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On the cover: NRHA/John Snow Inc. Student Leadership Award winner Hallie Foster (center), along with classmates Kat Weimer and Laura Brudecki, makes friends with a calf at Sayland Dairy in Jonesborough, Tenn., during East Tennessee State University's Appalachian Preceptorship.

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Lisa Kilawee

Election brings a sense of hope for rural

In my daughter's school in the village of Amherst, Wis., fall brings the beloved "Drive Your Tractor to School Day."

This fall also brings the presidential election. With a new leader in the White House as well as new members of Congress, many pundits predict the November election could lead to a political landscape with an unprecedented level of change.

While it's easy to look at the prospect of significant change with fear and dread, rural health professionals need to do what rural Americans do best and approach the future with hope and a commitment to hard work.

With new elected leaders, impending sweeping changes to health care reimbursement and continued stress on rural hospitals, the future also brings unprecedented opportunities.

I hope to see everyone at the National Rural Health Association's 15th annual Rural Health Clinic and Critical Access Hospital Conferences in the heart of the Midwest in September. These events will provide forums to learn about future rural health initiatives and opportunities and the chance to network with other rural health professionals and policy leaders.

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

Lisa Kilawee
2016 NRHA president

pit stop

things I picked up in this issue:

1. An Ivy League physician opened a small-town clinic in a converted flower shop in one of the poorest counties in Texas, seeing 40 patients a day while on call 24/7 as the center's sole physician. *page 17*
2. NRHA has trained nearly 600 community health workers since 2011. *page 64*
3. Patients who complete a medically supervised outpatient cardiac rehabilitation program can increase their life expectancy by up to five years and have 27 percent lower cardiac death rates and 25 percent fewer fatal heart attacks. *page 28*
4. Franklin Hospital nearly closed 20 years ago before the cycle of rural hospital struggles began. It almost happened again in 1995. Now, the hospital is thriving due to the diligence and cooperation that saved local access to health care. *page 32*
5. The resurrection of the streetcar has spurred more than \$1 billion in economic development in downtown Kansas City, the site of NRHA's Rural Health Clinic and Critical Access Hospital Conferences in September. *page 71*



*Hallie Foster
at Seneca Rocks
visitor center
in West Virginia.*

City girl plans to serve rural residents

By Angela Lutz

Before Hallie Foster ever began medical school, she knew she wanted to serve the underserved.

Originally from Columbus, Ohio, the third-year medical student at the University of Toledo College of Medicine and Life Sciences had initially planned to travel overseas to work after graduation, perhaps to Africa or the Caribbean.

Then she had an eye-opening conversation with one of her cousins, who lives in a rural community in eastern Ohio. Many of Foster's other relatives live in Appalachia as well.

"She said, 'Hallie, look around. The whole rest of your family lives out here, and we drive an hour and a half to Columbus to see a doctor,'" Foster says. "She really flipped the switch for me. I realized it made much more sense to pursue helping domestic populations that would need me."

Since realizing her rural calling, Foster has done

everything she can to immerse herself in small-town practice. Her university doesn't offer rural-specific training, but she has completed parts of her rotations in family medicine, pediatrics, psychiatry, and surgery at area health education centers in rural communities.

"It's not easy to convince students who have grown up in urban settings that practicing in a rural area is a good idea for them. But just because you don't have as many resources right at hand doesn't mean you can't deliver quality health care."

Hallie Foster, University of Toledo medical student

She also scoured the internet and pursued other opportunities in her region, including East Tennessee State University's Appalachian Preceptorship program and Ohio State University's Rural Health Scholars Retreat, which is run by National Rural Health Association member Randall Longenecker, MD.

These experiences have given this city girl a new perspective on and appreciation for country living – as well as insight into the possibilities for her future practice, in which she hopes to combine family medicine and psychiatry.


“One of the things I really enjoy about rural practice is the fact that you get to treat a lot of people who know each other or are related to each other,” Foster says. “I like building those long-term relationships with families in a community.”

She’s also gotten to know the challenges of providing health care in areas where provider shortages are common, including the fact that specialists aren’t always readily available.

“In more rural settings, coordinating referrals for people and trying to keep that web together is a lot trickier,” she says. “But the doctors I’ve worked with are really good at it. It improves your managerial skills from a primary care perspective. You’ve got to be a patient care manager in addition to a clinician.”

Through Longenecker, Foster has also become more involved with NRHA, attending the Rural Health Policy Institute and Annual Rural Health Conference this year. She serves as outreach coordinator for the association’s Student Constituency Group, a position that has allowed her to connect with students at medical schools across the country.

When it comes to convincing more urban students like her to consider rural practice, Foster says appealing to a future doctor’s desire to help people is a good place to start.

“It’s not easy to convince students who have grown up in urban settings that practicing in a rural area is a good idea for them,” she says. “But just because you don’t have as many resources right at hand doesn’t mean you can’t deliver quality health care. It’s about finding those who are interested in helping people and making an impact on a community for the better. This is an option where you’ll be able to do that in spades.” 

Hallie Foster received the 2016 National Rural Health Association/John Snow Inc. Student Leadership Award, which was presented at the association’s Annual Rural Health Conference in April. For more on Foster and the other Rural Health Award winners, see page 9.

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NRHA honors rural health's finest



2016 Rural Health Award winners

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

The 2016 recipients have used technology, teamwork and dedication to forge innovative programs and services, improving the lives of patients from coast to coast. NRHA celebrates the following rural health organizations, professionals and students, who were honored at the 39th Annual Rural Health Conference in May.

continues

Outstanding Rural Health Program

Disparities Elimination Summer Research Experience

Georgia Southern University Rural Health Research Institute and Mercer University Center for Rural Health and Health Disparities

Disparities Elimination Summer Research Experience (DESRE) brings together undergraduate and graduate students from across the country to participate in an intensive, six-week residential research training experience to learn how to engage in impactful rural health disparities research.

Students learn about and work with community-based groups including rural federally qualified health centers, migrant education programs, area health education centers, public health, Head Start, and others to help conduct and analyze rural-specific research. The 2016 program received more than 500 applications. DESRE is funded by the National Institute on Minority Health and Health Disparities.

“Georgia has one of the largest rural populations in the nation and faces significant disparities in health status between its rural and urban areas,” says Bryant Smalley, PhD, PsyD, Georgia Southern University Rural Research Institute executive director. “By forming broad partnerships across universities, schools, counties, social

agencies, government, health care institutions and local businesses, we are able to help in areas of the state where the unique needs of rural residents are all too frequently overlooked.”



Outstanding Rural Health Organization

The Richard G. Lugar Center for Rural Health *Terre Haute, Ind.*



Advancing rural health through the recruitment and training of rural providers since 1992, the Richard G. Lugar Center for Rural Health has facilitated the training of 84 family physicians who currently care for rural Americans throughout the country.

This focus extends beyond graduate medical education, as illustrated by the exponential growth in rural-focused health professions students who train

on the Union Hospital campus: from 60 to more than 600 in the past decade.

The center has also designed and implemented numerous outcome-based projects aimed at advancing access to and quality of health care in rural areas, including the Wabash Valley Rural Telehealth Network, which brings together independent rural providers and facilitates 6,000 live consults annually.

“For nearly a quarter century, the Richard G. Lugar Center for Rural Health has served as a catalyst for dialogue, education, innovation, collaboration and action aimed at advancing rural health in the Wabash Valley, the Midwest and across the nation,” says Hicham Rahmouni, grants and research director for the center. “The center has been a leader in rural graduate medical education, telemedicine, inter-professional training and practice, and partnership development to meet the health care needs of rural and underserved populations.”

Louis Gorin Award for Outstanding Achievement in Rural Health

Lynn Barr, National Rural ACO chief transformation officer *Nevada City, Calif.*



The first to propose a rural accountable care organization (ACO) model to CMS, Lynn Barr continues to work tirelessly on behalf of rural health systems. She successfully piloted the rural ACO model in 2014 and helped to establish six more the next year.

Barr went on to expand the opportunity to other rural health systems and now supports more than 170 systems in 22 ACOs. With CMS' Transforming Clinical Practices Initiative funding, Barr has provided assistance to help prepare 525 other rural health systems for health reform. The programs she developed could reach nearly a quarter of all rural health systems in the country.

"The people that work in rural health are the most selfless, dedicated people in health care," Barr says. "They care passionately about the people they serve, struggling without the resources they need yet always finding a way to get the job done. Rural leaders are working tirelessly to preserve the future of health care for the 62 million people we serve. I am honored and humbled to be counted among these giants."

Rural Health Practitioner of the Year

Dustin Hager, Heart of America Medical Center physician assistant *Rugby, N.D.*

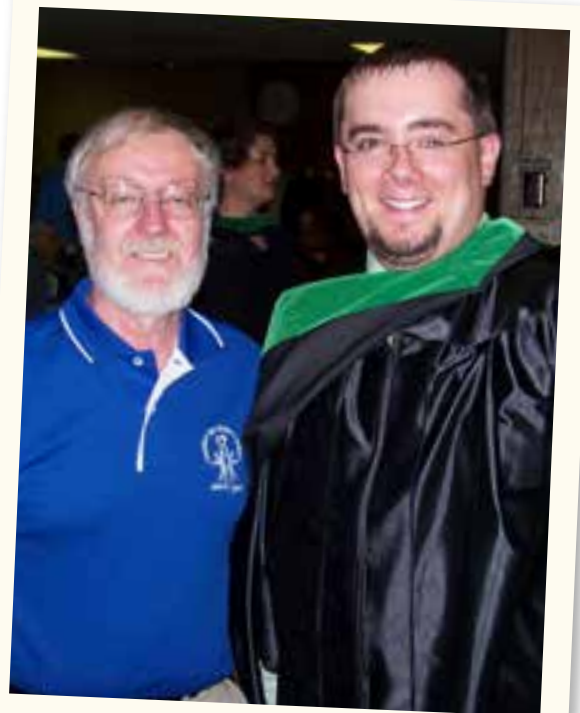
Growing up in a small town, Dustin Hager watched many of his friends and peers move to urban areas. But Hager wanted to raise his family in rural America while serving the people of his community.

