

rural roads

Summer 2012 National Rural Health Association



The friendliest skies

Aviator angels transport rural patients

Dental student brings awareness to hometown school

Rethinking design and culture at small hospitals

Family emergency introduces first-year doc to rural support system

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Get on the right track



I have been amazed over and over by National Rural Health Association members.

As I have visited with them this year, I am awestruck by their knowledge and expertise and am completely humbled by their dedication to rural health and their passion for serving the underserved.

Will Rogers once said, “Even if you are on the right track, you will get run over if you just sit there.” I’m confident NRHA is on the right track, and there is only one way not to get run over: Get involved.

The best way to do this is through NRHA’s various constituency groups and councils that provide an opportunity to network with your friends and colleagues who are passionate about rural health care, just like you.

You can get on the right track and expand your network during NRHA’s fastest-growing events, the Rural Health Clinic and Critical Access Hospital Conferences, in September in Kansas City, Mo.

See you soon,

A handwritten signature in blue ink that reads "Lance".

Lance Keilers

2012 NRHA president

pit stop

5 things I picked up in this issue:

1. A medical student offers a unique perspective on body bags and surviving his first year. *page 49*
2. In just one year, 25,500 U.S. patients received free flights to specialty health care thanks to 18,700 volunteer pilots. *page 6*
3. As one hospital in rural Nebraska rebuilt, it donated equipment to a hospital in Zambia, Africa. *page 14*
4. NRHA’s CEO was recently invited to 1600 Pennsylvania Avenue to talk about physician retention. *page 58*
5. When a first-year rural doc’s son was rushed into her ER, she learned a valuable lesson about community medicine. *page 46*



The friendliest skies

Aviator angels transport rural patients

By Lindsey V. Corey



Angel Flight Northeast volunteer pilot Roger D'Entremont, Odin Robinson and his mom Betsy Carnie and Angel Flight Northeast founder and president Larry Camerlin prepare to fly to Boston for one of Odin's many hospital appointments last year. Angel Flight flew the family roundtrip about 30 times over seven months for free.

His fourth word was propeller.

Earlier that week, Odin Robinson said “dadda.”

But this little guy quickly – and not-so quietly – became obsessed with airplanes. Mostly the kind with propellers and pilots, who gave him a Mr. Potato Head toy and a quick salute before flying the 18-month-old and “momma” from their remote fishing village to Boston Children’s Hospital for three months of Tuesdays.

His mom, Betsy Carnie, was obsessed too.

Right: Angel Flight patient Odin Robinson enjoys watermelon before the congenital giant nevus was removed last summer. Far right: Nine-year-old Daniel III with his dad, Daniel Jr., take many flights to and from Shriners Hospital for Children in Boston for medical care for Daniel III, who sustained burns over 80 percent of his body during a house fire. This time, they flew with Angel Flight Northeast founder and volunteer pilot Larry Camerlin. Below: Angel Flight Northeast volunteer pilot Lowell Powers prepares to take off from rural Maine to Boston with patient Herbert and his wife Patricia Albert. The Alberts have started an annual fundraiser to support Angel Flight, which relies solely on donations and volunteers. (Photo by Don Eno, The St. John Valley Times.)



Angel Flight Northeast volunteer pilots saved her at least eight hours on Odin's appointment days and enabled Betsy to tend to the pint-sized patient rather than worry about ferry and bus schedules.

“Angel Flight took care of getting us from here to there so all that was left for me to do was hold him, read to him, make sure he was comfortable and safe.”

Betsy Carnie, mother of an Angel Flight patient

“The first of those weekly appointments was so daunting,” she recalls. “There’s only so much a 1-year-old can handle, especially after being at a hospital and travelling all day. He wanted to crawl on the disgusting bus station floor, and by the time we were finally on the bus, he was literally banging on the window on the



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continues on page 10

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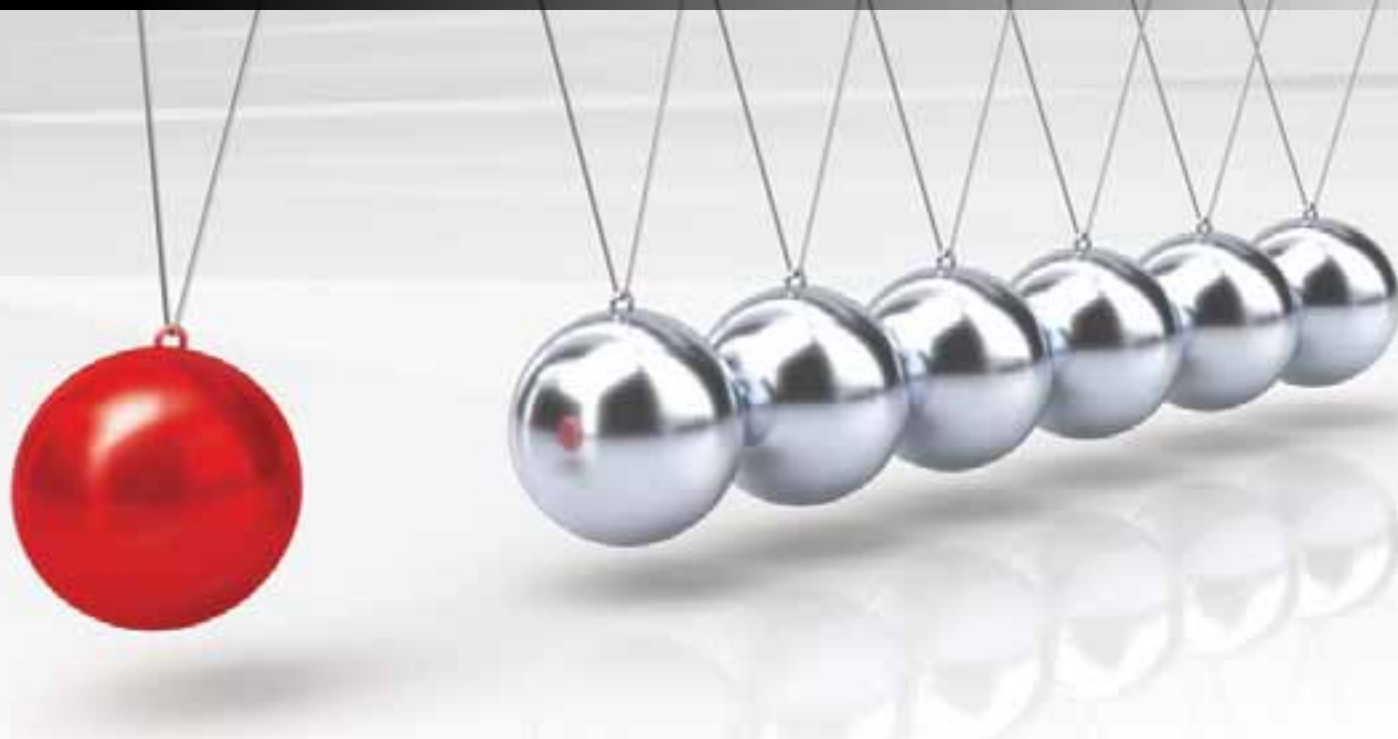


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Payton, 6, travels with Angel Flight Northeast to Ann Arbor, Mich., where she receives specialized care to treat an aggressive form of neutropenia, which causes an abnormally low level of white blood cells making her susceptible to infections.

way to the ferry.”

It had been a 13-hour day with four modes of transportation, a series of injections and lots of waiting.

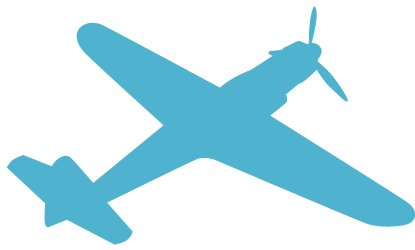
“For me, as a mother, I just wanted so desperately for all of it to be the best it could be for him, but I didn’t know how to protect him from these exhausting days,” Betsy says. “I thought, ‘there’s no way I can do this 11 more times.’”

Enter Angel Flight, a nonprofit that coordinates pilots and patients, taking many of them from rural areas to the health care they need, and often flying them back home in time to sleep in their own beds after painful procedures, nauseating chemotherapy, bad news.

Precious cargo

The service is free. And for Odin, who was born with a giant nevus (similar to a mole) on the back of his head that doctors worried would become cancerous and fatal if not carefully removed, the propeller planes were just plain fun.

“He thought it was wonderfully exciting,” Betsy tearfully remembers. “Once a week, the experience for him became ‘we get to go on the plane, then whatever, then we get to go on the plane again.’ It made the hospital procedures a minor detail to him. And Angel Flight took care of getting us from here to there so all that was left for me to do was hold him, read to him, make sure he was comfortable and safe. I think that really helped him get through the procedures. When we were done with the treatments and surgeries and they told us he’d be fine, not getting to ride on his Angel



Flights was a bummer for Odin.”

Herbert Albert, on the other hand, doesn’t miss the flights. But his gratitude is unending.

The retired papermaker from Frenchville, Maine, population 1,225, had four surgeries related to cirrhosis of the liver and frequent check-ups with a specialist in Boston while he was on the transplant list. Today, his health is stable enough to be off the list.

“Angel Flight is the difference between life and death as far as I’m concerned.”

Herbert Albert, Angel Flight passenger

In 2002, doctors near the Canadian border gave Herbert less than 24 hours to live.

“That scared me sober,” the 63-year-old Vietnam vet recalls. “After Nam, I decided to drink to get rid of the nightmares. Nothing had deterred me until I realized I wouldn’t see my next birthday or my kids get married and have babies. Determination, a lot of help from my wife and from God and a lot of help from Angel Flight got me here today, able to hunt and fish and see my grandkids. Angel Flight is the difference between life and death as far as I’m concerned.”

Up in the air

Herbert and his wife Patricia, who still works at the paper mill where they met, started an annual fundraiser at their local American Legion hall to give back to Angel Flight, which they also credit for enabling them to keep their house.

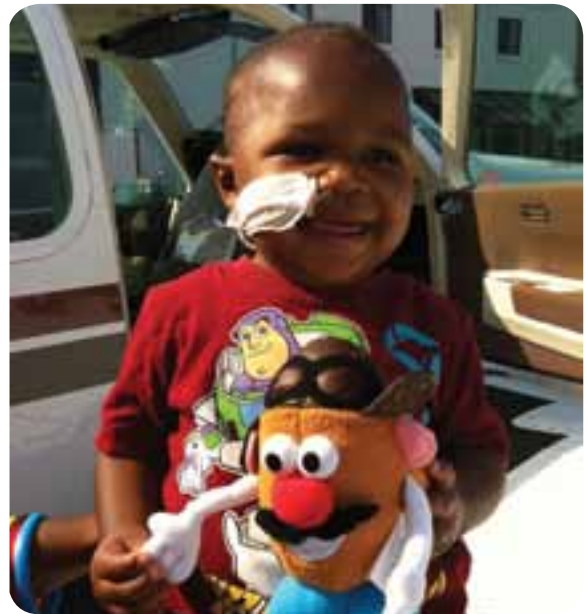
“That first year really took a toll on us,” Patricia says. “Herb was too sick to work, and I had to take time off. There’s no way we could have paid for all the lodging and gas they saved us. We had to refinance the house, but without those amazing pilots taking us on their own dime, it would have been much, much worse.”

