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Volume 13, No. 4
Winter 2015

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On the cover: When Lee County Regional Medical Center closed, residents of Pennington Gap, Va., lost access to health care in their rural community. But they banded together to get it back. The hospital is expected to re-open two and a half years after it closed.

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Jodi Schmidt

Partnership key to rural survival

The consequences of hospital closures are becoming increasingly real. For me, it's a Kansas tale of two cities.

In one, the inpatient structure is gone, an aging relic replaced by a vibrant set of outpatient services still meeting a clear set of community needs.

In the other, a lovely rural community is faced with losing local services entirely.

The difference: partnership.

But partnership is difficult. Finding common ground, negotiating details, seeing another's point of view – this complex set of challenges is not for the faint of heart.

I know from personal experience, having “survived” the merger of two rural hospitals more than two decades ago. And that's what we called ourselves, those who made it through the tough times to become what we ultimately could be: survivors.

Communities must certainly enter any partnership with eyes wide open, but I grow increasingly convinced partnership holds the single greatest key to rural survival, and most importantly, future success.

Thank you for the opportunity to have contributed to this important conversation.

Jodi Schmidt
2015 NRHA president

pit stop

things I picked up in this issue:

1. With one in three Native women assaulted during her lifetime, sexual assault on U.S. Indian reservations is estimated to be the worst in the world, higher than war-torn Serbia or the Republic of Congo. *page 17*
2. Lee County Regional Medical Center, soon to re-open after being closed for more than two years, is one of 59 rural hospitals closures across the country since 2010. *page 7*
3. Six percent of the 5.3 million rural veterans are women, the fastest growing group within the veteran population, with a 5 percent enrollment increase since 2012. *page 21*
4. One of the cornerstones of the Obama Administration's Improving Rural Health Care Initiative is to build upon evidence-based solutions to address rural health care challenges. *page 24*
5. Fifty-four percent of the clinic and hospital leaders at NRHA's attendance record-setting Rural Health Clinic and Critical Access Hospital Conferences were first-time attendees. *page 28*



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Rural community wins fight to re-open hospital

By Luanne Rife



Lee County Regional Medical Center in Pennington Gap, Va., was closed by Wellmont Health System in 2013. Community leaders expect to re-open the hospital in early 2016.

On Oct. 1, 2013, the day Wellmont Health System shuttered Lee County Regional Medical Center, access to health care became easier for pets than people.

“There is no doubt that people have passed away because there was no hospital here,” says Sheriff Gary Parsons. “We lose the golden hour in the amount of time that it takes to get them to another hospital in Big Stone or Kingsport.”

And that’s if one of the county’s too-few ambulance crews is nearby.

continues



Pennington Gap, Va., is home to 18,000 of Lee County's 25,000 residents.

Lee County stretches 70 miles west from its border with Scott County before jutting into Tennessee and Kentucky and forming Virginia's farthest southwest corner. Its claim of being "where Virginia begins" counters outsiders' perception that Virginia ends in Roanoke. Jonesville, the county seat, is closer to eight other states' capitals than it is to Richmond.

When the hospital closed, the forgotten part of Virginia was put to the test. Did the people of Lee County still have a political voice that carried beyond their borders?

The answer arrives later this year. The Lee County Hospital Authority will re-open a hospital its commissioners claim was closed for all the wrong reasons.

"What I think is a remarkable story is that communities moan and give up. The folks in Lee County stood up and said, 'We'll fix this,'" says U.S. Sen. Mark Warner (D-Va.).

The betrayal

A year before it closed, even patients had begun to suspect something ailed their hospital.

"Wellmont was saying they were losing money. They hired people to bring in and then put them somewhere else. There was a lot of double-talk," Parsons says.

He served on a hospital board that acted as a liaison between ownership and the community. His tenure predated Wellmont's presence in Lee County, and he was familiar with hospital financial statements. He believed the balance sheet would have shown a profit if Wellmont hadn't subtracted a share of corporate overhead and debt.

Why else would Wellmont have pumped more than \$2 million into emergency room renovations, a department that treated 17,000 patients a year?

The local board held little sway in running the hospital; members couldn't even carry documents out of the meetings. Parsons

tired of what he saw as poor decisions coming from Wellmont's Kingsport, Tenn., corporate suites. He resigned in 2012.

"People knew what was happening, and I didn't want them thinking I had anything to do with it," he says.

"There is no doubt that people have passed away because there was no hospital here."
Gary Parsons, Lee County sheriff

Meanwhile, J. Scott Litton, MD, an independent family physician and one of a handful of doctors who took after-hours hospital calls, was perplexed.

"Wellmont's three employee physicians stopped taking calls," he says. "I don't know if that was their decision or Wellmont's."

Litton says the hospital didn't pay doctors to be on call and then claimed it couldn't get any to cover after hours.

"The reason I did it was I was able to care for my patients," he says.

The local government opened Lee County Hospital more than 70 years ago on a hill above Pennington Gap. Patients had to cross, or sometimes wait, at the railroad tracks in order to reach it. In the early 1980s, a new building rose on the other side of town with easier access and room for 70 inpatients. An adjoining building of doctor suites followed, and an administrator hired to lead the enterprise away from the brink of financial collapse did so, only to later drive it over a fiscal cliff.

By the late 1990s, the hospital owed \$15 million. Federal investigators

figured out that the former administrator had illegally diverted \$7.5 million. He and several others went to prison. The hospital slipped into bankruptcy court.

In 2001, for-profit Health Management Associates of Naples, Fla., bought it for \$24.9 million, then flipped it six years later to the nonprofit Wellmont in a package deal. The price was not disclosed.

“What I think is a remarkable story is that communities moan and give up. The folks in Lee County stood up and said, ‘We’ll fix this.’”

U.S. Sen. Mark Warner

Wellmont picked up Lee County, which some say it didn’t really want, and Mountain View Regional Medical Center in Norton, which it coveted. Now it could go head-to-head against its regional rival, Mountain State Health Alliance and its Norton Community Hospital.

Parsons says Wellmont began to change the hospital a few years ago and drove away Lee County residents who managed many of the departments.