Inspired by his mother, a nurse who worked in rural hospitals and nursing homes, Hager went on to pursue a career as a rural physician assistant (PA).

Nominated by a past winner of the award, Hager has been a member of his community health care team for many years, originally as an EMT and paramedic. Hager provides compassionate and competent care along with technological guidance and EHR support at Heart of America Medical Center in Rugby, N.D. He also cares for inmates at a nearby correctional facility and will soon be mentoring a PA student.

"I am both humbled and honored to receive this award," Hager says. "Having spent my entire life living

in rural America, it is very rewarding to be selected for this award. I also want to recognize my team at the Heart of America Medical Center and Heart of America Johnson Clinics, who work every day to meet the health care needs of rural America."



continues

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Outstanding Researcher Award

Jacob Warren, Mercer University School of Medicine
Center for Rural Health and Health Disparities
endowed chair and director *Macon, Ga.*



Spending part of his childhood in a rural Georgia town with fewer than 200 residents inspired Jacob Warren, PhD, to care deeply about rural communities. As a result, he has dedicated his career to improving health in rural areas through rigorous and high-quality research.

Warren has received more than \$6 million in federal funds for research projects and published two books on rural public and mental health. His research spans communities, geographies, universities and health conditions to directly advance the field of rural health disparities research and develop the next generation of rural health researchers.

“So many times, the sheer magnitude of health needs in rural areas seems to overshadow the tremendous resiliency, interconnectedness and determination that rural communities possess,” Warren says. “It is a privilege to conduct research on how to work with communities to bring together all of the resources and passion they already possess to tackle health issues head on. It is that unified sense of purpose and teamwork that keeps me passionate about rural health research.”

NRHA/John Snow Inc. Student Achievement Award

Matt Workman, East Tennessee State University Quillen College of Medicine medical student
Johnson City, Tenn.

Growing up in a small town in the foothills of the Great Smokey Mountains, Matt Workman has spent his entire life in rural areas, and he plans on making his career in a rural community.

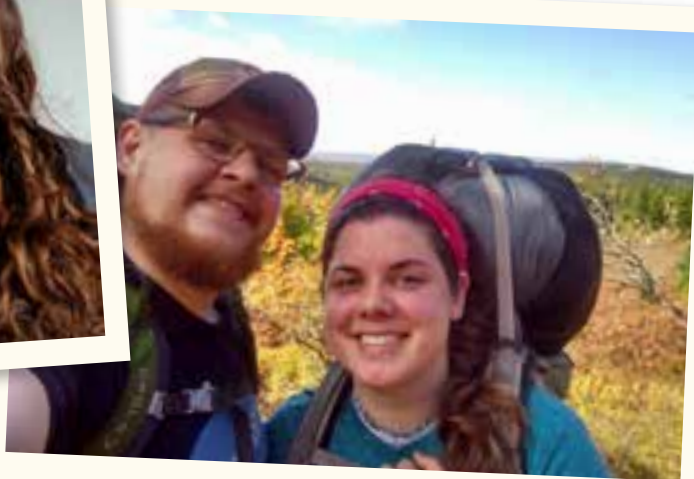
Workman is the student outreach coordinator for the National Rural Health Association's Student Constituency Group and an exemplar in the Rural Primary Care Track program at East Tennessee State University's Quillen College of Medicine. He has elected to complete his medical school experiences with rural faculty and in rural communities whenever possible.

"I can think of many other students who are more deserving of this award," Workman says. "There are countless others who came before me in developing the NRHA student liaison program and the 'Just Care' free clinic in rural Appalachia. This award is a testament to the hard work of those individuals who came before me."



NRHA/John Snow Inc. Student Leadership Award

Hallie Foster, University of Toledo College of Medicine and Life Sciences medical student *Toledo, Ohio*



Driven by a desire to serve populations in need, Hallie Foster's decision to pursue a rural career seemed like a natural choice. Originally from an urban area, Foster calls her journey into rural health care a "self-directed process."

The third-year medical student at the University of Toledo College of Medicine and Life Sciences has served as the rural medical education liaison for the National Rural Health Association's Student Constituency Group board since 2015.

Foster completed a clinical preceptorship at East Tennessee State University working with underserved Appalachian populations. In her volunteer role with NRHA, she led the way in developing a student-alumni network where she reached out to graduates to expand mentorship.

"Upon joining NRHA, I found a community of such enthusiastic professionals that

I find it hard not to be continually inspired by their efforts," Foster says. "To be recognized for student leadership amidst people I believe are truly exceptional is a staggering honor, and I have my student and professional colleagues to thank for considering me."

continues



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Volunteer of the Year

Janice C. Probst, PhD, South Carolina Rural Health Research Center director *Columbia, S.C.*

Nominated and selected by National Rural Health Association staff, Janice Probst received the Volunteer of the Year award.

After focusing on rural health in her 25-year career in research and academics, Probst says she was “humbled” by the award.

“Early on in my doctoral studies, I observed that rural populations, and particularly rural persons of color, both experience significant disparities in health and access to health care and are markedly underrepresented in the worlds of research and advocacy,” Probst says. “Rural health seemed like an appropriate area for someone with a public health mindset to dig in and start working.”



President's Award

Alana Knudson, PhD, North Dakota and NORC Rural Health Reform Policy Research Center deputy director *Bethesda, Md.*

2016 National Rural Health Association president Lisa Kilawee selected Alana Knudson to receive the President's Award.

Having working in rural health since 1993, primarily focusing on health care reform issues that impact rural residents and providers, Knudson says she's grateful to receive the award.

“Rural is who I am; it is where I feel most at home,” she says. “It is very rewarding to work on projects that can make a direct impact on the health of a rural community – they are the best incubating labs in the country.”



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Physician grows flower shop into rural care network

By John Commins



Jasmine Sulaiman at the center of the ribbon cutting for a clinic opening in March.

When Jasmine Sulaiman, MD, was interviewing for a job as the only primary care physician at the nascent Health Center of Southeast Texas, she couldn't help but look toward the heavens for guidance.

That's because there was no roof on the Cleveland, Texas, bank where the interview took place. It was 2005, and Hurricane Rita had just blown through the small town of 7,707 souls located 45 miles from Houston.

Coming from Ivy League-affiliated St. Elizabeth's Medical Center in Utica, N.Y., and with a family practice specialty, Sulaiman knew she could have her pick of jobs in physician-starved rural Texas, where she and her husband had relocated to escape winter's grip.

She picked Cleveland, where the local hospital was in financial straits (it closed in 2014), and where she was hired on as the sole physician, earning considerably less than the market could demand and working at a health center that as yet didn't exist. The hospital served a patient mix that included 70 percent uninsured.

continues on page 20

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Jasmine Sulaiman is named 2016 Country Doctor of the Year by Staffcare.

“I was interviewed by a group of people all from the community,” she says. “They formed a board to start a clinic because the hospital was losing a lot of money through the ER. This is one of the poorest counties in Texas. When I came, they held hands, about 10 of them, and they prayed, and I was thinking, ‘OK, I really want to be here and see if I can make it work.’”

“They didn’t have a clinic. Actually, they didn’t have anything. They had one person from the hospital to help set up the clinic,” Sulaiman says. “I said, ‘OK. I’m going to take this job.’ My husband said, ‘It’s a 40-mile drive.’ I said, ‘I don’t mind. I want to take this job.’”

Within a few months, a clinic opened in a converted flower shop. Sulaiman began seeing 40 patients a day and remained on call 24/7 as the center’s sole physician.

“I knew that what I was getting into was going to be totally different than a regular cookie-cutter practice.”

Jasmine Sulaiman, rural physician

Not surprisingly, the federally qualified Health Center of Southeast Texas (HCST) quickly grew to meet the urgent demand. Today it includes seven physician assistants and nurse practitioners, all of whom rotated through Sulaiman’s practice during their training. The center moved out of the flower shop and now operates in a 6,300-square-foot building with nine exam rooms.

But that’s not all.

HCST expanded to include three additional clinics in a three-county service area, all supervised by Sulaiman, who also continues to see patients in addition to her administrative tasks.

She also created a program to upgrade medical care at the county jail, led the movement to designate HCST as a level 2 patient-centered medical home, helped develop an educational program that exposes local high school students to careers in health care, and volunteers once a year to provide free care in Mexico.

The newest challenge for Sulaiman is improving access to mental health care through a tele-psychiatry program.

“We have no psychiatrists practicing in this county or the adjacent county,” she says. “We serve a population that is 70 percent uninsured. There is a lot of mental illness, a lot of substance abuse. We see it more and more. We couldn’t afford a psychiatrist, and so we got a grant from HRSA for behavioral services. We hired a counselor. We just signed a contract with a tele-psych services, and that should be operational in a couple of months.”

Sulaiman has to provide diagnostic services for mental health “every single day” because there is no



Jasmine Sulaiman visits with a patient.

other path to treatment.