Tonya Barent can relate. Her daughter Emersyn has had six surgeries in just her first year. That’s a lot of testing and follow-up appointments in Denver, a 10-hour drive from their home in Red Lodge, Mont., population 2,483.

But when Life Line Pilots, a similar nonprofit association based in Illinois, transports the mother-daughter duo for non-emergency appointments, Emersyn sleeps through the two-and-a-half hour flight.

When they have to drive, each of the dozens of trips costs the family about \$500. Insurance doesn’t cover hotel or gas, so the Barents had to refinance their house and downsize their vehicles.

“Having a sick child definitely changes everything,” Tonya says. “We’ve



Mishon, 3, flies to Boston Children’s Hospital for follow-up care after his kidney transplant. Mishon was excited about his Mr. Potato Head Aviator, donated by Hasbro Toys, which also provides financial support for Angel Flight. The toy is given to all young patient passengers to keep them busy during and after the flights.

had a ton of financial struggles. We went from a two-person income and two healthy kids, and then I had to quit my job to care for our baby with special needs. We’re so thankful that there are such generous people out there who help. It’s been a blessing for us, and we’re grateful every day.”


Betsy says she never climbed out of a plane “without crying all over the pilot” or talked with an Angel Flight coordinator without sobbing.

“Now, I’m flying more often, and it has meaning.”

Lowell Powers, Angel Flight volunteer pilot

“They became our lifeline. That can’t be expressed in words,” she says with more tears. “I have to trust that the reason they do this is they know just how valuable it is.”

Lowell Powers gets it. He’s been flying patients in the Northeast for five years, and in retirement, he says “‘Angel Flight pilot’ has become my new identity.”

“Instead of flying around for myself just to see how fast I can get where I’m going,” he says, “now, I’m helping others. It’s kind of a spiritual purpose when you’re up there. Now, I’m flying more often, and it has meaning. You can’t top that.” 



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Rural hospitals share facility replacement ideas

By Angela Lutz



Hospital employees and board members gather for a ribbon-cutting ceremony, marking the grand opening of Beatrice Community Hospital and Health Center.

It was out with the old and in with the innovative when the new Beatrice (Neb.) Community Hospital and Health Center (BCHHC) facility opened its doors in February.

“We bought a lot of new equipment,” says Tom Sommers, BCHHC CEO. “We weren’t planning to bring the old equipment into the new hospital.”

Around the same time, a BCHHC employee who was involved in mission work introduced Sommers to the CEO of Zimba Mission Hospital in Zambia, Africa.

“I asked [the CEO] if he could use some of our equipment, and he just looked at me and said, ‘Well, yeah,’” Sommers recalls. “We said we’d donate it, but they’d have to get it there.”

Fortunately, other members of the community contributed shipping containers and helped pay to transport the equipment, which included three full maternity suites and two hospital beds. The donation not only helped improve patient care half a world away, it also fit perfectly with BCHHC’s mission.

“Our board has a real strong commitment to our mission of providing service,” Sommers says. “It worked out in good ways all the way around.”

Getting an upgrade

In addition to state-of-the-art equipment, the new Beatrice facility boasts 145,000 square feet, an upgrade from 89,000, making it one of the largest critical access hospitals (CAHs) in the country. According to Sommers, the facility's size – as well as the 40 acres of land on which it was built – will help “direct how health care is delivered in the community” in the face of an uncertain future.

“We don’t want the Taj Mahal. We just want something that’s new and workable.”

Chad Netterville, Field Memorial Community Hospital CEO

“We tried to come up with two options,” he says. “Should nothing change, and the population in the community stay the same as it has for 20 to 30 years, we need to have a larger outpatient presence and really work on the ER and outpatient services. But we bought the 40 acres so we can expand should Lincoln move south just like Omaha moved west. If that were the case, then we would be able to expand with that.”

The extra space also allowed for all rooms, baths and showers to be private, as well as an increase in emergency department rooms from five to 12, which gets patients out of the waiting room faster. The hospital also expanded surgery, recruited an orthopedic surgeon and a third obstetrician and now offers aqua therapy.

“It has led to a tremendous increase in patient satisfaction and helped with privacy,” Sommers says. “We’re trying to prepare ourselves for the future.”

The new facility has also generated excitement from the town of 12,459.

“When we had our open house, we had 3,800 people come in two days, and that was in a blizzard,” Sommers says. “The community has found it to be a really beautiful hospital. We’ve also gotten a lot of compliments on patient care.”

Passing it forward

Sommers says touring other CAHs and discovering what worked for them was vital to designing the new



When the new Beatrice Community Hospital and Health Center opened, a lot of their old hospital equipment was donated to Zimba Mission Hospital in Zambia, Africa. Local volunteers loaded the equipment to be shipped.

Two days, four hospitals, 800-plus miles

The National Rural Health Association organized a two-day tour of four rural hospitals in Kansas and Nebraska, all of which have remodeled or replaced their 25-bed facilities within the last four years.

Atchison County Hospital

Atchison, Kan., population 10,432
25 beds; opened in February 2010

Beatrice Community Hospital and Health Center

Beatrice, Neb., population 12,459
25 beds; opened in February 2012

Community Memorial Healthcare

Marysville, Kan., population 3,105
25 beds; opened in March 2011

Fredonia Regional Hospital

Fredonia, Kan., population 2,331
25 beds; renovated and expanded in October 2008

continues

Beatrice facility.

“We made a commitment that we want to pass this forward,” he says. “Our hospital is built out of three different hospitals. We went to three, took what we liked, and designed it.”

In that spirit, when the National Rural Health Association organized a two-day tour of four recently built or under-construction rural hospitals in the Midwest and scheduled a stop in Beatrice, Sommers was happy to show his guests around.

Present for the tour was a team from Field Memorial Community Hospital in Centreville, Miss., population 1,680. Chad Netterville, CEO, says they are preparing to replace their 60-year-old facility, which serves approximately 18,000 people in one and a half counties.

“We were wanting to see what new designs were out there and get an idea of architects that were focusing on critical access hospitals,” Netterville says. “There are a lot of new CAHs in eastern Kansas, western Missouri and into Nebraska.”

Of the hospitals toured, Netterville noticed that most had “a lot of adjacencies and efficiencies built in,” such as the sharing of the nurses’ station between the acute floor and the emergency department. Bringing




Field Memorial Community Hospital representatives visited Atchison County Hospital in Kansas as part of an NRHA-coordinated tour of new hospitals in Kansas and Nebraska. They took this image of a patient room in the hospital, which opened in 2010.

core services together physically, he says, helps staffing issues and keeps square footage in reimbursable areas.

“We were surprised at what the dollar was able to buy and how nice the hospitals were,” he adds. “The amenities were nice; they weren’t overdone. We don’t want the Taj Mahal. We just want something that’s new and workable.”

Following the tour, Netterville chose one of the architects for his facility’s replacement project and drafted a design. He is finalizing financing opportunities and discussing options with the hospital board, and he hopes to be breaking ground by next year.

“An older facility is perceived as providing poor care, but when you have the new facility, people want to check it out,” he says. “But the only thing that changes is the building. It’s the same staff providing the same high quality care.” 

Building support for a new building

Don’t miss the National Rural Health Association’s Critical Access Hospital Conference Sept. 26-28 in Kansas City, Mo.

Learn how Effingham Health System’s staff and board garnered community support for a \$30 million expansion to its 40-year-old hospital. The rural Georgia hospital recently modernized its outdated facility without disrupting hospital and nursing home operations.

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Social club connects rural medical residents to community, patients

By Angela Lutz

William Fruehling stands near the grave of Susan Haile, along the Oregon Trail. The longtime Grand Island, Neb., physician started a club that introduces new doctors to the rural region's history and culture – and to local pizza joints and each other.



Every year around March, hundreds of thousands of sandhill cranes en route from Mexico stop along the Platte River in eastern Nebraska to fuel up before completing their long migration north to Canada, Alaska and Siberia.

And every year, along with avid birdwatchers from across the country, the medical residents at Family Practice of Grand Island in Grand Island, Neb., are there to watch.

While completing their two-year residency in Grand Island, population 48,861, the students get to experience many such wonders in and around their community. Along with their spouses and their professor, William Fruehling, MD, the four residents typically meet monthly and travel to nearby historical sites, listen to guest speakers and learn about the history

of the region – or sometimes just to eat pizza and socialize.

They call the group Journal Club, but unlike traditional, formal medical school gatherings of the same name, it has nothing to do with reading or writing about medicine. Instead, according to Fruehling, “it gives them something different to think about.”

“My wife, Sandy, and I thought it would be important that our residents develop some interests outside of medicine,” Fruehling says. “We do [presentations] on natural history, the history of the plains, and growing up gay in central Nebraska. We have psychologists come in and talk about learning disabilities. For the most part, they’re quasi-medical at most.”

Fruehling founded Journal Club at the same time the residency program began 20 years ago. During this time, the opportunity to interact with members of the community and with each other has been invaluable to many rural training track residents, who do the first year of their residencies at either the University of Nebraska Medical Center in Omaha or St. Francis Hospital in Grand Island before completing the final two years at

Fruehling's family practice.

"It helps me understand my patients a little more," says second-year resident Susan Newman. "Without Journal Club, I would feel more isolated as a resident. One downside of being in a rural program is that there are not many other residents to share the day-to-day experiences. Journal Club not only gives us the chance to hang out together but also to become involved in the community."

Journal Club has proven especially valuable to foreign-born residents, Fruehling says, because it helps them appreciate the diversity and understand the culture of their new community. Grand Island has hosted residents from across the globe, including Colombia, Venezuela and Poland.

"A lot of the foreign residents don't have a lot of background about the United States, so it's part of their learning curve for a different culture," Fruehling says. "A lot don't realize how diverse the communities were when they were first settled."


"One downside of being in a rural program is that there are not many other residents to share the day-to-day experiences. Journal Club not only gives us the chance to hang out together but also to become involved in the community."