By mid-2013, rumors circulated that Wellmont might close Lee’s hospital. County leaders pressed for a meeting. On Aug. 13, 2013, they gathered at the airport with their congressman, state senator, members of several local boards and Wellmont’s top managers.

Is Wellmont going to close Lee Regional Medical Center, the county contingent asked.

No, the Wellmont team answered. But it couldn’t continue to operate without cutting some services.

“We never got a chance to work with them on what the cuts would be,” says county administrator Dane Poe.

Less than a month later, with no warning, Wellmont announced that Lee Regional Medical Center would close by month’s end to avoid losing \$4 million in the upcoming year. It offered three reasons: too few patients, lack of consistent physician coverage, and the Affordable Care Act.

The locals weren’t fooled. They claim the first two reasons resulted from a crisis manufactured by Wellmont managers to shift doctors and patients to other hospitals in their network.

“They were transferring out people to pad the pockets



Top: Larry Mosley, vice chairman of the board of supervisors in Lee County, said Wellmont was “transferring out people to pad the pockets of the mother ship – Holston Valley.” Above: Ron Anderson, owner of Lone Pine Exterminating Co., shows a cell phone photo. He had to take his wife an hour away after she slashed her hand with a knife in the kitchen. He’s not happy the local hospital closed.

of the mother ship – Holston Valley [in Kingsport],” says Lee County Board supervisor Larry Mosley.

Many in Lee County believe their hospital and their health were sacrificed to improve the nonprofit’s bottom line because Wellmont was searching for a merger partner.

During the fiscal year covering the closing, Wellmont reported to the IRS that it made \$22 million in profits, or half as much as the previous year. Its net assets, though, grew by \$57 million, to \$504 million.

Wellmont CEO Margaret DeNarvaez was paid \$1.1 million in compensation, the same amount Carilion Clinic paid Nancy Agee to run its Roanoke-based nonprofit health system, which takes in double Wellmont’s revenue.

continues



Gary Parsons, 50, has been Lee County's sheriff since the age of 31. Parsons served on the local hospital board for several years but was unhappy with what he thought were poor decisions made by Wellmont and resigned in 2012.

Current Wellmont CEO Bart Hove agreed to an interview. Hove retired as CEO of Wellmont's Bristol hospital in 2013 before Lee County closed. He returned to Wellmont in September 2014 after DeNarvaez left. He said he could not answer questions about events that occurred during the gap in his tenure, but he confirmed that Wellmont had been seeking a partner for several years to survive in an increasingly complex regulatory environment.

A Wellmont spokesman declined to answer questions that would establish a timeline of when it decided to close the hospital, and said its Sept. 11, 2013, news release "provides a comprehensive explanation of the reasons why our health system had to make this difficult and complex decision."

The fixers

"I was in my office in Gate City when I heard. It shocked me because we had been told it wasn't on the table," says Terry Kilgore, a Republican Virginia delegate. "Our phone and email were lit up with folks calling in. It was devastating to the county for health care concerns and to the hospital employees who had good-paying jobs."

Without a hospital, all hope ended for courting new

possesses an enviable contact list. But he knew nothing about health care.

Tom Clarke did. On the day Wellmont announced the closing, Clarke was in Richmond meeting with cabinet officials to figure out how to structure a deal to buy Natural Bridge. Clarke's Kissito Healthcare was forming a new nonprofit to purchase the iconic limestone arch with the aim of protecting it in perpetuity.

"Every day I see ambulances running up and down the road bringing the citizens of Lee County to other counties. I pull over and pray they make it on time."
public hearing speaker

"Everyone was talking, and I'd hear 'Lee County,' 'Hospital,' 'Pennington Gap.' Truth of it is, I had no idea where Pennington Gap was. I don't even know if I had heard about Lee. I asked them about it, and all these people, cabinet members, were deeply concerned that it closed without any notice," Clarke says.

"I'm a health care guy, so I'm like, 'wow, that really is unfortunate.' But I think it's part of what's happening in America. This must be some small county with a couple thousand people who can't sustain their hospital, probably losing millions of dollars each year," he adds.

Thirty-five communities across the country lost their hospitals that year.

Other than to Google "Pennington Gap," Clarke gave it no more thought until he got a call a few months later from a consultant Mitchell had asked to go find him a health care partner.

businesses or enticing older ones to expand.

Kilgore picked up the phone and placed a call across the aisle but close to home. Blacksburg attorney Jeff Mitchell answered. Mitchell's family is to the Democratic Party and Tazewell County what Kilgore's family is to the GOP and Scott County.

"Terry said, 'I want you to talk to these people in Lee County and help them get their hospital back,'" Mitchell recalls.

And, by the way, Kilgore told him, you might not get paid. Mitchell, who specializes in acquisitions and mergers, worked for former governors Gerald Baliles and Mark Warner and

By then none of the big or small hospital players were interested, save one: Wellmont's regional competitor Mountain State Health Alliance. No way would Wellmont agree to that.

Clarke agreed to a meeting in Richmond. He entered the room thinking he'd lower their expectations, talk them down from a hospital to maybe an urgent care center, perhaps some nursing home beds.

He changed his mind when he met the players. Mitchell was working on spec. Kilgore seemed to genuinely want to help. Most of all he was impressed with Sonny Martin, a former bank president and patriarch of Lee County. Clarke agreed to pitch in without pay.

They hatched a plan. Kilgore would push through legislation to allow Lee County supervisors to create a hospital authority whose members would then buy their hospital from a reluctant seller. Martin steered the authority and remains its chairman, though he has taken ill. Unable to get medical care in Lee County, he's now staying in North Carolina.

The toll

No matter how difficult negotiations became, Lee County supervisors and hospital authority commissioners vowed to say only nice things about Wellmont in public. That determination required periodic renewal when talks stymied. Authority members once flirted with an idea of loading up all the church buses and driving to Kingsport to picket outside Wellmont's headquarters.

They resisted the temptation. But they knew the buses would jam U.S. Highway 58. Their people had already spoken.

Wellmont would not give the hospital building to the authority unless commissioners could demonstrate people needed it. And Virginia would not grant a Certificate of Public Need unless the authority had a building.