“It’s not fun at all. Yesterday a patient was verbally abusive to me because I couldn’t help her,” she says.

“They didn’t have a clinic. Actually, they didn’t have anything.”

Jasmine Sulaiman, rural physician

“If they don’t have access to care, then they don’t have access to treatment. It affects these individuals, their families and their communities. Even when we are here providing access to care, often they don’t have the money to pay for the medication. That’s a gap in treatment and continuity of care. It’s frustrating. I feel helpless, they feel helpless, and some days I wonder, ‘What am I doing here?’”

Frustrations aside, Sulaiman’s accomplishments have not gone unnoticed. In 2012, she was named Texas Family Physician of the Year by the Texas Academy of Family Practice. And in March, she was named the 2016 Country Doctor of the Year by physician recruiters Staff Care, which is providing HCST with a temporary physician for two weeks so Sulaiman can take a vacation. She plans to use the time off to travel to India, where she was born.



Jasmine Sulaiman meets with a family.

“I work more hours than usual, but I don’t have any complaints. I really enjoy what I do,” Sulaiman says, when asked if she worries about physician burnout.


“This is the two-sided coin,” she says. “I knew that what I was getting into was going to be totally different than a regular cookie-cutter practice. It is not time equals money. There are a lot of frustrations, but at the end of the day you’ve helped someone or you’ve started some new program, and you’ve provided access to care for people who otherwise have none.”

This article originally appeared in HealthLeaders Media in March.

Clinic connections

Learn about other successful rural health clinics and network with rural health colleagues from across the country at NRHA’s Rural Health Clinic Conference Sept. 20-21 in Kansas City.

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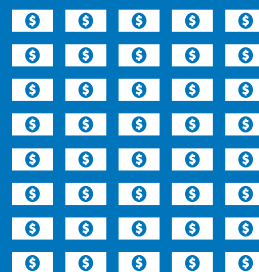


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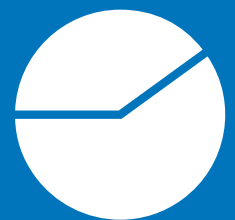


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Federal office aims to expand telehealth



William England

The Office for the Advancement of Telehealth (OAT) in the Federal Office of Rural Health Policy was established in 2002 to promote the use of telehealth for health care delivery, education and health information services. “Telehealth is especially critical in rural and other remote areas that lack sufficient health care services, especially specialty care,” explains William England, PhD, JD, who in June became OAT’s third director.

Prior to leading the office, he was senior director and vice president of the Universal Service Administrative Company Rural Health Care Program, which funds telecommunications and broadband for thousands of rural providers.

To learn more about federal efforts to advance telehealth, *Rural Roads* talked with England about his passion and OAT’s priorities.

Tell us about your interest in telehealth.

Early in my career at HHS/CMS, I was asked to manage a demonstration of how Medicare might cover telemedicine. I quickly discovered the potential for broadband to multiply access to advanced health care. I also discovered the problems of doing that with site-based reimbursement and licensing systems that did not consider patients and providers being at different locations.

As an engineer and a lawyer, I was fascinated by these challenging problems, which we are still trying to solve today. Initially, telehealth was primarily a means to improve rural access to care, but we are now seeing that telehealth can provide more efficient, more convenient and sometimes better quality care, thanks to reduced travel by patients and providers, leading to more timely care delivery.

Why does rural health matter to you?

It is easy to forget when you live within 20 miles of five major hospitals that much of America does not have such access.

But every time I buy food, gas or many of the resources essential to daily life, I am reminded that much of the strength of our cities comes from the strength of rural America.

So I view advanced health care services as one product that urban is good at. Telehealth is a practical, virtual way to transport urban health care access to rural Americans.

What are the biggest challenges in expanding rural telehealth?

Reimbursement and licensure are the most obvious challenges. Ideally there would be no distinction between electronic and face-to-face visits, with patients and practitioner determining the best mode of care.

But health care resources are limited, and we must focus on what gives the best value: What are the services where electronic practice creates efficiency, quality or better access to care? That may not always be obvious to patients, practitioners or policy makers, so we can help highlight what makes the most sense.

Fortunately, the technology for telehealth has become incredibly affordable, and through programs such as Universal Service, broadband is also ceasing to be a limiting factor in telehealth service delivery.

As our children grow up using wireless technologies, they will expect and demand that to be their mode of health care.

But the challenge is us baby boomers who will overwhelm the system in our old age if it does not get more efficient. We need to create telehealth technologies that are easy for patients and providers to embrace, that will allow us to age at home and in our communities with electronic access to the services we need.

What are your goals for the office?

We have stories of how telehealth has saved lives or provided quality or cost-effective access to care in specific instances, but we’re just starting to aggregate

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such stories into controlled studies to drive evidence-based reimbursement policy.

Through the grants we fund, we have been collecting information on telehealth service delivery, but our data is not sufficient to drive hypothesis on what is really effective. And it lacks ready access to help researchers inform policy makers on funding priorities. We hope to improve on that, in conjunction with HHS initiatives to use data to improve health care quality initiated by the Affordable Care Act.

We are also encouraging our grantees to experiment with new types or venues of telehealth service delivery. Again, that is so we can discover and have data to target barriers to efficacious use of telehealth.

For years we have been providing free information, training and technical assistance to networks and practitioners getting involved in telehealth, and we hope to expand and focus our work in that area to be an effective resource for the telehealth community. We

have also been funding work on licensure portability, to help resolve some of the complexities created by telehealth practice.


What excites you most about this work?

I get to work with wonderful people in the Federal Office of Rural Health Policy whose enthusiasm for improving rural health care is infectious.

I also get to work with brilliant telehealth providers in our pool of grantees who are at the cutting edge of telehealth practice and who are leading solutions to the issues I've mentioned.

As an engineer, I am constantly amazed by the technologies I see deployed in telehealth. Some are things we thought were nearly impossible when I was in school. Of course, we have not yet created the medical tricorder for a full body scan and repair of injury with a single pass, but some handheld devices are starting to resemble that.

It is an exciting time to be in telehealth because we're at the cusp of revolutionizing care delivery, much as the cell phone revolutionized how we communicate with social media.

Most importantly, I hope the efficiencies in care delivery we are introducing through telehealth will ensure Medicare is still around when I start to need it. 



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Cardiac rehabilitation is just a phone call away

Rural veterans receive guidance to improve health

By Angela Lutz



Kariann Drwal

For many rural veterans, heart disease can “turn their life upside down,” says Kariann Drwal, a health science specialist at the Veterans Rural Health Resource Center in Iowa City, Iowa.

“It’s a scary time for them if it’s their first diagnosis, they just had surgery, or they’ve been prescribed new medications,” she explains.

Cardiac rehabilitation can help veterans with heart disease – specifically those who recently had a heart attack, coronary bypass or a stent placed – get back on the road to wellness.

Following a cardiac event, U.S. Department of Veterans Affairs (VA) patients are advised to undergo a three-phase cardiac rehabilitation process. Phase two is a medically supervised outpatient program that begins following discharge to slow or even reverse the progression of the underlying hardening and narrowing of the arteries.

Studies show that patients who complete a phase two cardiac rehabilitation program can increase their life expectancy by up to five years and have 27 percent lower cardiac death rates, 25 percent fewer fatal heart attacks, 21 percent fewer nonfatal heart attacks and an improved quality of life.

But rehab is often an intensive process, requiring multiple weekly appointments. And many VA facilities do not have on-site cardiac rehabilitation services.

Also, specialists in rural communities nationwide are often few and far between, which creates barriers for rural veterans, such as geography, travel, childcare and time off work, Drwal says. That’s why she helped start the Home-Based Cardiac Rehabilitation (HBCR) program, which is based in the VA Iowa City Health Care System.

HBCR began with support from the VA Office of Rural Health (ORH)

in 2010 and was identified as an ORH Rural Promising Practice in 2015, giving HBCR the funds and support to expand and address barriers rural veterans face when trying to access care. HBCR programs are now available at 19 VA sites across the country.

A nationwide effort since 2014, the Rural Promising Practice program supports innovative programs that address challenges rural veterans face when trying to access care and services, according to ORH. Programs are carefully evaluated, and the strongest are designated Rural Promising Practices.

According to ORH, Rural Promising Practices have four primary goals: increase access to care and services for rural veterans and their families in the communities where they live; share operational and clinical knowledge with providers who serve rural veterans; mentor people to implement Rural Promising Practices; and contribute to long-term improvements in rural care and services delivery.

“A lot of people have this stigma that patients can’t make changes because they’re set in their ways, but that’s not true.”

Kariann Drwal, Veterans Rural Health Resource Center health science specialist


HBCR meets these goals by working with rural veterans via its 12-week, home-based program, which offers individualized guidance and counseling on exercise prescription, heart-healthy nutrition, medication adherence, smoking cessation, and stress management related to heart health. Drwal says the majority of participants complete the program.

“Generally patients seem very pleased that it’s something they can fit and tailor to their schedule and that they can do in their own home,” Drwal says. “I think patients really like the one-on-one calls because

it's just them and a provider. For some of our patients who have co-morbidities or mental health issues, that one-on-one time is really valuable."

Drwal says VA aims to expand HBCR and perhaps find ways to incorporate a similar model to treat other disease populations.

She also hopes the program's success and high satisfaction rates help shift the perception that patients who seem "set in their ways" are capable of making healthy lifestyle changes.