Susan Newman, second-year resident

Some of the most memorable Journal Club outings include a visit to nearby Ashfall Fossil Beds State Historical Park, where prehistoric animals were buried in volcanic ash; a stop at the gravesite of Susan Haile, one of very few marked graves along the Oregon Trail; and a presentation from local meteorologists who explained how radar technology has advanced since Grand Island was almost wiped out by a tornado 32 years ago.

By encouraging students to develop an interest in the communities they serve, Fruehling's residency program has also encouraged graduates to stay in rural areas. Between 1994 and 2011, 29 students have graduated from the rural training track, and 24 have stayed in rural practice, with nearly two-thirds practicing in rural Nebraska.

Developing a connection to a town's past, Fruehling says, is a valuable tool in connecting with present-day patients.

"Many people in small towns are descendents of original founders," he says. "It gives them a way to talk to their patients about their lives and background. If they know the story of their community, they can learn the story of their patients." 



Rural medical residents and their families visit an Oregon Trail gravesite as one of Journal Club's activities.

NRHA brings together rural training track leaders

Building on the success of last year's inaugural event, rural training track (RTT) program directors, rural residency site directors and individuals involved in developing RTTs convened at the University of Nebraska Medical Center for the second annual Rural Training Track Conclave.

Forty people — representing 14 existing RTTs and five developing programs — participated in the three-day meeting.

"During the successful meeting, participants shared lessons and models to encourage the development of a nationwide network of rural training track program directors and key collaborating partners," says Amy Elizondo, National Rural Health Association program services vice president. "The conclave also included a discussion on the development of a sustainability plan that would help to maintain the network and provide technical assistance."

The three-year RTT Technical Assistance Program began in September 2010 as a cooperative agreement between NRHA and the U.S. Department of Health and Human Services' Office of Rural Health Policy.

A consortium that taps into the expertise of individuals and programs across the nation, the grant-funded program works to sustain RTT residency programs as a national strategy in training physicians for rural practice.

Nebraska's network of five RTT programs and the Nebraska Office of Rural Health hosted the spring event and shared what these programs have done to ensure success. Robert Phillips, MD, director of the Robert Graham Center, provided an update on rural health workforce issues. And Tom Morris, ORHP director, and Dan Mareck, MD, ORHP chief medical officer, took part in the conclave.

— Derek Dye



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Dental student Laci Rector teaches rural elementary students about oral hygiene as part of her Rural Smiles project.

All smiles

Dental student brings awareness to hometown school

By Kacie Fodness

As the wheels on the bus went round and round in one rural Colorado town, its small passengers were overheard chattering about dental health.

Inspiring this unusual conversation was a grad student's new program, Rural Smiles.

By the end of her first year of dental school, Laci Rector was spearheading her newly founded project, a curriculum aimed at educating rural Colorado elementary school children about the importance of oral hygiene.

"Brushing your teeth is a simple act, much like when we teach kids how to wash their hands or say their A-B-C's," says Rector.

Lessons in rural

Rector grew up in Byers, Colo., population 1,160.

"We always talk about underserved areas as 'inner-city' and as 'rural.' Inner-city gets more attention," says Rector. "But my heart is in rural."

The last school year marked Rural Smiles' first outreach trip. Ten University of Colorado-Denver School of Dental Medicine students – including Rector, now in her second year – traveled to Byers Elementary School over the course of two visits. While the volunteers involved plan to practice dentistry in both urban and rural regions, all were interested in impacting underserved areas.

continues



Laci Rector receives the 2012 Student Leadership Award from NRHA president Lance Keilers in April.



Laci Rector (at right) and a fellow University of Colorado dental student and Rural Smiles volunteer take a break during class.

And that's exactly what they did.

The pilot year of Rural Smiles served all 267 students at Byers Elementary.

"As a high school student Laci was always very driven and focused," recalls Eve Pugh, Byers School District guidance counselor. "When she emailed me about a program she was developing called Rural Smiles, I was excited about the opportunity. But, I have to say when I actually saw the curriculum, I was awed by the clearly thought out, precise, age-appropriate and dynamic plan."

"We always talk about underserved areas as 'inner-city' and as 'rural.' Inner-city gets more attention. But my heart is in rural."

Laci Rector, Rural Smiles founder

Pencils, bulletin boards, glue and crayons are in most elementary school classrooms. But in Byers, Rector and her classmates added lab coats, a dental "explorer" tool and a set of fake teeth.

"When you're younger, you develop your daily habits," Rector says. "You are really learning about health."

In this spirit of prevention, she and her peers prepared a curriculum for preschool to sixth-grade students as well as educational materials for their parents that included a list of local, low-cost dental practices.

Demystifying the dentist

In addition to brushing technique and frequency, Rural Smiles teaches children proper nutrition, flossing and what they can expect when visiting a dentist's office. Rector aims to take the mystery – and, she hopes, some of the fear – out of dental appointments by letting the kids try on white lab coats and practice using common dental instruments on a model set of teeth.

"They were actually really scared of the lab coats," remembers Rector.

And, while the dental students were surprised by the kids' initial reservations, as the elementary students became more comfortable with the program, they seemed to really enjoy the process and curriculum. In fact,

Rector says "the bus driver told teachers the kids were raving about Rural Smiles on the bus ride."

Though initially reluctant to answer questions about their own oral health habits, the children were very animated in recounting their family and friends' dental


history – and outing their lack of flossing – to the volunteer University of Colorado students.

"Laci's passion and enthusiastic personality captivated our students," Pugh says. "They were engaged in the program for the entire presentation, and I feel it has made a very positive long-term effect on our students."

And while many of her classmates will go on to urban dental practices, Rector was proud to introduce them to the many reasons she plans to practice in a rural area.

"This program lets those who haven't been out into rural really see it," she says.

This fall, the University of Colorado Denver School of Dental Medicine is launching a student chapter of the American Association of Public Health Dentistry, which plans to adopt Rural Smiles. Rector will continue to head up the program throughout the next school year; and, along with visiting another rural school, she'll work to introduce fellow students to Rural Smiles so the project maintains its momentum and expands to more elementary schools.

In addition to her own scholarship money used to start Rural Smiles, Rector says she's thankful for the support of companies that donated materials in the program's early stages. With continued support, interest and funding, Rector hopes to see Rural Smiles grow and ultimately have the chance to visit multiple schools alongside even more of her classmates. 

A winning smile

Laci Rector received the National Rural Health Association's 2012 Student Leadership Award for founding Rural Smiles, a service-learning project aimed at incorporating preventative oral health strategies into rural schools.

The award was presented during NRHA's 35th Annual Rural Health Conference. This year's other NRHA Rural Health Award winners are highlighted in the following pages.

For more information on Rural Smiles and how to help, email Rector at laci.rector@ucdenver.edu.

NRHA honors rural health's finest



NRHA 2012
award winners

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

The 2012 recipients have stretched the boundaries of possibility by forging innovative programs and services, making rural life healthier and more compassionate. Selected from a record number of nominations, NRHA celebrates the following rural health organizations, professionals and students who were honored at the 35th Annual Rural Health Conference in April.



Beartooth Billings Clinic

Outstanding Rural Health Organization Beartooth Billings Clinic, Red Lodge, Mont.

In Red Lodge, Mont., residents share a vision and come together to make a difference.

This success is based on the promise of progressive, compassionate local health care. In the months since Beartooth Billings Clinic opened its doors, it has created a model that links primary care, outpatient services, partnerships and quality, all while allowing the facility to remain independent and community-owned.

Financing for the new facility was made possible through community

continues on page 28



Insurance solutions designed for NRHA members



The National Rural Health Association has listened over the past 35 years to members about their needs and concerns for access to insurance and employee benefits programs. We are proud to announce the NRHA Insurance Services program (NRHAIS), establishing our own internal insurance agency for members. NRHAIS will deliver world-class solutions to members to offer a full array of property, casualty and employee benefits insurance products, designed to lower the overall cost of risk for NRHA members across the country. The program includes:

- Life/accidental death and dismemberment
- Long term disability and short term disability
- Medical and dental self-insured administration
- Property and casualty program management liability

For more information visit NRHAinsurance.com or contact insurance@NRHAinsurance.com or call 617-646-0348.

“We are always striving to expand NRHA value to our members. It has been a long-standing priority of NRHA to identify and provide rural relevant business solutions to our membership. As a result, we are delighted to present the new NRHA Insurance Services program.”

Alan Morgan

Chief Executive Officer

National Rural Health Association

William Gallagher Associates is the chosen insurance broker partner to the newly formed NRHAIS, an agency that provides solutions that address the specific needs of NRHA members. To find out more visit NRHAinsurance.com or call 617-646-0348.



fundraising. In just over two years, the residents of Carbon County raised more than \$3 million for a new health care facility, and the hospital staff secured an additional \$1 million in grants.

“Our success is based on what Harvard’s Robert Putnam calls ‘social capital,’ and on the notion that trust, interaction and participation are what build healthy communities,” says Kelley Evans, CEO.

Outstanding Rural Health Program Access Health, Quincy, Ill.



Access Health patient and staff

Access Health was formed in 2006 to provide health care to the uninsured in rural Adams County, Ill. The initiative is a collaboration

of health care and social service providers, business and economic leaders and consumers.

Services offered by Access Health were based on research that found that, though many community services were available to improve access to care, making the necessary connections was not always easy. Providers voluntarily join the physician-led network to care for Access Health patients.

“Access Health is worthy of this recognition not only because it provides care on a sliding fee scale to people some would consider less fortunate, but because it empowers people to play a key role in improving the quality of their life by providing the knowledge and support to become participating members of the team providing their health care,” says Maureen Kahn, president and CEO.

Rural Health Quality Award Crete Area Medical Center, Crete, Neb.

Crete Area Medical Center offers a medical home with rural health clinics in Crete and Wilber, Neb., as well as a critical access hospital for the residents of Saline County and surrounding areas.

In 2009, the center set a strategic goal to measure the difference made in patients’ lives through high-value



A Crete Area Medical Center physician examines a patient.

care. They listened to patient concerns and examined the overall well-being of their community to develop a personalized plan for managing health, known as a patient-centered medical home.

“We wanted to make a greater difference in our community, and this resulted in the birth of the

medical home,” says Carol Friesen, CEO. “We are committed to delivering a better future for our patients who have entrusted us with their lives.”

Crete Area Medical Center earned national distinction in 2010, when it was recognized by the National Committee for Quality Assurance as the first rural clinic, and only the third medical practice in Nebraska, to earn patient-centered medical home status. In 2011, the results were reaffirmed when its medical home status was elevated to the highest level of distinction based on clinical results and outcomes.