Mitchell crafted an agreement with Wellmont that said it would donate the building once the authority obtained the certificate. The authority commissioners drummed up public support and presented Virginia's Department of Health with 10,370 signatures, representing nearly half the 25,000 people living in Lee County. Then on Oct. 8, 2014, 400 residents packed the Lee High School auditorium for the type of public hearing that usually draws next to no one.

Their voices, captured on tapes from the hearing, spoke of how many owed their lives to quick treatment at the local hospital.

"We have heard documented cases of people dying while waiting for an ambulance," said one.

"Every day I see ambulances running up and down the road bringing the



Top: Deadra Howard has worked for Lee County in dispatch for nine years. She talked about the strain on the crews and inconveniences due to the regional hospital closing. Above: Angel Head has worked in EMS for Lee County for 30 years and works in the dispatcher's office. She is an advisory to the captain of the Jonesville Rescue and on the original board of rescue squad as a trauma tech.

citizens of Lee County to other counties. I pull over and pray they make it on time," said another.

One supervisor hobbled to the mic, a cast on one leg. She developed blood clots from her injury, she said. As she stood there, she didn't know whether one would break loose and if she'd have time to make it to Big Stone or Norton or Kingsport. Or whether there would be an ambulance ready to take her. Even non-emergency medical care is now a burden.

"It's pretty sad when we can take our dogs and cats to get an X-ray in 30 minutes, and it takes us the better

continues



Dane Poe is the Lee County administrator.

part of a day,” one said.

The hardships continue. Patients go off for tests and come home only to find they need to turn around and go back for more.

Litton’s waiting room is packed with patients needing wounds stitched or bones set. Sometimes they wait all night until he opens in the morning because they don’t have a ride to Big Stone.

At the Ham Robert Lee Nursing and Rehabilitation Home, care became more complicated for the 110 residents who no longer can take a quick trip down the hill for hospital treatments. The nursing home now has a mobile lab that arrives periodically, but residents who need quick lab work or X-rays or a blood transfusion must be driven 30 minutes away.

A federal maximum security prison in Lee County also has had to adjust. Last month, during the hospital authority meeting, a riot broke out. Parsons, Litton and another doctor on the board abruptly left. Eight injured inmates were driven to hospitals outside Lee County. In the past, they’d have been brought to a secure wing at the local hospital.

Economic development prospects withered. With 140 jobs, the hospital was one of the county’s largest employers, behind Wal-Mart, the prison and the school system.

“It’s tough enough to bring people into our industrial

park,” says Michael James with the county’s Industrial Development Authority. “There’s zero chance without a hospital. If you don’t have a hospital, it just screams ghost town.”

The Virginia Department of Health was convinced. There is a need in Lee County for a critical access hospital.

The deal

Donations poured into the Lee County Hospital Authority, first from the IDA, the farm bureau, Pennington Gap Town Council, then the civic groups. If residents needed to wash cars and bake cookies to get their hospital, they’d do it.

But if the hospital were to open, could the authority keep it going?

“The former CEO created a phony crisis to show Lee County was losing all this money,” says authority vice chairman Ronnie Montgomery. “On paper you can show anything you want. ... If you aren’t counting the interest payment and depreciation, it was making money. That’s why we say it will go.”

Clarke commissioned a feasibility study. Though the hospital would lose about \$1 million the first year, projected revenue would exceed expenses by \$101,000 beginning in the second year.

Now all they needed was the building.

“It’s pretty sad when we can take our dogs and cats to get an X-ray in 30 minutes, and it takes us the better part of a day.”
public hearing speaker

“There were people inside Wellmont who never believed the people of Lee County would make it this far,” says Mitchell. And by November 2014, Wellmont’s board was no longer willing to donate the building without a stipulation.

Lee patients were going to Lonesome Pine Hospital in Big Stone Gap, another Wellmont facility, for routine emergencies and tests. To protect its competitive advantage, Wellmont wanted the authority to promise it would never bring in a competitor to run the Lee County hospital.

Without the electronic medical record system and doctors another health system could provide, the authority could not afford to open and run the hospital.

Wellmont had abandoned Lee County, Clarke reasoned. Wellmont had a moral, if not legal, obligation to let the county succeed without limiting its options.

The authority decided to buy the building free and clear. Months dragged out haggling over a sales price. Eventually they settled on \$1.6 million. Mosley said county supervisors voted to lend the authority taxpayer money because they weren’t willing to wait while the authority sought financing. They worried the terms would again change.

The merger

But there's still a hitch: The authority cannot sell or partner with any other health system without giving Wellmont the right to first refuse to do the same thing for the same payment.

"Wellmont paid a pretty penny for the facility. The asset expense stays on our books," Hove says. "We wanted to cooperate while protecting ongoing business."

Mitchell thinks there's a loophole. The hospital authority will own and operate the building but will craft an alliance for an experienced health system to offer services. Talks are underway with Mountain State.

"We have already started offering them guidance," says Mark Leonard, CEO of Mountain State's Norton Community Hospital.

Hove said Wellmont would read carefully through any deal between the authority and a competitor. But Mountain State might not remain Wellmont's fiercest competitor for long: The two are in negotiations to merge.

"It's like if Virginia and Virginia Tech decided to field one football team. It was that big of a rivalry," Kilgore says.

The Lee County contingent can't claim credit for prompting the merger, but they did nudge it by helping to raise public support for keeping local hospitals in local hands rather than allow an outside conglomerate.

Kilgore found a way to wiggle around a Virginia law that prevents health care competitors from joining forces by advancing legislation that carves an exception only in southwestern Virginia.

The future

With the property and a partner, Lee County's leaders went to Washington, D.C., in June to begin to seek the approvals necessary to get paid for treating patients.

Warner pulled together regulatory officials along with Sen. Tim Kaine (D-Va.) and Rep. Morgan Griffith (R-Salem).

"It's a real chicken-and-egg scenario," Griffith says. Without federal provider numbers, the new hospital can't bill Medicare and Medicaid for services. And without first providing services, it can't get the numbers.

