communities. And when a hospital dies, it's hard to keep the community alive.

NRHA thanks our rural champions for their support. From Capitol Hill to the efforts led by you at home, rural hospitals have had bipartisan support inside and outside of D.C.

Without your voices, more hospitals could close, and more patients could lose access to care.

Continue to stand up for the future of rural America. Ask your representatives to co-sponsor NRHA's Save Rural Hospitals Act today.

And join NRHA's continued campaign to #SaveRural hospitals, patients and communities by attending the Rural Health Policy Institute, the largest rural advocacy event in the country, Feb. 2-4, in D.C. Learn about the development and implementation of health care policy at the federal level, and meet with members of Congress and the Administration. Register today at [RuralHealthWeb.org/pi](http://RuralHealthWeb.org/pi) to save.



### Rural Health Clinic & Critical Access Hospital Conferences

Sept. 29-Oct. 2

[RuralHealthWeb.org/kc](http://RuralHealthWeb.org/kc)

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## Center stage

While you're in town for the National Rural Health Association's Rural Health Clinic (Sept. 29-30) and Critical Access Hospital (Sept. 30-Oct. 2) Conferences, reserve your seats at Kansas City's internationally acclaimed Kauffman Center for the Performing Arts, just 10 blocks from the conference hotel.

An architectural marvel, it is the performance home of the Kansas City Symphony, the Lyric Opera of Kansas City and the Kansas City Ballet and houses two unique performance venues.

The Kauffman Center has put KC on the map as a performing arts destination, so while you're in town be sure to check out a performance of the lyric opera "Don Giovanni," the string ensemble Project Trio or a retrospective on the music of the great musicians, singers and orchestras who performed at New York City's legendary night club, The Cotton Club, during the 1920s and '30s.

Completed in 2011, the building contains 40,000 square feet of glass, 25,000 cubic yards of concrete, and 27 steel cables and was one of the most complex structures in the world to design and build.

The main lobby, Brandmeyer Great Hall, has a glass ceiling and sloping glass walls that provide a panoramic view of Kansas City to the south. Visit [kauffmancenter.org](http://kauffmancenter.org) for show times and tickets.



## shifting gears

### Eco-friendly education

When it comes to going green in the dorms or on a college campus, a few minor decisions can have a major impact.

**Paper:** By reducing your printer usage or choosing the electronic or used version of a course text, you're sure to cut your paper use, which is preferred to cutting class. Also consider utilizing the free recycling option many companies have put in place for printer cartridges, and set your print quality to "draft" as often as you can.

**Power:** When possible, give your laptop and lights a rest. Take advantage of natural light and common campus spaces. Unplug unused electronics and appliances when you leave a room, as they continue to use energy even when they are "off" or not charging your devices.

**Caffeine:** And that coffee you get every morning before class? Make a reusable container an equally essential part of your morning routine.

### Off the beaten path

## A whale of a gift

Route **66** is home to many of America's most memorable tourist destinations and local oddities. Passersby will encounter the Shoe Tree, Cadillac Ranch and the Santa Monica Pier — to name a few.

And just outside of Catoosa, Okla., population **7,159**, drivers of the open road happen upon a sight normally reserved for the open water: the Blue Whale of Catoosa, known as "Ol' Blue" to locals.

Zelta Davis, a collector of whale miniatures, received the whale as an anniversary present from her husband, Hugh Davis, who built this **80**-foot mammal. As time went on and the whale's popularity grew, Hugh enhanced the family's roadside property by adding a reptile facility and swimming area.

Like other attractions of its kind, the Blue Whale site eventually could no longer be supported by the efforts of its owners. A little more than a decade after it closed in the late **1980**s, this big catch was restored by the big efforts of Catoosa residents.



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