Rural Health Practitioner of the Year Tyler Hughes, MD McPherson Hospital chief of surgery McPherson, Kan.



Tyler Hughes

Tyler Hughes, MD, has given his time, energy and heart to the practice of rural surgery.

A successful surgeon in Dallas, Hughes was faced with the opportunity to advance on an administrative track in the metropolitan area, but instead chose to pursue his dream of practicing in a rural community. When he initially arrived in rural McPherson, Kan.,

Hughes didn’t have a student to mentor so he decided to pay college students to shadow him in hopes that they will be inspired to serve rural residents as well.

In 2011, Hughes was the second rural surgeon in history to be appointed as a director for the American Board of Surgery.

“No one achieves a goal by themselves,” says Hughes. “When Neil Armstrong stepped on the moon it happened not just because he was a very good pilot but because of the dreams and hard work of an entire nation. For me, this award is my moon landing and is the result of the efforts of thousands of people as well.”

Louis Gorin Award for Outstanding Achievement in Rural Health Care

Joanne Cochran, PhD, EdD
Keystone Health CEO
Chambersburg, Pa.



Joanne Cochran

Joanne Cochran, PhD, EdD, has dedicated her life to helping those less fortunate.

She doesn't just see need, she finds ways to address it, such as developing one of the first community health center-based urgent care centers in the country.

Cochran co-founded Keystone Health in 1986 to provide health care to migrant farmworkers in Franklin County, Pa. At that time, Keystone was comprised of three volunteers providing part-time seasonal care to 500 patients. Under her leadership, Keystone Health has grown into a community health center that employs 325 people and provides comprehensive quality medical, dental and behavioral health care to more than 40,000 patients through 167,000 visits a year.

"I hope, through this award, to inspire others to continually improve access to health care for the underserved by always being alert to their needs and finding opportunities to address those needs," Cochran says.

Distinguished Educator Award

Therese Zink, MD
University of Minnesota Department of Family Medicine professor and associate director of research and evaluation
Minneapolis, Minn.



Therese Zink

Therese Zink, MD, is devoting her career to providing medical care in rural Zumbrota, Minn., and creating the next generation of rural

physicians as a professor at the University of Minnesota Medical School and through her work as a physician educator in the Rural Physician Associate Program.

Zink collected rural health professionals' experiences through essays, poems and stories in the anthology,

"The Country Doctor Revisited: A Twenty-first Century Reader." She secured funding to sponsor book discussion groups with students at 11 medical schools across the country to promote rural health careers.

"Teaching is always a privilege," Zink says. "Any teacher will tell you that they learn from their students. Most recently I have been challenged to learn the tools of social media in order to engage and promote rural health practice to the next generation of practitioners."

Outstanding Researcher Award

Timothy D. McBride, PhD
Washington University Brown School of Social Work professor and associate dean for public health
St. Louis, Mo.



Timothy McBride

Timothy McBride has conducted rural health services research for more than two decades.

His research is far-ranging. From his commentary on the Health Security Act in the early 1990s to his current interest in the Affordable Care Act, McBride has

been a passionate and reasoned voice for rural people and places.

McBride has provided testimony to Congress, educated legislative staff members and composed persuasive editorials for national media, all in support of rural health.

"This award is a great honor, but I will interpret it as reflecting recognition of my work over the years on behalf of underserved and vulnerable rural Americans," says McBride. "I know that the reason I am considered for this is because of the support and collaboration I have had from so many great coauthors over the years, and I share this honor with them."

Student Leadership Award

Laci Rector
University of Colorado-Denver School of Dental Medicine student
Denver, Colo.



Laci Rector

Laci Rector is promoting and improving oral health in rural Colorado through the Rural Smiles program she developed.

Rural Smiles features lesson plans for elementary school educators as well as interactive presentations provided by dental students. The project offers service-learning opportunities for Rector and her dental school classmates and a chance to become

engaged in a community in rural Colorado.

Her curriculum provides education regarding the importance of proper oral health, prevention of dental disease, visiting the dentist, nutrition

continues

and overall health. Rural Smiles not only educates elementary students, but also raises awareness in the community of the importance of supporting local oral health providers.

"I never imagined to be recognized at the national level for my rural health promoting efforts. I am very honored," Rector says.

See page 23 for more on Rector's Rural Smiles initiative.

Student Achievement Award

Chuck Jantzen
Oklahoma State University College of
Osteopathic Medicine student
Tulsa, Okla.



Chuck Jantzen

Chuck Jantzen grew up in rural Oklahoma, and through his understanding of rural health needs he has become a role model for other students.

He is a leader in his school's new Students for Osteopathic Rural Medicine club and shares his passion to care for the underserved with first- and second-year students. He also serves as a rural volunteer firefighter and volunteers at rural health fairs.

In 2010, Jantzen was appointed to NRHA's Rural Health Congress as a student representative.

"It is truly an honor to be recognized by this great association," Chuck says. "Many individuals have helped me along my journey in becoming a physician. Their work and dedication has established a foundation on which students from the Oklahoma State College of

Osteopathic Medicine can gain the training and knowledge necessary for success as future rural physicians."

President's Award

Tim Size
Rural Wisconsin Health Cooperative
executive director
Sauk City, Wis.



Tim Size

Tim Size says he's been a member of NRHA "since before it was called NRHA," and he's been the executive director of the Rural Wisconsin Health Cooperative since 1979.

NRHA's 2012 president, Lance Keilers, selected Size for the President's Award and said this during the surprise presentation at NRHA's Annual Rural Health Conference: "On a professional level, each of us should consider ourselves fortunate if we are lucky enough to have a mentor that guides us and gives us advice in our career. On a personal level, to have a friend that is a mentor is something that rarely happens. I have been that fortunate because Tim Size has been a friend and mentor to me."

Size was humbled by the honor.

"What makes this award incredibly special for me is the depth and sincerity of Lance's comment when he was making the presentation," he says. "Now the tough part is the challenge of trying to be the person he described."

Volunteer of the Year Award

Becky Conditt
West Texas Area Health Education Center director
Lubbock, Texas




Sabina and Becky Conditt

Becky Conditt has been actively involved with NRHA for at least a dozen years.

She currently serves on several NRHA committees and councils, has worked to promote NRHA to Texas Rural Health Association members and secured funding for the first student track at NRHA's Annual

Rural Health Conference. NRHA staff selected her for the Volunteer of the Year Award.

"My mom always told me you will get out of something what you are willing to put into it. As with most things, she was right," Conditt says. "I feel I have received so much from my involvement in NRHA. I have the opportunity to meet so many intelligent, passionate and driven people. Every opportunity that has come forward that I have had the privilege to work on has enriched my knowledge and understanding of rural health. I feel like I should be thanking NRHA for all the opportunities, not the other way around." 

Future honorees

The National Rural Health Association will accept nominations for its 2013 Rural Health Awards at RuralHealthWeb.org beginning in December through Feb. 14.

Winners will be selected by a committee of NRHA members and honored during the 36th Annual Rural Health Conference May 7-10 in Louisville, Ky. Each student award winner will also receive complimentary conference registration, a one-year NRHA membership and a \$500 award from John Snow Inc.

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Top-notch telemedicine

Resource center grantees improve patient care

By Angela Lutz



Left: Daniel Newell, Sparks Health Systems desktop analyst, tests a new telemedicine cart with South Central Telehealth Resource Center outreach team member Tamara Perry. Above: Perry shows Bradley County Medical Center emergency room nurses Christy Spencer and Steve Smith how to use the telemedicine clinical cart.

Thanks to telemedicine, health care providers at Benton County Health Unit in Rogers, Ark., can access specialist expertise with the click of a button.

“We’re able to give top-of-the-line care,” says Sharon Loftis, women’s health nurse practitioner. “We have a physician at our fingertips, literally, for any complications that we have with our maternity patients.”

Previously, Benton County patients would travel more than 200 miles to Little Rock to receive specialized care. But telemedicine and videoconferencing technology have provided a direct, face-to-face conduit to physicians and specialists at University of Arkansas for Medical Sciences (UAMS). According to Loftis, the ability to connect to UAMS has been beneficial for patients with complicated or high-risk pregnancies, including women who have diabetes or rheumatoid arthritis.

“Telemedicine has cut down big time on transportation,” Loftis says. “We used to make an appointment in Little Rock and hustle around to find transportation if they didn’t have it. It’s tremendous for so many clients that have trouble getting gas money to see us as opposed to going to Little Rock. It’s beyond awesome for our clients.”

Supporting cultivation

Because studies indicate telemedicine is beneficial to both patients and providers, in 2006 the U.S. Health Resources and Services Administration (HRSA) Office of Rural Health Policy (ORHP) began offering telehealth resource center (TRC) grants. These grants provide \$350,000 per year over a three-year project period for the development of telemedicine services, resources and tools. There are currently 11 active centers nationwide.

“It’s cost-effective from a provider perspective in that equipment is much cheaper now than it was, say, five years ago,” says Carlos Mena, Telehealth Network Grant program coordinator. “It also has been shown to increase patient satisfaction.”

One of the TRC grantees is the South Central Telehealth Resource Center (SCTRC) in Little Rock, which is part of the UAMS Center for Distance Health and received funding in 2010. Through an interactive website that offers continuing education, training and social networking, SCTRC serves providers, administrators, students and lay people in Tennessee, Mississippi and Arkansas. The mission of the site, learntelehealth.org, is to promote and support the cultivation and enrichment of clinical telemedicine and distance education.

“We’re always trying to focus and explain the concepts of telehealth and the things people can do in an easy, simple way,” says Adam Rule, SCTRC project director. “We want to bring rural communities together and show them how they can improve their patients’ outcomes within their own

communities instead of shipping them off to bigger cities.”

SCTRC’s free online social network has more than 700 members, who collaborate across the region to exchange ideas, information and best practices. Additionally, the site offers free continuing education modules, and SCTRC provides both online and face-to-face telemedicine training at UAMS.

“We want to bring rural communities together and show them how they can improve their patients’ outcomes within their own communities.”

Adam Rule, South Central Telehealth Resource Center project director

“We want to be able to reach everybody, so we use online, face-to-face, hands-on and interactive training,” Rule says. “We offer expert advice from people in the field who have been doing it a long time. We are able to put them in contact with other telehealth experts and allow collaboration and sharing of best practices.”

According to Rule, historically the biggest barriers to telemedicine implementation have been the costs of equipment and high-speed Internet line fees. But in Arkansas broadband internet access was paid for by a 2010 Broadband Technologies and Opportunities Program (BTOP) grant awarded as part of the federal economic stimulus package.