Mountain State's Leonard said they bring experience



Top: "It's hard to recruit industry anyway [regarding the hospital closing] because of Lee County's remote location and no interstate access. No one wants to be the first occupant of your industrial park," says Industrial Development Authority director Michael James. Above: Scott Litton Jr. started his family practice in 2003 in Pennington Gap. His office is adjacent to the now-closed Lee County Regional Medical Center. He said his waiting room is filled with people who need wounds stitched or bones set. They sometimes wait all night for him to open because they don't have a ride to another hospital.

in navigating the processes for accreditation, certification and licenses, all needed to push through the red tape. Later this year, Lee County will open an urgent care center to treat patients at night and on weekends. Once that's established, they can establish an emergency room and have diagnostic and imaging services – and again become a hospital.

It will differ from most community hospitals as it will open as a critical access hospital. That designation carries limitations, such as no more than 25 inpatients at a time, but it also brings the benefit of a larger reimbursement from Medicare.

Mountain State will help the authority with staffing, possibly bringing

continues on page 15

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in specialists. Meanwhile, the authority is seeking \$12 million in government and foundation grants to re-open a building that was stripped of all hospital furnishings.

Commissioners plan to have the hospital running in early 2016.


Warner says the bureaucratic process won't block them.

"I asked the federal regulators for their personal numbers to stay in regular contact," he says.

Lee County will still need to meet all the criteria, but applications won't wait on desks for months only to get rejected on technicalities.

"The folks in Lee County aren't giving up, and I'm not going to give up on them," Warner says.

Authority commissioner Montgomery says everyone is anxious.

"I had two people ask me at lunch today and one when I went to the courthouse this morning: 'When are we opening the hospital?'" 

This article originally appeared in The Roanoke Times on Aug. 2, 2015.

One of the lucky ones

Lee County Regional Medical Center is one of the 59 rural hospitals closures across the U.S. since 2010, and 283 more are still at risk. More than 10 percent of all rural hospitals, more than one in every eight, face the threat of closure.

Since the start of 2013, more rural hospitals have closed than in the previous 10 years combined.

The National Rural Health Association's Save Rural Hospitals Act promises to stop the flood of rural hospital closures, provide needed access to care for rural Americans, and create an innovative delivery model that will ensure emergency access to care for rural patients across the nation.

Learn more about how you can influence the decisions made in D.C. that affect rural health care and help save rural hospitals and the communities they serve by registering for NRHA's 27th Rural Health Policy Institute Feb. 2-4 at RuralHealthWeb.org/pi.

And check out Accelerating Advocacy on page 41 for more information on how you can help.



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Unique program delivers emergency care in person to Native victims of sexual assault

By Melodie Edwards



U.S. Indian reservations have a high rate of sexual assault.

By some estimates, sexual assault on U.S. Indian reservations is the worst in the world, with one in three Native women assaulted during her lifetime.

Unbelievably, it's higher even than war-torn Serbia or the Republic of Congo. And the Wind River Indian Reservation in Wyoming is no exception.

It's the kind of big issue that would normally scare most people away. But not the nine courageous women at Wind River Reservation who are trying a totally new approach.

They deliver emergency care in person.

It all started when Eastern Shoshone descendant L'Dawn Olsen started writing letters to the editor of the *Wind River News*. Some of them directly addressed her daughter's accused attacker.

"I will do it as long as I breathe," Olsen says. "Every year on the anniversary ... which was the morning of Thanksgiving was when she was raped. So in every Thanksgiving issue, I write a letter."

And she kept writing, even when friends warned her that the alleged

attacker's family might retaliate, which is common when victims try to prosecute.

"Take extra insurance out on your house, this is what I was told," Olsen says, laughing. "Also, is your house bulletproof? So, and it is."

But the bullets never came.

Instead, she found support from her tribe, who invited

continues

her to help start a program to address the problem.

That's when she discovered Safe Stars, a growing national effort on reservations that trains respected women in the community as first responders for victims of rape, providing them whatever support a victim needs, whether physical, legal or spiritual.

The women take a lifelong vow to protect victims who come forward.

“We’re going to stop that cycle of violence. And how we’re going to stop it is, when you get older, you’ll know it’s not normal, you don’t raise your kids that way, you hug your kids and you tell them, ‘I love you,’ and you mean it. That’s how we’re going to stop that cycle.”

Millie Friday, Northern Arapaho Safe Star volunteer

It's the brainchild of Hallie Bongar-White, an attorney for the Southwest Center for Law and Policy in Tucson.

“Several years ago, we realized there was a huge disconnect between the volume of sexual violence in Indian Country and the criminal justice, health care, social services and community responses to sexual violence,” she says.

For instance, there is not a single sexual assault nurse examiner on the Wind River reservation. And Bongar-White says rural hospitals just aren't equipped to provide the kind of culturally sensitive services Native victims might need.

The Safe Star women aim to bring those services to victims in person, even if they call from a car or remote house.

Bongar-White says they adapted a 40-hour nursing course and now are training lay Native women as sexual assault nurses in 10 tribes with requests for many more around the country and the world.

“They're able to photograph injuries, use buccal swabs,” Bongar-White says. “If there's clothing with semen on it or panties have saliva from the perpetrator on them, they're able to package all the evidence.”

Northern Arapaho Millie Friday is a trained Safe Star. She unlocks her rape kit to show its contents. It's a black metal box specially designed by the FBI just for Safe Stars to use in the field and includes things like a magnifying glass, camera and the morning-after pill.

Friday also plans to stock her rape kit with

healing plants.

“I would add sweetgrass and I'd even add cedar, and then sage is good too,” she says.

Friday volunteered to become a Safe Star after her own daughter was raped by a close relative. In the hours afterward, Friday witnessed how badly the hospital and law enforcement handled her daughter's case.

“We went straight to the emergency room, and FBI was contacted. So she never even had that choice of what she wanted to do. It was just straight in,” Friday says. “And then all the re-victimization that happened in the hospital.”

Like being asked to remove her clothes and put her feet up in stirrups. Friday says this insensitivity is one reason why few Native women report their assaults.

Nationally, fewer than 68 percent of assaults are ever reported, and that number is likely much, much higher on the reservation. Even now, almost 70 percent of all reported assaults on the reservation never make it to trial, let alone a conviction.