"A lot of people have this stigma that patients can't make changes because they're set in their ways, but that's not true," Drwal says. "Seeing patients take that small step of taking their medication how they're supposed to, asking questions, getting active, eating well or stopping smoking – and occasionally seeing a patient who does all that – is rewarding." 

Promising practices

To be identified as a Rural Promising Practice by the U.S. Department of Veterans Affairs' Office of Rural Health (ORH), a program must meet the following criteria:

- Improvement in access to care
- Evidence of improved direct program impact or clinical results for rural veterans
- Patient, provider and/or caregiver satisfaction
- Return on investment via reduced costs of care, but not at the expense of quality
- Operational feasibility and replicability at other facilities or service sites
- Strong partnerships or working relationships that maximize efficiency or effectiveness

Learn more about ORH's Rural Promising Practices at ruralhealth.va.gov.

And hear about VA initiatives impacting rural clinics and hospitals at NRHA's Rural Health Clinic and Critical Access Hospital Conferences Sept. 20-23 in Kansas City. View the full agenda and register today at RuralHealthWeb.org/kc.



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Rural hospital that nearly closed twice now thriving

How engagement saved access

By Hervey Davis with Pat Schou



Hervey Davis



Franklin Hospital

Of the many challenges rural hospitals face today, the most heart-wrenching is, “Can we keep our doors open?”

Our hospital was on the chopping block twice, but hospital board, community, state and national diligence — and cooperation — saved local access to health care.

Today, Franklin Hospital is fully operational, financially secure and growing. We serve as an example that when all looks bleak for a small, rural hospital, there is hope.

A southern Illinois public hospital located in the small, economically depressed rural community of Benton, Franklin Hospital’s first near-closure threatened 20 years ago, before today’s cycle of rural hospital struggles began.

But our story isn’t old news; in fact, I believe the steps to our success can help rural hospitals in trouble today.

The struggle

Benton, population 7,000, is the county seat of Franklin County, population 39,000. The hospital competes with five prospective payment system hospitals, two 25 miles to the north, two 20 miles to the south and one 35 miles away in the college town of Carbondale. There are nine critical access hospitals (CAHs) within a 50-mile radius. The CAHs compete for medical and technical staff but tend not to compete for patients.

The county suffers from high unemployment and a large indigent population. As a result, a third of Franklin County patients are either covered by Medicaid or are uninsured. This directly influences the payer mix of the hospital.

Until about 1990, jobs in southern Illinois were plentiful due to large, local deposits of high-sulfur coal. The Clean Air Act Amendment of 1990 caused utility

companies to stop buying the coal. Mines closed, and jobs were no longer plentiful. Profitable operation of hospitals in the area became difficult. In fact, in 1995, the Franklin Hospital District Board was told by its auditors that, absent an influx of cash, the hospital would close. Fortunately, Southern Illinois Healthcare (SIH) had, at that time, as part of its mission, horizontal integration of the area's health care market. SIH presented a management contract, which was signed with Franklin Hospital in October 1996. First closing averted.

“Revenue growth is important in keeping a hospital viable, but we have never shifted from the mindset of our tightest budget days, believing it is equally important to proactively control expenses.”

Unfortunately, many small, rural hospitals suffered under the federal prospective payment system in the late 1990s (before institution of the CAH program), and SIH incurred losses of more than \$10 million.

Five years after saving us from closure, SIH leaders realized Franklin Hospital's operations were not sustainable. In 2001, SIH informed the Franklin Hospital Board that it would no longer manage and operate the hospital. The board then tried to sell the hospital through a broker, but there were no takers due to the area's financial history.

By spring 2002, Franklin Hospital owed large management fees to SIH and had no access to funding to remain open. Hospital board members, thinking there was no other choice, voted to close the facility. Distraught community members contacted the Illinois Department of Public Health (IDPH) seeking another option. Two weeks later, after IDPH helped commission a financial feasibility study, the Franklin Board again voted – this time to remain open. In the four months that followed, the hospital stripped

services to the bare minimum, downsizing to two beds, keeping only the emergency room and essential services open. A loan for operating capital was secured.

Through hard work and sheer tenacity, the hospital reassessed and revamped. With time, full operations were restored, and despite the region's continued economic hardships, hospital service lines and our associated clinic have grown.

Access for our neighbors was pared down, but never lost. This is a key element for struggling hospitals to bear in mind today.

What worked?

Bottom line, bringing in the right leadership and the fortuitous alignment of the right partnerships made all the difference. Working with the Franklin Hospital Board, the community leaders contacting IDPH found the timing to be perfect. IDPH's federal plan to implement the CAH program had just been approved, and an experienced rural hospital consultant was appointed to meet with Franklin Hospital's staff.

Together, the hospital and key community stakeholders were able to recruit a seasoned chief executive officer with the desired necessary financial and leadership skills. (I humbly note that being recruited for this role warms me to this day.)

The task at hand was to restart hospital operations and manage with an unbelievably tight budget. As a newly hired CEO, not only was I tasked with rebuilding the medical staff, but also with reopening basic hospital departments and once again generating community confidence in the hospital and its medical providers.

I'm forever grateful for the working relationships established while serving as a CEO in other small, rural Illinois hospitals. In rebuilding Franklin Hospital, these relationships proved invaluable. With our administrative team, new relationships with both the community and state agencies were forged.

Everyone had to be on the same page, being creative and committed to the long-term success of the hospital. During this period, the Franklin Hospital Board gave me its support and acted on the tough decisions necessary to restart an operation from scratch. The community was fully behind its hospital, recognizing not only the need for health care access, but also its role as an economic catalyst for maintaining and growing local businesses.

Fast forward to 2016

Today, Franklin Hospital is still serving the Benton community. Our emergency room volume is about 6,700 patient visits per year, down from 9,600 in 2004. Rural health clinic visits for 2016 are projected at slightly

continues on page 36

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more than 23,000, up from zero in 2004.

Franklin Hospital has been able to shift many unnecessary, avoidable emergency department visits to its clinics. This reduces overall cost of care by moving provision of care to less expensive outpatient modalities. (Emergency room registration costs a patient or an insurance company more than \$2,300, whereas a rural health clinic registration comes in at around \$136.)

Between 2005 and 2015, hospital revenue grew from about \$16.5 million to almost \$42 million. Expenses grew at a smaller rate than the corresponding revenue. For example, between 2010 and 2015, revenue grew by 27 percent and expenses by 16 percent.

Revenue growth is important in keeping a hospital viable, but we have never shifted from the mindset of our tightest budget days, believing it is equally important to proactively control expenses.

Finally, payer mix has radically changed through the years. In 2010, nearly 9 percent of revenue generated was for “self-pay” or uninsured patients. By the end of 2015, the percentage had dropped by roughly 6

percent, and the total charges for that piece of the pie dropped by nearly half, if adjusted for inflation.

“The community was fully behind its hospital, recognizing not only the need for health care access, but also its role as an economic catalyst for maintaining and growing local businesses.”

Medicaid and “other” (primarily commercially insured) patients grew substantially. Part of the growth came from the state of Illinois’ willingness to utilize Medicaid expansion to fulfill Affordable Care Act requirements for covering the health care needs of

Events that saved a rural hospital

The most critical events helping Franklin Hospital stay open and expand had to do with financing and reimbursement factors, says Hervey Davis, the hospital’s CEO:

- The United States Department of Agriculture provided a \$4 million loan for operating capital to kick start hospital operations.

Normal USDA provisions for approving loans were waived; typically, operating capital loans are not made by the USDA. Without this operating capital, the hospital would not have been able to take those first steps away from closing its doors.

- The hospital was certified as a critical access hospital.

This provided cost-based reimbursement for the facility from the Medicare program. Between the cost-based reimbursement on the Medicare side of the ledger and the 20 percent of business that was covered by commercially insured patients, there was enough cash to operate the hospital for the first few years.

- In 2010, the Illinois legislature passed a law that gave CAHs cost-based reimbursement for outpatient Medicaid patients. This provided roughly \$1 million

in additional reimbursement for Franklin Hospital, increasing from about 10 cents on the dollar to about 22 cents on the dollar.

- The state of Illinois made the decision to expand the Medicaid program. This, for Franklin, caused the “self-pay” business of the hospital to shrink from about 9 percent of total charges to just under 4 percent. Adjusted for inflation, this equaled a decrease of about 50 percent of previous expectations.
- A well-qualified, dedicated, creative management team and board of directors worked in tandem.
- In addition to receiving necessary reimbursement from governmental sources, rural hospital operations were carefully overseen. Expenses were controlled, and revenue growth was pursued.

Gain effective strategies to improve rural hospital and clinic revenue at the National Rural Health Association’s Rural Health Clinic and Critical Access Hospital Conferences Sept. 20-23 in Kansas City. Go to RuralHealthWeb.org/kc to register today.

And visit RuralHealthWeb.org to learn about NRHA’s bipartisan Save Rural Hospitals Act to preserve federal funding and create a path forward for the hundreds of struggling rural hospitals.

street smarts

the indigent. A portion of the growth came because of successful recruiting efforts on the part of the hospital.


Overall, the effect on the hospital's viability has been dramatic and a real improvement for our outlook. We attribute a great deal of our success to the state's willingness to expand Medicaid; in states where the Medicaid program was not expanded, many rural hospitals like ours have closed.