“We work in tandem with the BTOP team,” Rule says. “They actually did a lot of work in terms of laying down high-speed Internet access across the state of Arkansas, and there were 467 telemedicine units included in that grant. So recipients from that project got a free telemedicine unit and broadband charges paid for three years.”

Encouraging sustainability

After grant funding ends, Rule hopes to sustain SCTRC by expanding longer-term consulting, continuing education and training opportunities. SCTRC also plans to reapply for a TRC grant when funding becomes available through HRSA in January.

To help health care providers recognize the benefits of post-grant sustainability, Rule recommends the telehealth impact calculator available on learntelehealth.org. It approximates how much time and money a hospital or clinic might save by utilizing telemedicine.


“It can show the dollars and cents of telehealth,” Rule says. “We work with a lot of rural providers, and they can plug in factors such

as miles driven for patient or provider, and it calculates how much time and money they’ll save. It helps explain the savings to people.”

In addition to the TRC grants, ORHP and the Office for the Advancement of Telehealth, which became a division of ORHP in 2010, also offer funding through the Telehealth Network Grant Program (TNGP). There are 25 active TNGP grantees receiving \$250,000 per year over a three-year project period. HRSA’s Office of Research and Evaluation and the University of North Carolina-Chapel Hill will continue evaluating the effectiveness of the TRC and TNGP grants through the end of the year.

“We are currently identifying services and other important indicators through the outcome data we’ve collected from various cohorts of telehealth network grantees since 2006,” Mena says. “For the most part, however, chronic disease management, such as chronic heart failure and diabetes, has shown significant improvement over the years as a result of telehealth.”

But for rural health care providers such as Loftis, the benefits of telemedicine are already evident.

“It’s immediate,” she says. “We’re able to get a consult within a week, and the patients are present for the consults. The patients get the reassurance of seeing the physician and hearing the words, and it’s really neat because it involves the patients in their own care. We feel really privileged to be able to access the service.” 

Resources at your fingertips

Learn more about the South Central Telehealth Resource Center and share ideas and information at learntelehealth.org.

Determine how much telemedicine can help you save at learntelehealth.org/telehealth-impact-calculator.

Find a telehealth resource center in your region at telehealthresourcecenters.org.

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*Diane Kline, Director, Material Management
Lewistown Hospital, Lewistown, Pa.*



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Rural Multiracial and Multicultural Health Conference

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Asheville, N.C.

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NRHA, Dartmouth create ethics guide just for rural hospitals

By Lindsey V. Corey



William Nelson

Ethics committees are less likely to exist in rural hospitals, compared to urban facilities.

To address the need for developing ethics committees in critical access hospitals (CAHs) and overcome the obstacles that may present themselves in this process, William Nelson, PhD, and Barbara Elliott, PhD, developed the *Critical Access Hospital Ethics Committee Resource Guide* with funding from the National Rural Health Association through a cooperative agreement from the Office of Rural Health Policy.

“Many critical access hospitals have indicated they would like to have an ethics committee, but because they’re small, they may not have the resources,” says Nelson, director of Dartmouth Medical School’s Rural Ethics Initiative. “NRHA recognized the importance of

effective ethics resources because rural hospitals certainly encounter clinical and organizational ethical issues, but no one really focused on how they uniquely play out in rural settings. So we wanted to develop a very practical guide to help them develop a committee.”

The free guide was created to assist rural hospital leaders in developing an effective and useful resource for patients, clinicians and administrators in rural health facilities. It’s based on research and real-life situations that highlight the challenging and frequent ethics conflicts common in rural hospitals.

“The issues of privacy and confidentiality are very different than if you’re in Kansas City where you’ll probably never see that patient outside of the hospital.”

William Nelson, *Critical Access Hospital Ethics Committee Resource Guide* coauthor

“Everyone knows each other in rural communities,” Nelson says. “So the issues of privacy and confidentiality are very different than if you’re in Kansas City where you’ll probably never see that patient outside of the hospital. In rural settings, it really alters that relationship because you may be treating your next door neighbor. It raises a lot of issues that are rarely, if ever, discussed in ethics literature.”

The guide may also be used to assist CAHs that already have an ethics committee to enhance its effectiveness, Nelson says.

“A lot of the small hospitals I talked to that have these committees have a lot of obstacles because in rural settings, staff wear so many hats – the head nurse might also be the patient safety officer and there might not be a psychiatrist or chaplain available – so we tried to give practical, step-by-step guidance rather than a theoretical approach,” he says.

Nelson is a long-time NRHA member, a graduate of NRHA’s Rural Health Fellows program and has presented at multiple NRHA conferences. He also coauthored the *Handbook for Rural Health Care Ethics* in 2009.

The free rural hospital guide is available at <http://dms.dartmouth.edu/cfm/resources/cahe/>.

Rural hospital gets lean



Sampson Regional Medical Center's lean team: David Masterson, CEO; Tammy King, lean coordinator; Jacquelyn Butler, nurse and lean coordinator for surgical services; and Randall Caldwell, service excellence director and lean coordinator for patient-family centered care.

A year ago David Masterson, CEO of Sampson Regional Medical Center, decided to try lean management, hoping to reduce costs and improve quality at the rural hospital in Clinton, N.C., population 8,639.

He explained to *Rural Roads* why and how he did it and why he thinks other small hospitals should follow Sampson's lean lead.

What is lean management?

Lean management is a cultural transformation that promotes involvement from the front line of the organization to identify opportunities for streamlining processes and improving results.

Lean has added excitement and enthusiasm back into health care.

This gives us a way to survive that's fun and one we know shows immediate results and satisfies our need to help other people. That's why most of us are in health care to begin with.

What is the North Carolina Rural Hospital Lean Culture Transformation Collaborative?

Three or four years ago, Jeff Spade, North Carolina Center for Rural Health executive director, identified the opportunity through his exposure to a hospital in Wisconsin. Jeff talked to several of the hospitals in the western part of North Carolina – rural and small hospitals for the most part – and several of the hospitals

took the idea and ran with it hoping to improve quality of care.

Years later during a conference, I heard my peers from the western hospitals present on the advantages of lean initiatives for their organizations. They discussed the waste that was removed from the system, money that was saved and quality that was improved.

That really caught my attention. It was something I felt was very much needed in our organization and started asking questions and looking into it. From there, the eastern collaborative was born. One of my peers from an eastern hospital called me and felt we should get together to do the same thing here that the western collaborative did. By pooling our resources together to obtain grants, we would be able fund consultants who could coach us toward improved performance and cultural change.

What convinced you that your hospital needed to adopt a lean culture?

As a small, rural hospital very challenged by health care advances, and given the bars continuously rising on quality performance, it was clear to me that for our hospital to succeed, we needed to embrace change and transform expectations within the organization.

What challenges were you trying to solve?

We were seeing mediocre performance in quality indicators, and I think our employees were feeling more and more distanced from decision making and even felt victimized by changes that were coming down the pike, and they really hungered to be involved in making change or setting the direction for where the organization was going.

Lean culture does all that, and the biggest advantage is that it gives you a structure to pull frontline advice, recommendations and experience. When people see that put into action, they embrace it, they own it, and they make it happen.

How does lean management help rural health facilities?

Many of our organizations are stand alone, and even if you are not stand alone, you're part of a larger system and sometimes feel out of the mainstream.

A lean transformation doesn't bring the improvement from the top down, or from the big house out to satellite hospitals. It truly is a way for the small, rural hospitals to demonstrate to larger hospitals that sometimes we have the best ideas and the best practices, and putting those practices into action and showing the results is a way of highlighting our rural hospitals as think tanks for the future.

What are some of the economic challenges rural hospital face?

Of course, in this day and age, preserving employment is the big one, and that is one of the challenges with the lean transformation: if employees perceived this as a way for them to lose their jobs if we become so lean that we cut positions in the organization, they would feel threatened by the program.

So we told them upfront that the savings we would find would be a way for us to preserve jobs. In fact, we currently have three designated, full-time lean coordinators within our organization, all of whom have had other jobs within the organization previously. We have been able to reduce positions through attrition, but no one's employment was threatened.

For small hospitals that's a big challenge for leaders... to ensure that your hard-working employees have a future. And again, sustaining the hospital in improving quality and the bottom line certainly position us for future success.

How is this approach different from the way many hospitals try to reduce cost, increase efficiency and deliver better care?

I don't think there is a way most hospitals approach financial challenges today because it requires a lot of creativity. What the lean approach does for us is gets to the core of preserving what is most important about the services we provide to our patients and our community.

It looks at the tangential expenses or delays or wastes that have innocently accumulated over the years, and this process allows us to go back to zero base and say "OK, what is that we want to do, where do we want to go with this, and what are all the things we are doing that really don't make any sense today?" Let's cut that out and go to the core. That is overwhelming in health care, but I think a zero-based approached to process has been needed in health care for a long time.

How did you implement this culture transformation at Sampson Regional?

It required a commitment from the top of the organization. As CEO, I had to be a 100 percent behind it and really a cheerleader in front of it. I wanted to make sure our board was informed but did not expect them to take the lead. We did not want to exclude our medical staff. Therefore, early on, our first areas of focus would have to be very transparent and inclusive. More so, it had to be in an area where medical staff would immediately see the improvements. Surgical services was that area for us.

We really started slowly and pulled a few key people into the first meeting that we knew would go out and talk to others about what a positive experience they had. It is like going to a church retreat; you go and come back a renewed person. That feeling of renewal is infectious with the people around you, and you're sort of riding high. Lean does that, but lean does that and, at the same time, finds ways of cutting costs and improving quality.

Rapid improvement events are week-long incubator-type activities that we commit staff time for identifying quick fixes that are implemented immediately, and people see

continues

the satisfaction of having made a positive change in the organization and that builds a lot of buy in.

How important is strong leadership in implementing lean within a hospital?

It is a necessity. I have seen some hospitals that have implemented lean culture where the top of the organization wasn't fully engaged and it took a long time for them to develop it.

There is nothing more frustrating to the middle manager in a organization to feel that they are being held accountable for something that they are not seeing the support from at the top. The CEO and the C-suite participates have to be in the first few meetings and commit themselves to a full week of engagement with the staff. It's a great way for leaders on all levels to get out into the organization, engage in conversation with the frontline staff and the middle managers to understand what is happening within their organization.

What suggestions do you have for other hospital administrators considering implementing lean management?

My recommendation to other hospitals is to start slowly with something very transparent and visible to everybody involved, and instead of you pushing the lean process on the organization, allow yourself the time to plant the seed so that the staff are pulling the lean process through the organization and are asking for it.

I think a big concept here is letting go a little as a leader and not micromanaging but allowing people to come up with their way of doing it, implementing it and making it happen and showing you the results.

Right now I've got doctors and department managers saying, "How can I get involved? When can you come to my area and help me improve processes here?"