But Friday thinks more women will report with the help of Safe Stars.

The question is, will more reports turn into more convictions?

Assistant U.S. Attorney Kerry Jacobson has worked on numerous sexual assault cases on the Wind River Reservation.

“One issue as a prosecutor is how is the evidence by the Safe Stars going to hold up in federal court? Because it wasn't collected under sterile circumstances, and so if you've got physical evidence being collected out of a Safe Star's car or home, then there's going to be at least the specter of potential tainting.”

The rape kits do include latex gloves, a drop cloth, and other items to assure sterile evidence. But in their five years, Safe Stars have helped in only three convictions.

But Jacobson says even if Safe Stars can't get many convictions, they will do something even more important: give a victim a circle of respected women to protect her.

Many times, she says the victim is so scared of retaliation and social shunning, she stops cooperating with her lawyer.

“Very often [the rapist and his family] will obstruct the prosecution, hide the victim, pressure the victim to recant,” Jacobson says. “These are very hard cases to move forward with because, by the time we get to trial, our victim is either scared or has withdrawn her support for the prosecution out of her own personal necessity.”

Jacobson says it's a cycle of abuse and silence that comes from historical trauma.

“The females of the family have all been sexually assaulted, they have all kept it under wraps, they've buried it deep down inside,” she says. “And so

that woman begets that same method of dealing with victimization to her daughter and her daughter and so on and so forth.”

Friday says such trauma is left over from when Native children were sent to boarding schools.

“Because the majority were parochial schools,” she says. “The nuns, some of the people who worked in those boarding schools. And then, [the victims] becoming perpetrators later in life and the cycle going round and round and round.”

Friday says Safe Stars’ goal is to start to help heal that historical trauma. She has a message for the new generation of young women.

“We’re going to stop that cycle of violence,” she says. “And how we’re going to stop it is, when you get older, you’ll know it’s not normal, you don’t raise your kids that way, you hug your kids and you tell them ‘I love you,’ and you mean it. That’s how we’re going to stop that cycle.”

The Wind River Safe Stars plan to complete their final phase of training this fall and begin offering their services in coming months. 

This story originally appeared on Wyoming Public Radio on Aug. 28, 2015.

Spreading the word

The following letter by Safe Star volunteer L’Dawn Olsen appeared in the local newspaper.

Women Restored is the name of the original organization that adopted the Safe Stars program. Hear Olsen read the letter at wyomingpublicmedia.org.

You never “deserve” it

Often, when a woman gets raped she is blamed...“You know you shouldn’t have walked down the dark road alone. You know you shouldn’t have worn clothes so tight; that was just egging him on. You know you shouldn’t have hung out with people you don’t know.”

If she did know him, and even trusted him...“You must have done something to make him want to do that to you.”

And, definitely, if she drank too much and laid there listless or even unconscious...“What did you expect? You had it coming.”

Then there are the excuses of the rapist who evades, denies or minimizes the rape...“She asked for it. She enjoyed it. She deserved it. She wanted it. I did it for her.”

Demeaned, humiliated, degraded, defiled, betrayed, powerless, isolated and dirtied from the rape, she is made to feel this again in blame.

As if she caused her own rape, she lowers her head in guilt and shame.

Women Restored wants to make it very clear, no matter if you wear a shirt that is tight against your body. No matter if you make someone angry or they get jealous. No matter if you take a shortcut home, are out late and alone. No matter if you give directions to someone you do not know. No matter if you know them and get in the car with them. No matter if it is someone you care for and love. No matter if you have been drinking. No matter if you are passed out...

Dear woman, no matter what you did or did not do, you never deserve to be raped. It is never your fault.

You are a holy beloved woman that deserves honor, support and protection. Any treatment of your body in the unholy of rape is not only wrong and criminal, but it is evil.

Your body holds the mysteries of life.

It has the power to bring forth and continue human life. Your everyday actions of making a meal, putting comforting arms around the other nurture and restore life. Your laughter eases suffering, reminding all those lucky enough to hear and be near you how wonderful life is. And, your thoughts of good help us remember we are all good.

Like the water, wind, sun and earth – without you, life would be impossible.

Without your intelligent, loving and forgiving heart, hands and arms, life would be hard to live. Without your joy, laughter and forgiveness, life would have little meaning. Without your good thoughts of us, we would be lost.

This makes you incredibly important and powerful.

When you believe suggestions you are less than you are, deserving of unholy acts, you dishonor the sacred life you hold and represent.

Do not allow yourself to be persuaded that you are less, deserving of less. Do not believe brutal actions against your sacred feminine.

Lift your head. Lift your heart. Be who you are and meant to be: woman beloved, woman respected and sacred, holding the life-giving knowledge and power of the Great Mystery inside you.

Woman Restored.

Women Restored is organized and managed by a steadfast group of women serving as board, staff, consultants and volunteers and is currently funded by the Office of Violence Against Women. If you have any questions, concerns or care to become involved, please contact us. We welcome you.

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GOLD LEVEL PARTNER

Program helps rural veterans find maternity care

By Angela Lutz



Rural veterans often have a more difficult time accessing maternity care than pregnant urban veterans.

Pregnancy can be an exciting but challenging time for any woman. Women in rural areas often face an added layer of difficulty due to the shortage of obstetrics providers in their communities.

“When you live in big cities like Boston, Washington or New York, there are a lot of resources in a very concentrated area, and you can get a lot of support,” explains Kristin Mattocks, PhD, Department of Veterans Affairs (VA) Central Western Massachusetts Healthcare System associate chief of staff and University of Massachusetts Medical School associate professor. “But when you live a couple of hours from a VA medical center in a rural area, sometimes those social supports are not as easy to find.”

To help pregnant rural veterans locate medical providers and social support in their communities, the Central Western Massachusetts Healthcare System established the Maternity Care Coordination Program in 2014, using federal funding from the VA Office

of Rural Health. Because many VA facilities do not offer obstetrics care, pregnant veterans must utilize community providers.

Mattocks and her team decided to focus on maternity care coordination in rural parts of New England out of a desire to connect these women with service and community providers closer to home.