The result of teamwork

Patients now have the option to locally access a great primary care system (hospital plus rural health clinics). Our neighbors are receiving primary care in the appropriate venue. This keeps them out of the emergency room and inpatient beds because, overall, they are getting good, solid preventive treatment in their doctors' offices close to home. This saves the state of Illinois the cost of transporting Medicaid patients to facilities 25 miles or more outside the county, and long term, it will save millions of dollars in the cost of providing chronic condition care to these patients. And, again, our hospital is showing an excess of income over expenses.

“Access for our neighbors was pared down, but never lost. This is a key element for struggling hospitals to bear in mind today.”

While we will never be immensely profitable, our hospital is able to make it on its own and serves as an important economic engine for the area. We have come full circle, and the 360-degree engagement of all entities – from our local hospital board to our patients, the community as a whole, and state and federal agencies – tells our story.

It took all of us, working together, to bring Franklin Hospital back home from near closure. We share our story to help other rural hospitals. Our message is, “You, too, can keep your doors open. You can find solutions. Continuing to bring health care home to your citizens is possible, and it is priceless.” 

Hervey Davis became CEO of Franklin Hospital in 2002. Pat Schou is executive director of the Illinois Critical Access Hospital Network. This article originally appeared in the Arkansas Hospital Association's spring 2016 magazine.

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“Giving Some Advice” by Susan Guin

Grand prize winner

“My sons on our farm. They’re 22 months apart, so Joey felt like it was his role to explain things to Jake all his life.”

Susan Guin took the winning image of the 2016 Rural Lens photo contest on film. Twenty years ago.

“I’ve been making pictures for as long as I can remember,” says the nurse practitioner, associate director of the University of Alabama Rural Scholars Programs and associate professor of community and rural medicine. “When digital photography came out, my husband was so excited because I wouldn’t be taking bags of 35mm film to be developed all the time.”

The photo entered in the fourth contest organized by the National Rural Health Association and the Rural Health Information Hub is one of thousands of images Guin says she captured of her sons, now 27 and 25, on

their farm in Coker, Ala.

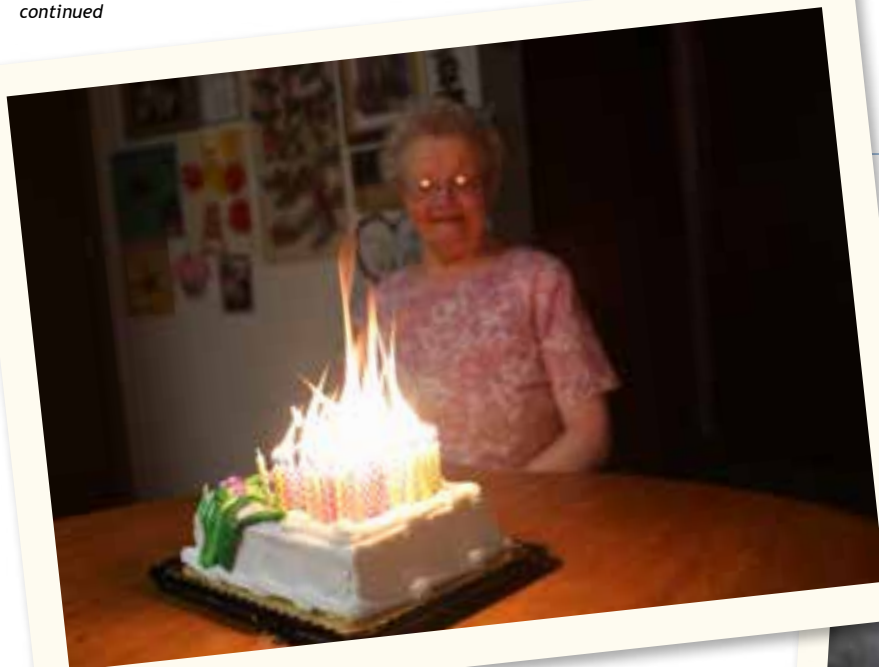
“They were surprised and are asking for royalties,” she says, laughing. “I told them we’re going to get them in jeans and plaid shirts and back on that rock, and I’ll take that picture again now. We’ve had a lot of fun with this.”

Guin says she’s lucky to live and work in such a photogenic area.

“Rural life gives you ever-changing options for pictures,” she says. “I’m all over Alabama’s backroads for work, and there’s always something worth stopping to take a picture. And if I’m at the house, I can pick up my camera, walk out in the woods and start taking pictures of leaves or mushrooms or acorns and be happy doing it.”

Visit facebook.com/ruralhealth to view all the entries, including Guin’s photo of a bobcat, and for the latest in rural health news and events.

continues



“Happy Birthday, Grandma Palmer” by Karl Palmer

Rural Health winner

“My Grandma Palmer turned 99 this May. She lives independently in an apartment and is quite healthy. She grew up during the Great Depression and was a dairy farm wife for many years. When asked, ‘How do you live to be 99?’ her answer is, ‘I don’t drink, I don’t smoke, and I don’t swear. And I laugh a lot.’ We honored her with a full 99 candles on her cake lit by propane torch.”

“After the Rain” by Karl Palmer

Landscape winner

“I captured this photo early in the morning on my way from a client visit to the airport. There were heavy rains in the night toward Portland and heavy wet snow where I had been staying. Nobody on the roads, so I had the falls to myself. Magnificent.”



“Big Win” by Lisa Guerra

Community and People honorable mention

“This boy has participated in the Gage County (Nebraska) Fair every year showing horses and has given his all in hard work and heart. He was surprised this year with a trophy, his first, to award his efforts and enthusiasm. His excitement and appreciation was felt by all.”



“Mountain Sunrise” by
Douglas G. Puffenbarger
Landscape honorable mention

“Summer sunrise on Allegheny Mountain”

“Learning about Beaufort
County’s health ranking”
by Nora Ferrell

Rural Health honorable mention

“Kim, an X-Ray technologist, Proud Equestrian Program (PEP) volunteer, golfer and football mom”



“Autumn colors over the
lake” by Adam Newman, MD
Landscape honorable mention

“On my way to take my daughters to dance and saw these trees and the lake. Wow!”



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Beginnings & Passages



Austin Gillard, his wife, Michelle,
and son, Gavin

“What could be more gratifying than knowing you are having a positive impact on the lives of your friends, neighbors and community?”

Driven to serve

By Austin Gillard

What an exciting time to work in rural health care!

It seems that every week a new bill is introduced, a new policy is implemented, or CMS is asking for feedback on a proposed rule. Many of these political decisions change the way we in rural America function and operate our hospitals and clinics. At times it can be overwhelming, but with the correct poise and execution, we can flourish.

My rural health journey started in 2013 after presenting the idea of a “rural health care administrative fellowship” to several rural hospital CEOs in Kansas and Missouri. Fortunately, Susan Page, CEO of Pratt Regional Medical Center in rural Kansas, was willing to take me under her wing to teach me about the intricacies of rural health care and hospital operations.

After just a few weeks in Pratt, I saw the true impact our rural hospitals have on the communities we serve. From that point forward, I knew how rewarding this career path would be, and I have not looked back.

I chose to work in rural health care to serve others. It is that simple.

In a rural environment, your decisions at the top directly affect the population you serve. I wanted to help turn around struggling hospitals and give them a direction for the future. In return, these hospitals will have the ability to continue serving others in our rural communities. While this is not an easy task, I have truly enjoyed the experiences working with passionate employees, dedicated medical providers and committed board members.

Challenges arise on a weekly, if not daily, basis in rural health care. Most of the challenges are financial in nature, but that can easily be overcome with the proper growth strategy. One of the great advantages of being a small organization is the ability to turn the “ship” without meeting after meeting. This has helped our team implement strategies and look for opportunities, all while focusing on the patient experience.

Every day is rewarding in rural health care. What could be more gratifying than knowing you are having a positive impact on the lives of your friends, neighbors and community? I value our rural communities and view them as a vital resource to America. I am fortunate to be able to work in rural.

Austin Gillard is the chief executive officer of Clay County Medical Center, a critical access hospital with three rural health clinics and more than 325 employees in rural Kansas. Gillard joined the National Rural Health Association in 2013.

Innovative rookies and seasoned professionals share their experiences.

“Serving in a rural community helps with building relationships and teamwork because those we care for are our neighbors, families or friends.”



Aspirus physician assistant Andy Tait and CEO Paula Chermiside at an annual snow-shoeing event, co-sponsored by the hospital

Hospital leader enjoys community connections

By Paula Chermiside

I grew up in a small town and really liked the close-knit community I experienced as a child.

For 24 years as a rural health professional, I have been passionate about finding ways to connect or develop services to meet the needs of others, both as a social worker and a health care administrator.

I was drawn to health care administration in a rural community because there are so many opportunities to make a difference for patients who entrust our organization with their care, as well as for the community.

It is fulfilling to be able to collaborate with providers, staff, community members and local organizations to develop programs and services patients either had to travel great distances to access or could not utilize due to not being able to travel.

Serving in rural communities has challenges to overcome, such as provider and staff recruitment. However, it is so exciting and fulfilling when a new member joins our team, shares our vision and changes the life of a patient.

I have found that serving in a rural community helps with building relationships and teamwork because those we care for at the hospital are our neighbors, families or friends.

My current organization, Aspirus Grand View, a critical access

hospital and clinic located in the western part of the Upper Peninsula in Michigan, is an integral part of our community and has had the opportunity to collaborate with other organizations to meet the health care needs of our region.

Members of our team of providers, employees and volunteers take part in athletic events and community gatherings to educate our neighbors about health prevention and promotion, as well as care for patients in need.