And then you have to give it time. It's not an overnight process. It takes years to implement throughout your whole organization, and they say it takes five years to really change a culture. But, it's a start, and, a year into it, I'm beginning to see some real improvement and willingness to change.

Is it possible to quantify the cost savings through lean?

Absolutely, but it's tricky. You have hard savings and soft savings. For example, when we looked at inventory

in ophthalmology, we had kits for eye surgeries that were on the shelf, and the ophthalmologist changed kits – until they realized from one of our staff that we still had 12 sitting on the shelf that soon would be expired, so they used those right away. That saved us thousands of dollars just in that one day, a hard savings.

A soft savings might be the savings related to reduced patient wait times. Some of that is labor savings; a lot is savings related to improved process overall, and it's hard to put a figure on that. We do have a financial designee here at the hospital who has responsibility for managing, tracking and recording our savings on an ongoing basis because oftentimes the savings take a while to kick in.

How has participating in the collaborative helped you reach your goals?

The collaborative offers us benchmarking against other hospitals. I can call on those hospitals and learn from their benchmarking and get an idea of comparing where they've gotten to after using lean. So the collaborative kind of raises the bar for what's possible.

We just reallocated time on the block schedule for surgical services, which was such a political issue for many years that nobody ever wanted to talk about. We were able to address it through a lean methodology by getting the surgeons involved and hearing their input. That truly has made a difference.

Does lean management have a shelf life?

It's not flash in the pan; it's not glitz and glamour or a flavor of the week; it truly is a change in culture and the way you approach that, from implementing patient- and family-centered care to changing block scheduling to eventually getting to revenue cycle and improving our days in accounts receivable, improving our collections at point of service, all things that lean can apply to. There is no limit to what can be improved in an organization through our lean culture.

What are your next steps?

We're continuing on the path that we're on and involving more employees. I've seen some hospitals step out and take lean into the community: Where does the uninsured patient in your town find access to care? How do you involve the health department, social services, primary care centers, federally qualified health centers? How do you build partnerships for providing health care here?

We look forward to taking lean beyond the walls of the hospital. 

Conference connection

Don't miss the Rural Health Clinic and Critical Access Hospital Conferences for more ways to cut costs and improve quality at your facility.

NRHA's fastest-growing events will be Sept. 25-28 in Kansas City, Mo. Go to RuralHealthWeb.org/kc to register.



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Beginnings & Passages



Tema Jessup with her son Joe

“After just one year, our clinic now feels more like a big family.”

Family emergency introduces first-year doc to rural support system

By Tema Jessup, DO

When I’m asked about my first year working as a rural physician, I often tell a story to illustrate the stressful situations that arise. A story that at the same time reveals the feeling of support I received from local physicians and the community.

It was the middle of flu season, and I was on call covering the ER. My children were with their grandparents as my husband was away at law school.

While I was examining a patient, my in-laws ran through the door holding my son. He was seizing. If that wasn’t scary enough, I realized my son wasn’t breathing.

I yelled at the nurse to call in backup, and my training took over. I rushed him to a bed and started performing mouth-to-mouth, suction and chest compressions as it appeared that he had aspirated during his seizure. As our local nurse anesthetist arrived, my son began coming around and was then breathing with supplemental oxygen.

Shortly thereafter one of the local physicians arrived and was able to take over as my son was still unable to move his right upper and lower extremities. After a few minutes, one of my partners showed up to cover the rest of my call.

As they took my son into CT, I sat on the edge of the gurney and cried, finally able to be a mom again. Never in my life has anything so scary happened to me. Today my son is doing well, and you would never know that terrible night occurred.

I learned that even though you are taking care of the entire community in a rural area, it is just as important to have the support of the other physicians. After just one year, our clinic now feels more like a big family.

I really enjoy the ability to practice broad-scope family medicine, and it is a comfort to know that I am not alone. I owe thanks to my training at Family Medicine Residency of Idaho, Wayne Hollopeter, MD, Daniel Griffis, MD, and the staff at Syringa Hospital in Grangeville, Idaho. I always wanted to go into rural medicine in the area I am in now, but David Schmitz, MD, [see next page] and Kimberly Stutzman, MD, helped me get here.

Tema Jessup, DO, completed the Family Medicine Residency of Idaho program in 2011 and began her current position as family physician at Syringa Hospital in rural Idaho in August 2011.

Innovative rookies and seasoned professionals share their experiences.

“They had an opening for a family doc but no need for a stoplight.”



Third-year resident Nikole Shepherdson talks with David Schmitz.

Physician tries to give back to rural patients through recruiting

By David Schmitz, MD

A good dose of my training came while practicing in a north Idaho logging town. They had an opening for a family doc but no need for a stoplight.

At first I thought it was the smell of the tamarack in the wood stoves that attracted me, but looking back now over those six years of early practice, I see it was the community itself. It was the way the people were more than patients; the way friends and neighbors and colleagues showed me why I had become a physician; and why I could be, in this community, more than just a physician.

The man in a flannel shirt who asked me if I had ever done this before and when I said “no” told me I would do a good job (which thankfully, I did). The ward clerk who made me brownies every ER shift for a month and then sent her family members to my brand-new clinic practice. The nurses who helped me understand we had all done our best when our best hadn’t resulted in what we had hoped for.

I have worked hard to give back some of what life in that rural town taught me. As a rural medical educator, it’s my job to help keep dreams alive – a dream I’ve personally seen can come true.

Ted Epperly, Family Medicine Residency of Idaho program director, once described what teaching and advocacy and leadership can do, inside and outside of an exam room. So my road of late, with rural residency building plans in hand, includes research on rural recruitment from Maine to Alaska, and a good number of board meetings along the way.

What I’ve learned is that it’s hard to out-give the community of rural. What I’ve discovered is that it’s really all about describing what I can’t forget about St. Maries, Idaho, a town that helped me build a volunteer clinic. Simple enough, but in the process they built this rural physician educator.

I also found out that what you can’t repay, you accept – with gratitude and a smile.

David Schmitz, MD, is associate director for rural family medicine at the Family Medicine Residency of Idaho in Boise. He is a graduate of the National Rural Health Association Rural Health Fellows program and is nationally known for his work with the Community Appgar rural physician workforce recruitment project, rural training track residency education and leadership on rural physician issues. Schmitz joined NRHA in 2005.

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Surviving the body bag

By Dustin Summers



Dustin Summers

“Annnnd how about this one?” she asked, moving her steel probe an indiscernible distance from a stringy, pale blood vessel to an identical structure directly adjacent. I strained for a better vantage

point, pretending to narrow my potential answers.

“I’ll give you a hint,” she said. “It’s a vein.”

“Oh, ok,” I said, stalling for time, “let me think.”

My mind was a jumble of directional terms and general musculature. Superior. Inferior. Lateral. Posterior. Greater. Lesser. Intercostal. Thoracic.

“I think it’s the hemiazygos vein,” I finally answered, failing to veil the uncertainty in my voice.

“No,” she said, “the hemiazygos originates here,” she repositioned the probe again, “not here,” another subtle adjustment. “The correct answer is the azygos vein.”

“Got it,” I said, completely baffled.

This was how gross anatomy began for me. Confusion, bewilderment, hopelessness.

Gross anatomy is the cornerstone of virtually every first-year medical program in the country. It’s a preview for all that follows: the other-worldly demands, the endless hours of review, the tension headaches. It also serves as the basis for one of the first questions newly minted medical students field from their friends and family: “Do you really have to dissect a person?”

The answer is yes.

In actuality, the exercise, like many things in medical school, moves so quickly one has little time for reflection and grandiosity. The gunners (the medical

student who aspires to be at the top of his or her class, who wishes to earn a residency in a super sub-specialty like hypothermic superficial right hand surgery and who will most likely suffer a mental breakdown during the first year) act as though they’ve done this a million times, which is frightening in its own rite. The skittish students linger in the back and bury their noses in dissection manuals. Then you have people like me and my group of three lab mates who, for the most part, have no idea what the hell they are doing because amateur experience dissecting a human is generally frowned upon.

“You have people like me and my group of three lab mates who, for the most part, have no idea what the hell they are doing because amateur experience dissecting a human is generally frowned upon.”

On day one, our cadaver was lying face down inside his body bag, inside another blue bag that looked and felt just like an old tarp and finally, wrapped inside a thin, linen shroud. The bodies don’t even look real. They are generally emaciated, faded and vaguely human at best. There’s no blood, minimal gore and it’s shockingly easy to fool yourself into forgetting what you are actually doing. Whatever discomfort or hesitation that does remain is suppressed by either the self-consciousness of looking like a squeamish sissy in front of your classmates or by the impeding terror of practical lab examinations.

Lab examinations, which come about five times a semester, can be generally explained thusly: Go to your kitchen and boil a pot of water. Now add a large quantity of spaghetti. Once the noodles are tender and indiscernible from one another, throw them in your living room floor. Now know the name of every noodle (hint: they’ll all sound similar and Latin), where each noodle came from and what makes it different from the other noodles. You have 50 minutes. Go. Oh, and invite over 40 of your most stressed out, type-A friends to fight for elbow room.

My routine for studying gross anatomy consisted of arriving at the lab early (5a.m.-ish) and alone. An empty cadaver lab in late October is an eerie, quality substitute for a haunted house. Once I figured out how to link my iPod to the sound system, I roamed from body to body with a steady stream of ’80s hair metal and ’90s alternative rock. The irony of studying the SA node with Mötley Crüe’s “Kick Start My Heart” blaring in the background is not lost on me.

continues on page 51

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street smarts

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In the end, I survived, as do most first-year students. It's a marathon, and after I crossed the finish line, I looked at my stacks of flashcards and pages of notes and thought, "There's no way in hell that I know all of that." But it sticks.

The azygos vein originates around the 12th thoracic vertebra and courses superiorly through the posterior mediastinum before arching over the right bronchus. Eventually, it reaches the superior vena cava and finally flows into the right atrium of the heart. Along the way it travels with other blood vessels, over bones and through narrow passes of muscle and tissue. Each vein following slightly different paths and originating from various locations, yet coursing together, climbing upward, flowing towards something larger.

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

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Medical Director and Pediatric Hospitalist

The Randall Children's Hospital at Legacy Emanuel is currently recruiting for a Medical Director and a Pediatric Hospitalist for a new Pediatric Inpatient Program in partnership with a thriving community hospital and community physicians in Oregon's beautiful mid-valley. This program will have a fully integrated relationship with The Randall Children's Hospital at Legacy Emanuel in Portland, Oregon.