“They have someone they can talk to on the phone who will connect them to the resources they need. They don’t have to drive two hours.”
 Kristin Mattocks, Department of Veterans Affairs Central Western Massachusetts Healthcare System associate chief of staff

“We became interested in what happens to women veterans when they leave VA to get pregnancy care,” Mattocks says. “How do they know what provider to go to in the community? How do they know what their benefits are? Do they come back to VA afterward? We knew [rural veterans] have more challenges because there are fewer providers, and we knew that might complicate matters.”

Maternity care coordinators help pregnant rural veterans navigate many

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Since last March, the Maternity Care Coordination Program has helped connect more than 300 rural women veterans with community providers.

aspects of care, starting with prenatal concerns, such as finding an obstetrician and proper nutrition, all the way through postpartum needs, including breastfeeding support and postpartum depression counseling, Mattocks explains. They also help women navigate VA, understand their benefits and handle billing concerns.

“What’s really important about this [program] is it provides a connection to women veterans living in rural areas,” Mattocks says. “They have someone they can talk to on the phone who will connect them to the resources they need. They don’t have to drive two hours.”

Since the program began last March, maternity care coordinators have worked with more than 300 women via seven VA facilities across five states. Surveys indicate that 93 percent of women were satisfied with the services they received from the program, and 79 percent say it helped them acquire breastfeeding support and supplies.

“The program was excellent, and the facilitator was amazing,” wrote a rural veteran in Northampton, Mass., who utilized Maternity Care Coordination services. “I don’t know what I would’ve done without the maternity care coordinator.”

Going forward, Mattocks says she would like to expand the services the program offers and make similar models of care coordination available for pregnant veterans in other rural communities. 



Resources for veterans

Women are the fastest growing group within the veteran population. Of the 5.3 million rural veterans, 6 percent are women, who make up the largest rural veteran special population group.

There has been a 5 percent increase in enrolled rural women veterans since fiscal year 2012.

For more information, visit the VA Center for Women Veterans at va.gov/womenvet or call 855-VA-WOMEN.

With the passing of the Veterans Choice Act, which established the Veterans Choice Program, receiving care in the community is more accessible.

Through the Veterans Choice Program, eligible veterans have the choice to receive pre-authorized health care in their communities from non-VA providers participating in the program, rather than waiting an extended time for a VA appointment or traveling a significant distance to a VA medical facility.

For more information on the Veterans Choice Program, visit va.gov/opa/choiceact or call 866-606-8198.

Federal grants focus on models replicable in rural

By Linda Kwon, Tanisa F. Adimu and Amanda Phillips Martinez

Ginny Keiser, a nurse at Ephraim McDowell Regional Medical Center, counsels a client regarding goals and a plan for lifestyle changes to reduce stroke risk during a HRSA-funded stroke risk screening event at the Boyle County (Ky.) Cooperative Extension Service.



Rural communities are continuously implementing innovative health care delivery models that have the potential to be replicated.

“Rural communities are not just a smaller version of urban communities, and we can’t assume that health care initiatives that work in urban areas will work just as well in rural areas,” says Tom Morris, Federal Office of Rural Health Policy (FORHP) associate administrator. “We need to figure out what approaches work best in rural communities and how they can be adapted and expanded into other rural areas.”

One of the cornerstones of the Obama Administration’s Improving Rural Health Care Initiative is to build upon evidence-based solutions to address rural health care challenges.

The Rural Health Care Services Outreach program was the first FORHP grant program to require grantees to implement evidence-based projects.

“We broadly define evidence-based to include program models that have attained a ‘level’ of evidence, so it’s not only rigorous evidence-based programs, but promising practices and effective practice programs that are proven to work and can be replicable in other rural communities,” explains Nisha Patel, FORHP community-based division director. “To that end, we don’t want rural communities to have to re-invent the wheel, and we believe that this approach and the resources we are able to provide can benefit rural communities.”

“This new approach allows FORHP to position grantees to replicate and tailor models and strategies in order to enhance the delivery of health care services,” she adds.

Diabetes prevention

At Mount Desert Island Hospital (MDIH), a 25-bed critical access hospital on the coast of Maine, there’s no time to re-invent the wheel.

“Our plan was to reach out to the community and bring diabetes education in the form of a group program. Our diabetes educator was assigned to do a literature review to learn [what programs] were out there.



At left, Richard Szatkowski, a technician at Ephraim McDowell Regional Medical Center, obtains the body mass index of Mary Nardin during one of the bi-annual HRSA-funded stroke risk screenings. Above, Mount Desert Island Hospital lead its new Diabetes Prevention Program on Swans Island, Maine, a fishing community accessible only by ferry. From left to right: participants Jackie May and Karen Martin with coach Elise O'Neil and another participant, Katelyn Riedel.

She stumbled upon the Diabetes Prevention Program (DPP), and we were ecstatic,” says Elise O’Neil, a nurse and care coordinator at the rural hospital. “It was a proven tool, approved by the Centers for Disease Control and Prevention (CDC), and has been used by thousands of people across the country.”

“We don’t want rural communities to have to re-invent the wheel.”

Nisha Patel, Federal Office of Rural Health Policy community-based division director

MDIH is pursuing program recognition with CDC’s Prevention Recognition Program. Achieving recognition as a prevention program provider will make the program eligible for insurance reimbursement and ensure its sustainability.

“Maintaining a high level of fidelity to the program model required for CDC recognition is more challenging in a rural area with transportation

barriers and a highly mobile population,” O’Neil says.

“The DPP program lasts a year, and it’s difficult to get people to commit for that long. Sessions require face-to-face contact with participants,” she says. “In Maine, we have a lot of people who go away for the winter. We hosted make-up sessions to keep people engaged and followed up by phone. We kept to the fidelity of the program, but with creativity.”

And it seems to be working, O’Neil adds. During the grant period, MDIH educated 12 DPP cohorts and reached 117 people. Data collected from program participants at six months showed statistically significant improvements in body mass index. Among those who completed the program, the average weight loss over the full intervention period was 8.4 percent.