I have really enjoyed the snow-shoeing and cross-country skiing events since relocating to the Upper Peninsula a few years ago. I always had to travel to ski before and had never snow-shoed until I came here. Now I can snow-shoe and cross-country ski right out my front door.

And I quickly discovered that our community loves playing together in the snow, which has really helped me meet community members, build relationships and network with other leaders.

Paula Chermiside became CEO of Aspirus Grand View in Ironwood, Mich., in 2013. She joined the National Rural Health Association in 2015. A physician from Aspirus will present at NRHA's Critical Access Hospital Conference Sept. 21-23 in Kansas City. Visit RuralHealthWeb.org/kc for details.

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



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Kansas City, here you come

with NRHA member Matt Heyn

Side trip



Union Station's Body Worlds exhibit

Ever since Matt Heyn relocated to lead Ransom Memorial Hospital, he's been exploring Kansas City in his spare time.

The hospital in rural Ottawa, Kan., is about 30 minutes from all KC has to offer.

"I'm lucky to be close to Kansas City, where there are so many great places to visit and things to do," Heyn says.

Some of his favorite KC spots:

Kansas City's **Union Station** is across the street from the National Rural Health Association's Rural Health Clinic and Critical Access Hospital Conferences. Attendees should make time to take in the **Body Worlds** exhibit, on display during the events. The 1914 building's architecture and restaurants are also worth a visit.



Nelson-Atkins Museum of Art

Kauffman Stadium is home to the Kansas City Royals – and some pretty impressive fountains. Arrive early for NRHA's September conferences to see the World Series champs take on the White Sox.

See why Yelp users ranked Kansas City's **Nelson-Atkins Museum of Art** No. 1 in the country. From ancient Egypt to contemporary art, it has

something for everyone. And it's free.

No visit to KC is complete without getting your fill of barbecue, and there's no better place than **Joe's Kansas City Bar-B-Que**. Get the ribs or the legendary Z-man sandwich. It's smoked brisket, smoked provolone cheese, onion rings and barbecue sauce on a Kaiser roll. You'll see why chef and author Anthony Bourdain named Joe's one of the 13 places to eat before you die.



Arabia Steamboat Museum

The **Arabia Steamboat Museum** is an impressive display of a sunken steamboat and features the largest single collection of pre-Civil War artifacts in the world.

And stick around after the conferences to see the Kansas City Chiefs take on the New York Jets at **Arrowhead Stadium**, the loudest in the NFL.



Matt Heyn joined the National Rural Health Association in 2010. He became Ransom Memorial Hospital CEO in 2014.

Best place for best practices

Take advantage of the educational and networking opportunities designed for rural clinic and hospital professionals and board members during NRHA's Rural Health Clinic (Sept. 20-21) and Critical Access Hospital (Sept. 21-23) Conferences in Kansas City.

They're NRHA's fastest-growing events for a reason.

Visit RuralHealthWeb.org/kc for details and to register.

Rural health leaders convene in California

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

The 12th annual clinical event attracted those practicing on the frontlines of rural health care, quality and performance improvement organizations and coordinators, students and others to Oakland, Calif., in July.

"This was my first NRHA Quality and Clinical Conference, and I found the learning opportunity excellent," one attendee wrote in an evaluation. "The small size provided good opportunity for interaction both through networking and Q&As with speakers during sessions."

University of California Davis Betty Irene Moore School of Nursing professor Kupiri Ackerman-Barger, PhD, addressed attendees about bringing diversity into nursing education and promoting comprehensive access to care for rural populations while battling the nationwide rural nursing shortage during the keynote presentation.

Just prior to the Rural Quality and Clinical Conference, more than 20 state rural health associations (SRHAs) were represented at the leadership event, including executive directors, board members and representatives from longstanding and newly developing SRHAs.

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

"The leadership conference is the best event for state rural health association members to network and share best practices. The environment is comfortable and relaxed, and valuable information, as well as contacts and friendships, can be taken from this event," says Tina Elliott, Indiana Rural Health Association community relations director. "This is my 13th leadership conference, and I learn so much each year that I share with IRHA staff."

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

Plan now for the 2017 SRHA meeting July 11-12 and the 13th annual Rural Quality and Clinical Conference July 12-14 in Nashville.



Conference attendees dine in nearby San Francisco.



Above: NRHA State Rural Health Association Leadership Conference attendees gather outside to soak up some California sun.

Left: Federal Office of Rural Health Policy senior health policy advisor and 2008 NRHA president Paul Moore addresses attendees at both conferences.



More friendly faces

Continue your trip down Memory Lane or see what you may have missed in California with more photos from NRHA's Oakland conferences and other NRHA events at facebook.com/ruralhealth.



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Remembering a pioneer in rural quality

By Wayne Myers



Left: Forrest and Pat Calico with a University of Kentucky College of Nursing student who received the scholarship they created. Above: Forrest Calico surrounded by family.

Though Forrest Calico died too soon at age 75 in June, he packed a lot of living and productivity into those years.

When I met him in Hazard, Ky., in the early 1990s he had accomplished a lot. He'd made it through college and medical school, quite an accomplishment for the child of a landless family who rented ground to farm and survive.

Upon graduating from medical school in 1966, he completed a family medicine residency. That was not

ordinary. Family medicine was brand new, more of a concept than a career path. Only smart, confident people took that gamble. Forrest would later repay the specialty by directing an excellent residency program in his home state of Kentucky.

He had also completed his career in the Air Force. He never talked about his days as flight surgeon for "Area 51," the secret test facility in the Nevada desert, officially nonexistent until 2005. You can bet the Air Force chose its best people to staff that sensitive program.

My acquaintance with Forrest began circa 1992. He was the newly appointed, and first, medical director of Appalachian Regional Healthcare (ARH). Within months, he became its CEO.

ARH, a private nonprofit, began as the medical care program of the



Forrest Calico shows one of his grandsons a book written by his cousin and namesake.



NRHA member George Miller introduces Forrest Calico.

United Mine Workers union in 1955 with hospitals, clinics and home health agencies in the poorest, most coal-dependent towns of Kentucky, West Virginia and, at that time, Virginia.

He instituted an intensive program to modernize the 40-year-old hospitals and clinics. He rebuilt local people's confidence and pride in the facilities and a system that had become pretty tired. The Harlan hospital went from impending closure to requiring expansion within a couple years.

"He was a good and faithful servant of rural people."

Wayne Myers


When Forrest left ARH in 1999, I immediately asked him to come work for the Federal Office of Rural Health Policy (FORHP), betting that I could find a way to hire him. He was the first person in FORHP with experience actually running rural health care programs.

The Institute of Medicine of the National Academy of Sciences issued its milestone report on medical errors, "To Err is Human," in the summer of 2000. This and following studies made Americans aware that a lot of people were dying, and costs rising, because of medical, nursing and hospital management errors, starting the current emphasis on quality.

Forrest saw the opportunity in this crisis. He found the money to support the Institute of Medicine in a parallel study of rural health care. It was finished in 2005 and published under the title, "Quality Through Collaboration: The Future of Rural Health Care." The study was chaired

by Mary Wakefield, PhD, who would go on to direct the Health Resources and Services Administration, and, more recently, serve as acting assistant secretary of the Department of Health and Human Services.

On returning to rural Kentucky a decade ago as owner of the farm his family rented in his childhood, Forrest did studies of best rural care approaches and practices for the National Rural Health Association, volunteering as the nonprofit's senior advisor on quality in 2006 and helping launch NRHA's rural quality initiative. He also served the Foundation for a Healthy Kentucky, and generally continued to contribute to his passion of improving rural health.

He was a good and faithful servant of rural people. 



Wayne Myers, MD, is a retired pediatrician and rural medical educator. He directed the Federal Office of Rural Health Policy from 1998 through 2000 and was president of the National Rural Health Association in 2003.

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Members on the move

Med school celebrates 40 years of graduates



James Boulger

June 2016 marked the 40th anniversary of the first awarding of the doctor of medicine degree to students who began their medical training at the University of Minnesota Duluth.

The state legislature funded the program in 1969, and recruitment of faculty and staff for the new school began in 1970.

Curricular efforts were designed to best select and educate students who were interested in rural and small

community family practice. In 1972, the School of Medicine Duluth opened its doors to the first class of 24 students, including Alan Johns, MD, who now serves as associate dean for curriculum, medical education and technology for the medical school in Duluth.

“The Duluth campus has attained all that was promised to the legislature – and more than most expected it would,” says James Boulger, PhD, University of Minnesota Duluth professor of family medicine, behavioral health and population sciences.

- Nearly 2,000 physicians have been trained and graduated from the medical school.
- More than 48 percent of all graduates have selected family medicine as their specialty. In the 2016 class, 38 percent of the graduates selected family medicine, a rate four and a half times the national average for graduating doctors.
- More than two-thirds have selected family medicine, pediatrics or internal medicine/primary care.
- The retention rate for physician trainees following residency training is high: 62 percent of those who are in practice are in Minnesota, and 71 percent practice in Minnesota or Wisconsin.

- In Minnesota alone, there are 508 graduate practitioners of family Medicine (57 percent) and 465 other specialists who started in Duluth.
- Most graduates are in rural and small Minnesota communities. More than 60 percent are in Minnesota, and (of all alumni) 49 percent practice in communities with populations smaller than 25,000.
- More than 100 Native American physicians have graduated after beginning their medical studies in Duluth. When the school opened in 1972, there had been eight Native American physicians trained in the history of the United States up to that time.

“Congratulations are in order to all the patients who have helped our students learn the science and art of medicine,” Boulger says.