These physicians will join an expert team of 30 pediatric hospitalists and nurse practitioners covering four sites providing superb care and service. Full consultative support services are available in all pediatric subspecialties. Pediatric Emergency Medicine, Pediatric Critical Care and Neonatology are also in place at The Children's Hospital for 24/7 immediate remote consultation and support. Clinical rotation, training and ongoing educational opportunities are available to all hospitalists and could include occasional rotation at Randall Children's Hospital.

This vibrant medical center is a 114-bed hospital currently providing a wide array of services including Cardiac, GI, Critical Care, Respiratory, Rehabilitation, Vascular Surgery as well as home to Oregon Institute of Minimally Invasive Surgery and the Sleep Solutions Center, the Hand Therapy Center and Women's Health and Birth Center. The addition of this pediatric hospitalist program will further enhance this already dynamic community based hospital.

Located between the Willamette and McKenzie rivers, Springfield Oregon is located minutes from Eugene, in the south-end of the Willamette Valley, just two hours from Portland, and one hour from Oregon beaches. This community is very family-focused, with quality schools, a variety of outdoor activities and provides the ability to live in the city or in the suburbs where acreage is plentiful. The combined communities of Springfield and Eugene are just over 350,000 in population making this area the second most populous in the state. The area is home to biking paths, wineries, art and river walks as well as home to The University of Oregon.

Randall Children's Hospital at Legacy Emanuel receives nearly 100,000 patient visits every year -- and over the past 100 years, we've become Oregon's largest provider of pediatric inpatient and trauma services. Our new nine story home for Randall Children's Hospital opened in February 2012.

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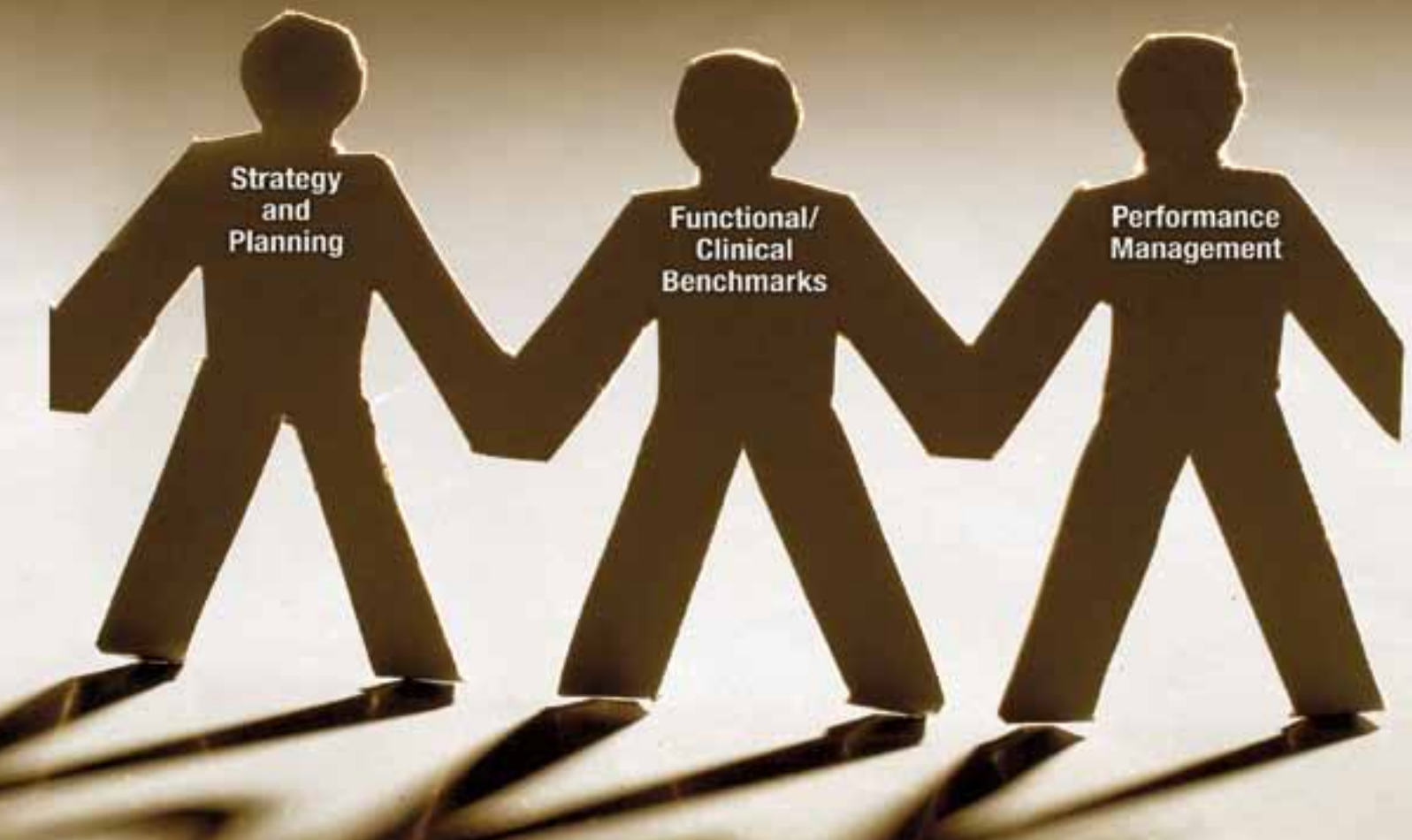
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Members on the move

NRHA members boast some of the cleanest hospitals in America



Marcum and Wallace Memorial hospitality staff

Five National Rural Health Association member hospitals made *Becker's Healthcare* list of the top 40 cleanest hospitals in the country.

More than 90 percent of patients at the top 40 hospitals

reported that their room and bathroom were always clean, according to the Centers for Medicare and Medicaid Services' Hospital Consumer Assessment of Healthcare Providers and Systems report.

These NRHA members made the list:

No. 8: **Marcum and Wallace Memorial Hospital, Irvine, Ky.**

No. 14: **Sanford Rock Rapids Medical Center, Rock Rapids, Iowa**

No. 19: **Nemaha County Hospital, Auburn, Neb.**

No. 32: **West Feliciana Parish Hospital, St. Francisville, La.**

No. 35: **River's Edge Hospital, St. Peter, Minn.**

No. 36: **North Sunflower Medical Center, Ruleville, Miss.**

"Maintaining a clean hospital has always been a priority at Marcum and Wallace," says Susan Starling, the hospital's president and CEO. "Our hospitality staff is engaged, and they understand how their job directly impacts the patient outcomes and is crucial in the prevention of hospital acquired infection. As a critical access hospital, we know patients receive the highest quality of care, but since it is sometimes difficult to measure and report our quality data due to smaller numbers, being recognized on this list is even a greater honor."

The reporting period for this data was from April 2010 to March 2011.

Kasmar leaves Alaska Primary Care Association



Marilyn Kasmar

After 16 years as CEO, Marilyn Kasmar is leaving the Alaska Primary Care Association in Anchorage.

"Involvement in NRHA has provided me with great learning opportunities and the ability develop relationships with others that have greatly

assisted in my work with the Alaska Primary Care Association," she says. "I've really appreciated the value of NRHA membership and look forward to continued participation."

Kasmar, a longtime National Rural Health Association member, led the Alaska association since 1996. She says she's taking a break and then will look for a new position. Her successor has not been hired.

Longtime employee earns grad degree



Rob McVay

While working full-time at the National Rural Health Association, Rob McVay earned his master's degree in nonprofit management from the University of Missouri-Kansas City.

Commencement was in May.

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

"Completing this degree while maintaining a high level of standards at the office is no small feat," says NRHA CEO Alan Morgan. "As always, we're quite proud of Rob and grateful for his dedication."

Send your career updates
to editor@NRHArural.org.

Past president leaves state job, starts consulting



Dennis Berens

2010 National Rural Health Association president and longtime member Dennis Berens is retiring from the Nebraska State Office of Rural Health.

He became director of the office shortly after it was established by the state legislature in 1990.

“The National Rural Health Association is this wonderful family that took me in 23 years ago and nurtured me,” Berens says. “Many of our members helped me all of these 22-plus years. I was honored to have been given a leadership role in an organization that has so much to offer to our nation and world. It is my hope that I have helped others in their work at their home and also within NRHA. We have much work to do yet and we need each other to get it done.”

Berens now works as a consultant for Nebraska Times, a firm he started.

“I have many wonderful collaborators around the country, and I am sure we can find work that will be helpful to rural areas, communities and people,” he says. “Rural and rural health was, is and will continue to be my focus and passion. It just won’t be out of this office and framework. There are many things that I would like to address that are too hard to do as a government employee.”

Miller elected to chair NRHA’s National Rural Health Task Force

Carol Miller, of Ojo Sarco, N.M., was recently elected to co-chair NRHA’s National Rural Health Task Force (NRHTF).

She joined co-chair Patricia Tarango in leading the group’s July meeting in Washington, D.C.

NRHTF is a coalition of NRHA members concerned with the sustainability of primary care

points of service including community health centers, federally qualified health centers and rural health clinics.

The task force developed and recently affirmed a consensus vision statement focused on workforce, social disparities and sustaining a rural safety net.

Miller says a primary goal of the task force for 2012 is “to build on this foundation to project a stronger voice for frontier and rural community and migrant health centers to assure their success and survival as the health system continues to evolve.”

Contact Derek Dye at dye@NRHArural.org for more information on NRHTF.

NRHA news

NRHA responds to health reform ruling

On June 28, in a 5-4 decision, the U.S. Supreme Court upheld the Patient Protection and Affordable Care Act (ACA) in its entirety.

National Rural Health Association members were notified of the ruling and its rural implications within minutes of the announcement, and within hours of the news, NRHA staff hosted a webinar with three times the usual number of participants.

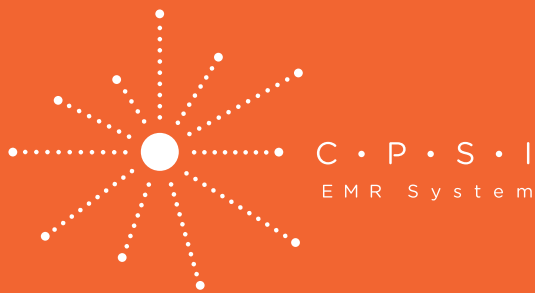
“Whether you support or oppose the health reform bill, it is important to know that many provisions were included in the bill that benefit both the rural provider and patient,” says Maggie Elehwany, NRHA government affairs vice president.

During the health reform debate, NRHA’s message was clear: Improve rural America’s access to health care providers by resolving the workforce shortage crisis in rural areas, and eliminate long-standing payment inequities for rural providers.