“The biggest impact to the community I see is that we have gone from a reactionary medical model to a proactive, preventive model. Providers and patients are recognizing that this program can prevent or delay the onset of diabetes,” O’Neil says.

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Cardiovascular health

When the staff at Ephraim McDowell Regional Medical Center (EMRMC), a nonprofit 222-bed licensed rural hospital in Kentucky, set out to address modifiable cardiovascular risks, they also sought out proven models.

They selected Stanford University's Chronic Care Model and the National Stroke Association's (NSA) risk score card to guide their program development, which has had a positive impact on their chronic disease management efforts, according to Audrey Powell, EMRMC nurse and program manager.

“We need to figure out what approaches work best in rural communities and how they can be adapted and expanded into other rural areas.”

Tom Morris, Federal Office of Rural Health Policy associate administrator

“The use of an evidence-based model sharpened our focus. It was central to the development of staff and client education, design of the documentation systems, and development of collateral materials for communication,” she says. “Using these models also gave us credibility within the medical community as referrals to providers were readily accepted.”

EMRMC adapted the models, tailoring its program to meet community-specific needs and interests.


“The grant requirement to use an evidence-based, promising practice model made us very intentional with our decisions regarding modifications to a model, developed and tested in an urban setting, so that it could then translate to a rural setting and culture. This intentionality contributed to our success,” says Laverne Slone, EMRMC care manager and nurse.

To address the literacy levels of its target population, EMRMC eliminated many paper forms and adapted NSA's risk score card, which uses a stoplight image (green, red and yellow) to communicate levels of risk.

“The concepts of danger, caution and go are easily understood,” Slone adds.

Morris says he's pleased with the work of the 70 grantees.

“Resources are scarce in many rural communities, and when we make an investment in a rural community, we want to make sure it has the best chance to succeed,” he says. “By building an evidence base for successful rural health approaches, we can build on what we know works given the unique challenges in rural America.”

Morris added that the outreach grantees will sustain all or parts of their project beyond federal funding. 

Linda Kwon is a public health analyst with the Federal Office of Rural Health Policy. Tanisa F. Adimu and Amanda Phillips Martinez are senior research associates with the Georgia Health Policy Center.

Tools to move toward an evidence base

Evidence-based toolkits to help you access and adapt proven strategies and best practices in your community are funded by the Federal Office of Rural Health Policy and available at raconline.org/communityhealth.

Toolkit topics include care coordination, community health workers, oral health, mental health/substance abuse and, health promotion and disease prevention.

A library of rural programs and interventions addressing various rural health issues are classified by level of evidence at raconline.org/success/project-examples/evidence-levels.

Access a summary of the 2012-14 Rural Health Care Services Outreach projects and descriptions of the models or practices each grantee adopted and adapted at raconline.org/pdf/2015-rural-health-care-services-outreach-grant-program-source-book.pdf.

And visit hrsa.gov/ruralhealth/index.html to view a list of current FORHP funding opportunities.

Latest NRHA conferences set record

A record number of clinic and hospital leaders arrived in Kansas City for the National Rural Health Association's 14th annual Rural Health Clinic and Critical Access Hospital Conferences this fall.

NRHA was thrilled to see so many new faces at our 2015 events – 54 percent were first-time attendees – and happy to reunite with our repeat participants.

NRHA's fastest-growing events featured rural-specific topics including hospital, clinic and EMS collaborations, evidence-based leadership, population health, patient-centered medical home and accountable care organization insight, and proven recruitment and retention strategies.

NRHA also partnered with 340B Health to host a free post-conference meeting to provide an introduction and review of the recently released federal 340B drug discount program guidance.

Plan now to join colleagues from across the country for next year's clinic and hospital events Sept. 20-23 in Kansas City.

Presentation submissions will be accepted at RuralHealthWeb.org for the 2016 events beginning in March.





Opposite page, clockwise: NRHA president Jodi Schmidt poses with past president Val Schott. Conference attendees take advantage of a photo station near registration. Attendees gather for ice cream during one of several networking breaks during the event. New Ulm (Minn.) Medical Center president Toby Freier gives the keynote address to a record-setting number of attendees.

This page, clockwise: Conference attendees chat near a slideshow of photos and activity from NRHA's mobile event app. Mississippi Rural Health Association president Jessica Hunt visits an exhibitor table. Conference attendees gather to network at NRHA's Member Center. Top 20 CAH winners pose for a photo with their award. Attendees and exhibitors network.

More friendly faces

Continue your trip down Memory Lane or see what you missed with more photos from the Rural Health Clinic and Critical Access Hospital Conferences and other NRHA events at [facebook.com/ruralhealth](https://www.facebook.com/ruralhealth).

Get to know incoming NRHA president Lisa Kilawee



Incoming NRHA president Lisa Kilawee, her daughter, Rowen, and her husband, Michael

In 2016, Lisa Kilawee will become the National Rural Health Association's 11th female president.

A South Dakota native, Kilawee has been an NRHA member for 15 years. Kilawee recently joined the team at Ministry Health in Stevens Point, Wis., as a provider recruitment specialist, and says her move to living in rural America "feels magical."

What led you to choose a career in rural health?

My father was diagnosed with leukemia when I was in college, and it really made me realize that not everyone in our country has access to the same health care services. It really depends on where you live and what your income is.

That led me to connect with some really great South Dakotans who were working to develop rural health services in South Dakota: Barb Smith,

then secretary of health; Scot Graff, of the South Dakota-North Dakota Primary Care Association; and Loren Amundson, MD, of the University of South Dakota Sanford School of Medicine. These connections resulted in professional positions with the Community HealthCare Association of the Dakotas and the South Dakota Office of Rural Health.

Tell us the best thing about your current job.

There are a lot of great things about my current job. One of the best is that, working in physician recruitment focused on primary care, I get to meet a lot of great doctors and future doctors, and I really believe that, although the challenges are many, the future is bright.

Plus, in working for Ministry Health, which is part of Ascension Health, I get to be part of one of the largest nonprofit health care organizations in the country doing very mission-focused work.

What is your most memorable moment in rural health?