He joined the National Rural Health Association in 1986 and received the association’s Outstanding Educator Award in 2003.

Dedicated rural nurse, educator receives prestigious award



Fran Feltner

Fran Feltner, University of Kentucky Center of Excellence in Rural Health director and College of Nursing instructor, recently received the Paul Mason Memorial Award.

Presented during the 68th Annual Conference of the Kentucky Public Health Association, the award recognized Feltner’s 40-plus years in rural health care, including her work with Kentucky Homeplace, a nationally recognized community health worker program.

The award is named for Paul Mason, a former Kentucky state representative who championed

legislation for and advocated on behalf of underserved, uninsured and underrepresented populations.

"I am a long-standing member of the National Rural Health Association," Feltner says. "This network has allowed me and team members to share and assist others in building and improving models that work with the goal of improving the health of the nation."

Feltner joined NRHA in 2001, and Kentucky Homeplace received the association's Outstanding Rural Health Program award in 2008.

Experienced hospital CEO leads new facility



Jeanine Gentry

Jeanine Gentry recently became CEO of Steele Memorial Medical Center in Salmon, Idaho.

In her new role, Gentry will be leading the critical access hospital as well as a rural health clinic, which just broke ground on a new facility that will expand primary care and specialist services to the community.

Prior to moving to Salmon, Gentry served as CEO of two critical access hospitals in Oregon. During that time, she oversaw the construction of a replacement facility and a major addition/renovation.

"The National Rural Health Association has always been a key partner in my rural health career," Gentry says. "They provide information about a variety of topics, excellent education, and serve as a key advocate on policy issues at the state and national levels. My work has been

more effective because I have NRHA to walk alongside me and help me in each step."

Gentry joined NRHA in 2011.

Member participates in political convention

Kurt Hahn was a California delegate to the Republican National Convention in July.

Hahn, Northern California Healthcare Authority interim executive director, has worked with the GOP House Doctor's Caucus in his efforts to improve access to care for rural patients.

"As a National Rural Health Association member, I have used various alerts and other materials to pitch a rural perspective to Congress," he says. "Absent ongoing vigilance, rural America is at risk of losing its access to quality care through ill-conceived actions by Washington bureaucrats."

Hahn joined NRHA in 2012.

The National Rural Health Association is a non-partisan organization.



Kurt Hahn

Award-winning hospital gets new CEO

Matt Shahan recently became CEO of West River Health Services in Hettinger, N.D.

In his new role, Shahan will focus on maintaining current services and expanding where necessary to provide quality care to the residents in the network's 20,000 square-mile service area.

He previously served as director of IT and clinic administrator at Glendive Medical Center in Montana.

"While I am new to National Rural Health Association membership, our organization has been rewarded twice in recent years as a top 20 critical access hospital," Shahan says. "This designation has brought pride to our organization and a heightened sense of trust within our service area."

Shahan joined NRHA in 2016, and West River Health Services joined in 1984.



Matt Shahan

continues on page 60

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NRHA members join National Rural Health Resource Center board



Jesse Tischer



Gary Wingrove

Jesse Tischer, president of Sanford Health Network in Sioux Falls, S.D., and Gary Wingrove, president of the Paramedic Foundation in St. Cloud, Minn., recently joined the National Rural Health Resource Center board.

The center provides technical assistance, information, tools and resources for the improvement of rural health care.

As board members, Tischer and Wingrove will help guide and shape the center's strategic direction and ensure it's meeting the needs of rural communities through collaboration and innovation.

"Throughout my career, the National Rural Health Association has helped to validate that I am not alone in the work that I do, nor am I alone in the challenges that I or my organizations have faced," Tischer says. "I view NRHA as another partner in advocating rural, promoting rural and helping to advance communities to the next stage of rural health care."

"My immersion in NRHA led me to become the first paramedic to be president of a state rural health association, a distinction that I cherish," Wingrove says. "EMS personnel are the only health care providers in the majority of rural communities, and they will become even more important to more communities as some critical access hospitals transition into providers of only outpatient services. EMS is the final medical safety net for most of rural America."

Tischer joined NRHA in 2015, and Wingrove joined in 1998. The National Rural Health Resource Center has been a member since 2001.

NRHA news

NRHA CEO invited to Clinton Global Initiative meeting

National Rural Health Association CEO Alan Morgan attended the Clinton Global Initiative meeting in Atlanta in June as part of NRHA's continued commitment to training rural community health workers.

"Our ongoing commitment to action as part of the Clinton Global Initiative really helped set the stage for initiating NRHA's community health worker training network and continues to help us build strong partnerships for carrying this mission forward," Morgan says.

In 2011, NRHA began training community health workers as a way to address access to care along the U.S.-Mexico border. In five years, the effort has evolved into the Rural Community Health Worker Training Network that spans the border region and also includes partnerships in Appalachia.

With funding from the Verizon Global Corporate Citizenship in 2013, NRHA established partners in the Southwestern, Southern, Midwestern and Eastern regions of the United States through the incorporation of a technological training module.

The purpose of the trainings has been to provide skill-building sessions in leadership, coordination, policy and pressing health concerns in the various regions.

NRHA is currently working in rural Georgia, where community health workers are working with Type II diabetes patients by incorporating the use of technology to help track their glucose and fitness levels to help improve health outcomes.

NRHA seeks volunteer leaders

The National Rural Health Association is seeking volunteers for leadership positions within its Board of Trustees and Rural Health Congress.

"NRHA's strength and success is largely the result of leaders, members and staff working together with a common purpose to ensure the broadest range and highest quality of health care services for rural America," says NRHA CEO Alan Morgan. "Our annual nomination and election process is key to

Send your career updates
to editor@NRHArural.org.

the ongoing need to maintain the flow of our volunteer leadership.”

The Nominations and Credentials Committee is soliciting nominations for several NRHA leadership positions that will begin Jan. 1, 2017.

Information on nominations, the leadership structure of the Board of Trustees and its development path are available at RuralHealthWeb.org/leadership.

Nominating, serving as and voting for NRHA leaders are privileges for dues-paying members. If you are unsure of your membership status, email membership@NRHArural.org.

Interns value lessons learned at NRHA



NRHA summer interns

Given the National Rural Health Association’s range of activities and programs, since 2005, its internships have allowed students to pursue a project in an area of interest to them while participating in the overall NRHA experience.

NRHA offers internships every semester and works with students to meet their internship requirements.

“I have long been passionate about rural health care issues and access, after experiencing the limitations of a rural health system at an early age,” says intern Katherine Hall. “While attending Texas A&M, I pursued all available opportunities to learn more about rural health care and the policies that affect it. This summer was amazing to share my experiences and gain more insight into the world of rural health care.”

Four students joined NRHA’s team in Washington,

D.C., this summer:

Sydney Crawford, University of Kansas, political science and international studies

Katherine Hall, Texas A&M University, master’s of public health

Hallie Nudelman, Ohio State University, public health and Spanish

Ada Pariser, University of Dayton, pre-medical sciences and psychology

Learn more, apply and share this opportunity at RuralHealthWeb.org/go/intern today.

NRHA, White House host annual rural philanthropy meeting

National Rural Health Association CEO Alan Morgan co-hosted the fourth annual Rural Philanthropy Meeting in May with the goal of strengthening current activities and leveraging regional and national relationships among foundations, researchers and federal partners.

Since 2012, NRHA, Grantmakers in Health, and the White House Rural Council have convened more than 120 public and private foundations, researchers and policymakers to discuss federal programs and foundation-led initiatives in rural areas.

“Throughout the meeting, many foundations emphasized the need for an overarching vision for rural health care in the future and the importance of thinking proactively about rural health care systems rather than reacting to changes in the landscape,” says Amy Elizondo, NRHA program services vice president.

NRHA members develop policy documents

National Rural Health Association members set the policies and positions the association advocates for at a national level by submitting potential policy positions for consideration.

The policy statements adopted by NRHA’s Rural Health Congress, which consists of a broad representation of members, represent an advocacy reflecting the mission and values of NRHA by highlighting issues important to the membership.

NRHA has published the following policy papers in 2016:

- American Indian and Alaska Native Health
- Definition of Frontier America
- Impact of Swing Bed Utilization
- Responsive Rural Health Delivery System
- Rural Communities in Crisis: Strategies to Address the Opioid Crisis
- Rural Public Health

NRHA’s policy paper about the opioid epidemic has garnered national attention, while John Gale, its principal author, was invited to speak at the United Nation’s Office on Drugs and Crime meeting in Austria in June.

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To read these and other policy papers and to participate in the process, visit NRHA's policy position page at RuralHealthWeb.org.

NRHA hosts 2nd annual Veterans Rural Health Initiative Meeting



Veterans Rural Health Initiative meeting participants

The National Rural Health Association hosted the second annual Veterans Rural Health Initiative in Washington, D.C., in June.

This meeting was held in collaboration with the Federal Office of Rural Health Policy, Veterans Affairs Office of Rural Health.

NRHA members who are veterans highlighted current regulations, barriers and best practices impacting access to care for rural veterans, both from the veteran perspective and the health care provider perspective.

"NRHA is proud to be leading this initiative for addressing rural veterans' care and enhancing access," says NRHA CEO Alan Morgan. "Through this collaboration, NRHA intends to continue to highlight rural veterans' issues through communications, education, policy and research for those who have served our country."

NRHA will be working with the members of this initiative throughout the year to highlight these issues and to coordinate rapid responses to address policy as opportunities arise.