NRHA fought for and won key rural workforce and payment improvements in the 2010 bill. Each will remain intact in light of the Supreme Court’s ruling. However, complete funding for several of the provisions will likely remain challenging, Elehwany explains. Many programs authorized in the ACA must be funded through a separate act of Congress.

“The court’s decision means that rural providers must continue to be vigilant as preparations for major provisions to go into effect in 2014,” Elehwany says. “Expect more push-back from Congress to repeal all or part of the bill, as well as efforts to de-fund key provisions.”

Visit NRHA’s blog at blog.RuralHealthWeb.org for updates and analysis of the law and what it means for rural Americans.



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John Henderson, CEO, Childress Regional Medical Center, Childress, TX

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Border Health Initiative identifies priorities



NRHA Border Health Initiative participants

The National Rural Health Association led its sixth Border Health Initiative meeting in June in El Paso, Texas. Representatives from the U.S.-Mexico

Border Health Commission, the Office of Rural Health Policy, state offices of border health, state rural health associations and community-based organizations attended the meeting to provide the latest updates and perspectives on the status of communities along the border.

“Since its first meeting in 2008, the purpose of the NRHA Border Health Initiative has been to create and maintain partnerships for addressing needs related to health care access in this part of the country,” says Amy Elizondo, NRHA program services vice president.

The group detailed its multi-year plan, which focuses on these priorities:

- Policy: NRHA will enhance policy and program development for border health issues.
- Education: NRHA will continue to highlight border health issues at its conferences, especially during the Annual Rural Health Conference and the Rural Multiracial and Multicultural Health Conference, and also promote best practices.
- Networking: NRHA will continue outreach efforts with other organizations to address border health issues.
- Research: NRHA will continue to work on policy development related to enhancing border health research including the key areas of public health and prevention.

“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,” Elizondo says.

For more information or to be part of the Border Health Initiative, contact Gaby Boscan at boscan@NRHArural.org.

NRHA invited to White House Rural Council meeting

National Rural Health Association CEO Alan Morgan was invited to the White House Rural Council Rural Health Stakeholders Meeting in May.

U.S. Department of Health and Human Services Secretary Kathleen Sebelius hosted the meeting with U.S. Department of Agriculture Secretary Tom Vilsack as part of efforts by the White House Rural Council to focus on the vitality of rural America and enhancing federal programs to meet the needs of rural Americans.

Approximately 35 rural health representatives attended the sessions, which included discussion topics such as rural hospitals, home health, hospice, patient safety, public health, mental health and dental care.

“A major focus must be on recruiting and retaining primary care physicians in rural areas,” Morgan says. “The rural council is coordinating efforts across the federal government to ensure that resources are addressing this issue.”

The meeting, on the White House grounds, included rural physicians, dentists, nurses, mental health care providers and hospital administrators from across the nation.

NCHN honors NRHA

The National Cooperative of Health Networks

Association (NCHN) named the National Rural Health Association the 2012 Friend of NCHN during its annual conference in April.

“NRHA is one of NCHN’s greatest friends and supporters,” says Rebecca Davis, NCHN executive director. “The NRHA staff members are wonderful



NRHA CEO Alan Morgan with NCHN executive director Rebecca Davis

to work with, and the coordination of national level activities that strengthen rural health services, meets the missions of both associations.”

NCHN is a professional membership organization of health network leaders across the nation and often partners with NRHA on advocacy issues and events.

NRHA hosts National Rural Assembly leaders

The National Rural Assembly Steering Committee met in May at the National Rural Health Association's Washington, D.C., office to review the objectives and priorities of the assembly for the remainder of this year and next.

The National Rural Assembly is a movement of more than 500 rural activists, nonprofit leaders, elected officials and public interest associations. The assembly's goal is to create a stronger rural voice in public policy through a system that encourages rural advocates in multiple sectors and regions to work together on a common policy agenda.

"The Rural Assembly connects people working in different fields, such as health, education, conservation and community development, to identify common policy needs and collaborate on their implementation," explains NRHA CEO Alan Morgan. "Rather than replicate the work of strong national organizations working in specific rural policy areas, the assembly's

role is to create mutual support among these sectors, connect national groups with strong D.C. presence to local communities, and create opportunities for rural residents to communicate directly with federal and state policy makers on important issues."

The 2011 gathering of the assembly brought together more than 350 leaders from across rural and tribal communities to address topics as diverse as climate change, broadband access, Social Security, community philanthropy, youth programs and health care reform.

The recent meeting of the 13-member steering committee highlighted the assembly's focus on a number of areas including rural health, broadband and youth policy. The group also adopted a longer-term campaign to encourage greater philanthropic investment in rural communities by public and private investors.

"As our leaders look for a more sustainable way to feed and fuel our country going forward, it will be important to consider rural America's role in achieving that vision," Morgan says.

continues on page 63

accelerating advocacy

NRHA fights for rural hospitals

National Rural Health Association staff and members are working to protect rural hospitals, patients and providers.

If Congress does not act by Oct. 1, funding for Medicare dependent hospitals (small, rural facilities that serve a high percentage of Medicare patients) will expire. Expiration would force more than 200 of these facilities to lose millions of dollars, causing many to reduce services or close their doors.

Hundreds more rural facilities are also threatened by the October expiration of the rural "low-volume" adjustment, a Medicare payment for rural facilities which incur higher incremental costs due to a low-volume of Medicare patients.

"Congress continues to wage its bitter budget battle and is looking to slash or eliminate many critical rural health programs," explains Maggie Elehwany, NRHA's government affairs vice president. "While reauthorization of these two programs is in doubt, important new data indicates that small rural hospitals have equal or better quality outcomes nationally and cost 3.7 percent less per Medicare beneficiary than their urban counterparts. The federal investment in rural health makes sense, both for the patient and the tax payer."

Other rural health provisions are also set to expire in December, including the extension of:

- the outpatient hold-harmless provision under the prospective payment system (PPS)
- the work geographic index floor under the Medicare physician fee schedule
- all current ambulance services including air ambulance
- the exceptions process for Medicare therapy caps

"The future of our facilities and the care of our patients are in grave jeopardy due to Congress' potential unwillingness to continue critical funding for rural hospitals," says Jodi Schmitt, CEO of Labette Health, a PPS hospital in rural Kansas, and chair of NRHA's Hospital Constituency Group. "The partisan battles on Capitol Hill have muffled the previously strong bipartisan support for rural hospitals. Your representatives need to hear from you before this funding expires."

Schmitt and other rural health advocates from across the country gathered in Washington, D.C., in July for NRHA's first March for Rural Hospitals.

Follow NRHA's blog at blog.RuralHealthWeb.org for the latest rural health news from Capitol Hill, and visit RuralHealthWeb.org for more advocacy information.

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Beth Dibbert, Quality Consultant
Rural Wisconsin Health Cooperative

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National Quality Forum selects NRHA for Hospital Workgroup

The National Rural Health Association was recently selected by the National Quality Forum's board of directors to serve as an organizational voting member of the Hospital Workgroup for the Measure Applications Partnership.

"NRHA is pleased to have a seat at the table in reviewing and approving hospital quality measures required under the Affordable Care Act before their implementation," says Brock Slabach, NRHA member services senior vice president and a former long-time rural hospital CEO. "It is important for this process to recognize the distinctive characteristics of rural hospital quality and how measurement systems must be sensitive to low-volume issues."

The workgroup's next meeting will be in August via conference call.

Apply now to become a Rural Health Fellow

The National Rural Health Association is accepting applications for its Rural Health Fellows program.

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

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

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

Applications are available at RuralHealthWeb.org and must be submitted by Aug. 31 to be considered for the 2013 fellows class.

NRHA kicks off photo contest

The National Rural Health Association's Communications Committee has planned the association's first photo contest, Rural Lens.

NRHA is accepting photos through Aug. 15 in three categories: community outreach, people and landscape.

"We all know that rural America is the most beautiful place on earth," says Stacy Young, committee chair. "There's nothing like sharing rural health pictures across the nation from scenery, community outreach and

the wonderful people that serve our rural communities across the nation."

NRHA Facebook fans will select their favorite photos throughout September. The winner in each category will have their image featured in *Rural Roads* magazine, and the grand prize Rural Lens photographer will also receive \$400 from the NRHA Partnership Program.

Visit RuralHealthWeb.org for submission details and contest rules.

NRHA enters partnerships to provide new member benefits

The National Rural Health Association has three new projects designed to benefit members and the association.

NRHA recently launched a Visa Platinum Rewards credit card. The association will receive a portion of every dollar each cardholder charges.

"Using the NRHA credit card for everyday purchases is an easy way for you to support the mission of NRHA," says Alan Morgan, NRHA CEO.

Visit www.cardpartner.com/affinity/app/nrha for more information and to apply. There is no annual fee for the card.

And the new NRHA Insurance Services will offer property, casualty and employee benefits insurance products to lower the overall cost of risk for members. For more information, visit www.NRHAInsurance.com.

The association has also entered an agreement with Amerinet, a national group purchasing organization with arrangements with health care suppliers and distributors. The company will provide support service and access to deals to NRHA member facilities. Contact Steve Tackett at steve.tackett@amerinet-gpo.com for details.



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CPAs & BUSINESS ADVISORS

Once bitten, twice the garlic

Summer is about long days and even longer road trips. Pool parties, campfires, golf and grilling – and doing battle with bugs.

It is widely believed that genetic or environmental factors beyond your control can determine how attractive you are to bugs. So, while insects respond differently to everyone, here are some tips to test this summer:



Apply fabric-softening dryer sheets to skin.



Use candles containing citronella oil.



Cover food, unless it's garlic, and avoid scented hair products or lotions, unless they're coconut. These smells have been proven to repel insects.



Remember that bugs are most prevalent at dusk and are often found near standing water or trash.



Bugs are attracted to sweat, so keeping cool and dry will make you less popular with them.



Allow sunscreen to dry completely before applying bug spray.



Off the beaten path

Paper work



This piano made from newspaper is just one of the intricate curiosities created by Elis Stenman for his summer home.

Paper covers rock, right? Not in Rockport, Mass., population **6,952**.

This town just northeast of Boston is home to the Paper House. With its walls constructed from **100,000** newspapers, this **1922** experiment-turned-hobby is still standing, with headlines still readable, **90** years later.

Along with his family, Elis F. Stenman — a manufacturer of paperclip machinery — began construction of this architectural “*novel-ty*” just off the coast of Cape Ann.

Though the walls are built of **215** layers of newspaper, visitors will find standard materials comprise the roof to protect the structure from nearby coastal elements. Inside, furniture pieces were also created from history's headlines.

On your next trip to New England, visit the Paper House and *read all about it*. Literally.

shifting gears

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