If you are an NRHA member and a veteran, contact Laura Hudson at lhudson@NRHArural.org to become involved.



Tim Putnam and Nikki King

NRHA members represent rural health at Senate Rural Summit

National Rural Health Association members Tim Putnam and Nikki King spoke on the opioid epidemic and rural hospital closure crisis at the Senate Democratic Steering and Outreach Committee Rural Summit in June.

A rural hospital CEO and EMT, Putnam reminded attendees that when a

hospital is forced to close, there is no transition program (to a 24-hour emergency room, for instance), so communities are left without access to health care.

Putnam also discussed the importance of rural training tracks and that "we must grow and train our own" to ensure workforce security.

King gave a heartfelt testimony about her experiences growing up in rural Kentucky.

"When I left my rural community, my goal was to make rural communities more sustainable," she told senators.

She said while growing up in Appalachia, she witnessed people in her hometown dying of black lung and overdosing on opioids that were prescribed to them.

She spoke of more and more children being raised by people other than their parents due to drug abuse and the rising death toll of the current drug crisis.

NRHA staff and interns also attended the summit in D.C., which focused on improving the quality of life for rural Americans.

The event featured a keynote address from USDA Secretary Vilsack and remarks from multiple senators, including Joe Donnelly (D-Ind.), who said, "When rural America works, everything works."

NRHA leads community health worker trainings

The National Rural Health Association led two community health worker trainings in June in Tucson, Ariz.

NRHA collaborated with the Arizona Community Health Workers Association, the Southeast Arizona Area Health Education Center and the Arizona Department of Health Services to develop the agenda and sponsor several Arizona Community Health Workers Association Conference training sessions.

Noelle Wiggins, Multnomah County Health Department Community Capacitation Center director, conducted one such training focused on community health worker supervision.

More than 230 community health workers participated in the two-day Arizona conference.

And NRHA has trained nearly 600 community

health workers over the past five years. The association's next training will be in the summer of 2017.

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

Journal seeks editorial board members

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

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

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

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

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

Applications will be accepted through Oct. 13 at RuralHealthWeb.org.

Clinic, hospital conferences return to KC

Chart your facility's success by joining experts and colleagues from across the country for the National Rural Health Association's Rural Health Clinic (Sept. 20-21) and Critical Access Hospital (Sept. 21-23) Conferences in Kansas City, Mo.

Keynote speaker Thomas Graf, MD, Chartis Group national director of population health management, combines his understanding of economic, social and regulatory issues with clinical experience in bridging the unique perspectives provided by physicians, hospitals, payers, patients and employers.

continues on page 69



Donor corner

Sandra Pope has given generously to the National Rural Health Association's Rural Health Foundation and to the Rosemary McKenzie Legacy Fund every year since it was established to honor a longtime NRHA staff member.

Pope, West Virginia Area Health Education Center director, joined NRHA in 1992.

Rural Roads: Why is rural health important to you?

Pope: Rural is all I know. And there is not a whole lot you can do in West Virginia that does not have a rural aspect.

I've been involved with statewide rural health initiatives and programs for over 30 years, and I've met so many wonderful people. I love working directly with rural people. They are generally kind, smart and truly dedicated to the communities where they live or serve.

Rural Roads: Why have you chosen to provide ongoing financial support?

Pope: I believe in the mission of NRHA and the great work the staff does, and I believe you should support those causes you truly believe in.

The NRHA staff has been so good to me. Because of them, I've had many opportunities and experiences I probably would have never been exposed to. For example, they nominated me to serve on the Federal Advisory Committee on Interdisciplinary Community-Based Linkages. At that time, I knew very little about this committee. What an honor it was to be nominated by NRHA!

I support the Rosemary McKenzie fund because I want to honor her memory. Rosemary was a very outspoken and direct person who was truly dedicated to minority health. Her work in partnering with organizations and soliciting support for minority health was untiring. But, not only that, her personal commitment and dedication to each Health Equity Council member was exceptional. Rosemary was truly one of a kind.

I challenge anyone who has been involved with NRHA's Health Equity Council (formerly the Multiracial and Multicultural Health Council), or anyone who ever benefitted from Rosemary's assistance to make a donation today. Let's do all we can to keep Rosemary's memory alive.

NRHA thanks Sandra Pope for her ongoing contributions.

For more information and to help build a permanent endowment for rural leaders, visit RuralHealthWeb.org/donate. Donations are tax-deductible.

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Nicole Clapp, FACHE
President/CEO
Grant Regional Health Center



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mile markers

accelerating advocacy

Help NRHA stop the bleeding

Rural America is in the midst of a closure crisis as more hospitals shutter their doors, leaving small towns and vulnerable populations across the country without access to care.

Seventy-five rural hospitals have closed since 2010. And another 673 facilities — or one-third of rural hospitals — are at risk of closing.

The National Rural Health Association has worked with allies on the Hill to fight this growing crisis with the Save Rural Hospitals Act (HR 3225).

This bipartisan legislation would stop the bleeding and offer a new payment model to ensure access to emergency care and allow hospitals the choice to provide outpatient care that meets the

population health needs of their community.

“I encourage you to join me for the Rural Health Clinic and Critical Access Hospital Conferences to learn about how NRHA is fighting to protect your facility,” says Maggie Elehwany, NRHA government affairs and advocacy vice president. “We will continue to work tirelessly for you and your community, and we promise NRHA will be at the forefront as we fight for rural health together, making your voice louder on Capitol Hill. We look forward to seeing you in Kansas City soon.”

Visit RuralHealthWeb.org/kc for the full agenda and to register.



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*Individual hospital partner results vary

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Presenters will share effective practices, policies and information and provide insights and practical solutions addressing many of the access, quality and patient safety issues confronted by rural hospitals and clinics.

Take advantage of the educational and networking opportunities designed for clinic and hospital professionals and board members serving rural patients.

Visit RuralHealthWeb.org/kc to register, and save \$100 by attending both conferences.

And check out page 47 for a local member's guide to Kansas City and page 71 for a new way to get around downtown.

NRHA hosts 10th border health meeting

The National Rural Health Association led its 10th Border Health Initiative meeting in June in Washington, D.C.

Representatives from the U.S.-Mexico Border Health Commission, the Health Resources and Services Administration and other border health partners participated in the two-day gathering to provide updates on the status of these rural communities.

"This longstanding collaboration with our association and its border health partners continues to be a priority for NRHA to ensure we address the challenges being faced by our rural communities along the U.S.-Mexico border," says Gabriela Boscan, NRHA program services manager.

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, Boscan explains.

Award nominations accepted soon

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

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

To carry on McKenzie's legacy and honor her

memory, NRHA established the Rosemary McKenzie Legacy Award to be presented annually during the Health Equity Conference.

Nominations for the award will be accepted Oct. 20 through Jan. 19 at RuralHealthWeb.org/equity.

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

Present posters at NRHA conferences

The National Rural Health Association is currently accepting poster submissions for two upcoming educational events.

Submissions for NRHA's 40th Annual Rural Health Conference, the nation's largest gathering of rural health professionals, are being accepted through Jan. 26. The 2017 event will be in San Diego May 9-12.

Posters for NRHA's Health Equity Conference, May 9 in San Diego, are also being accepted through Jan. 26.

To submit your poster for review by a panel of NRHA members, visit RuralHealthWeb.org and complete the online application.

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

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Streetcar connects to downtown destinations

During the late 19th and early 20th centuries, Kansas City, Mo. had one of the most extensive streetcar systems in North America, the first of which were horse-powered and later used cables like San Francisco's famous cars.

As cities began to replace streetcar networks with buses, the last of KC's 25 streetcar routes was shut down in 1957.

Now, thanks to federal funding and the support of residents, the resurrection of the streetcar as a mode of transportation has spurred more than \$1 billion in economic development and revitalized the once-idle downtown.

Locals and visitors alike can get from places like historic Union Station to Lego Land and Crown Center Shops, the Sprint Center arena, Power & Light nightlife district and River Market attractions.

Rural Health Clinic and Critical Access Hospital Conference attendees can ride from NRHA's conference hotel to a dinner in the eclectic Crossroads Arts District, a performance at the world-renowned Kauffman Performing Arts Center, and back again.



Kansas City Streetcar

Off the beaten path



The 1968 Hoover Constellation at America's Vacuum Cleaner Museum

Good, clean fun

St. James, Mo., a town of **4,162** along Route **66**, is home to America's Vacuum Cleaner Museum, the first of its kind in the world.

With more than **600** vacuums on display — some dating back **100** years — you might not expect to find that all of them actually work. But they do.

Tom Gasko, the museum's curator and a past president of the Vacuum Cleaner Collectors Club, not only donated a significant portion of the collection, but also leads educational tours of this quirky project.

From its displays of famous TV vacuums to modern technology, the museum, now in its **seventh** year, won't be a chore on your next road trip.

shifting gears

Green on the (clothes) line

Going green in the laundry room is one of the easiest ways to make a major impact on your energy use and the environment.

Line dry clothes. Did you know your dryer is the second biggest energy user in your house, second only to the refrigerator?

Keep it cool. Hand-wash when you can. And when you can't, choose the "cold" water cycle. According to treehugger.com, "34 million tons...of carbon dioxide emissions [would be] saved if every U.S. household used only cold water for washing clothes."

Buy a more concentrated detergent. Or better yet, make your own. These options not only cost less, they significantly cut down on packaging and energy required to ship to stores.

Upgrade your equipment. Laundry machines today are 88 percent more efficient than they used to be. An upgrade could save you energy, water and cash.



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