There are too many to choose just one. Every week or so I am in one of Wisconsin's rural clinics or hospitals and have a patient interaction. Often the patients are thanking the nurses or receptionists for helping them. Last week, a patient came up to one of my physician candidates and asked him to please consider moving to his town because everybody really needed the help. These are the moments I remember the most.

What are your favorite parts of working for rural America?

Every day I am reminded of how many dedicated rural health professionals are out here in rural America, doing what they can to make things work because they feel an obligation to the people they serve. I love how resilient rural people are. Now that I'm working in rural America, I'm living here too, and almost every day feels magical.

What's the biggest challenge facing rural health, and what can we do about it?

Two things: the decreasing political bipartisanship and the changing economy. Fewer people have jobs with benefits that include health insurance, and in general, average Americans have less disposable income. As rural health professionals, we need to keep leading the fight for bipartisan solutions that work for rural people.

We need to continue to work collaboratively for solutions. It's more important than ever to be an engaged member of NRHA.

Why do you choose to volunteer with NRHA?

It's the leading, and often the only, voice for rural America. Without adequate health care services, there can't be a viable rural America.

What excites you most about serving as NRHA president?

I'm excited to represent so many amazing rural health professionals and the rural people they work for. I'm proud to lead our organization in the amazing policy and development work that we do. I look forward to working with CEO Alan Morgan and the rest of NRHA's extraordinary staff.

What are your goals for next year?

My goals include continuing my grassroots approach and working with members and staff to revitalize our membership and increase participation in NRHA activities, including our committees and Rural Health Congress.

I'd also like to issue a challenge to all of our members to help me ensure our Annual Rural Health Conference in Minneapolis has a record attendance.

Through participation and numbers, we can all work together to ensure rural America is a priority in Washington.


Why have you continued to work in rural America despite the challenges?

I have a strong commitment to social justice, and fighting for rural America is a cause that needs a strong collective voice. Rural America represents a way of life that's worth fighting for.

Tell us about your family.

My parents, sister and niece all live in Sioux Falls, S.D. My husband, Michael, is a native of rural Bancroft, Wis. After living in my hometown of Sioux Falls for 17 years, our family embarked on an adventure in December 2014 and moved to the rural village of Amherst, Wis.

I commute 11 miles to my job with Ministry Health in Stevens Point. My husband is a corporate pilot. Our daughter Rowen is a high school sophomore in a class of 89 kids and has to be the happiest teen in America.

We've had so many great moments that you can only have in a rural community, like the whole town cheering at a state play-off soccer game. 

Beginnings & Passages



Cody Mullen

“Regardless of the path ahead, I know mine will be a rural journey.”

Student finds passion in rural research

By Cody Mullen

The support of a great mentor, Steve Witz, PhD, in my undergraduate studies taught me the importance of doing rural research.

The Regenstrief Center for Healthcare Engineering, which Dr. Witz directed and I interned with, was engaged in a hospital readmissions study with an urban system. Dr. Witz came to me and suggested we expand the study into a rural setting and particularly look at a group of critical access hospitals. A junior at Purdue University studying statistics, I had no clue what he was talking about: What is a critical access hospital?

I quickly turned to the existing literature and learned as much as I could. It wasn't until we took a trip to a critical access hospital to meet with their chief nursing officer that I saw both the important and vital role these facilities played in the community. Upon my graduation and transition to my doctoral studies in health policy at Indiana University-Indianapolis, I wanted to ensure my work included a rural focus. I'm now working on writing my dissertation and also work full-time with the Indiana Rural Health Association.

Every time I get the opportunity to visit a rural community for either school or work, I'm still awestruck at the beauty of the rural health care facility and what that facility means for its community.

Rural health care employees are among the most dedicated staff I have ever had the opportunity to work with, which is one of the most rewarding aspects of working in a rural setting. Their passion, knowledge and desire to improve their community is wonderful and a daily highlight of my work.

While there are great rewards, there are also challenges. Working in a rural setting makes it hard to get the attention of some of the federal agencies that fund research and program development. It also spreads fellow rural supports across the country, making it difficult to collaborate. Regardless of the challenges, the rewards are too great to not work in rural.

Upon graduation with my PhD in the next year, I hope to either pursue a tenure-track faculty position in a school of public health with a focus on rural public health or continue my work with the Indiana Rural Health Association. Regardless of the path ahead, I know mine will be a rural journey.

Cody Mullen is a project coordinator for the Indiana Rural Health Association and a doctoral student at Indiana University. He was a National Rural Health Association Rural Health Fellow in 2014.

Innovative rookies and seasoned professionals share their experiences.

“Access to health services in frontier southwest New Mexico looks very different and better now than it did then.”



Charlie Alfero

Finding freedom and possibility on the frontier

By Charlie Alfero

I moved from Westchester County, N.Y., to Silver City, N.M., in 1971 to attend Western New Mexico University. I knew immediately that the frontier western U.S. was for me.

There was and is a sense of freedom and possibility that I had not experienced in the dense and rigid economic and cultural East Coast structure. It seemed impossible for a poor kid from a “bad” neighborhood to compete, achieve – or perhaps even survive.

I got my first job in rural health after meeting the chairman of the regional health systems planning council at a 1977 Christmas party in Silver City. Several months later, I was the staff planner for a four-county effort to improve health services in southwestern New Mexico. Outside of Alaska and U.S. islands, this is about as remote and sparsely populated as it gets.

Many of the plans and projects we implemented in those days are still in existence today. Many have change dramatically, but access to health services in frontier southwest New Mexico looks very different and better now than it did then.

After a year and a half developing rural health planning skills, I moved to Albuquerque to manage the seven regional health planning offices of the day. A couple of years later, I moved on to start the state’s Office of Rural Health in the Department of

Health. After some other changes, I helped develop the Office of Community Health at the University of New Mexico (UNM).

However, 16 years of bureaucratic work environments, while critical in terms of policy and resource supporting rural health systems, proved to be inconsistent with my personal goals of changing health and social systems to support those who need it most.

So in 1995, along with UNM support, a small amount of state funds and incredible local investment, we founded Hidalgo Medical Services (HMS) two days a week in Hidalgo County. It was the last county in New Mexico without any primary care services.

Today Hidalgo Medical Services serves around 70 percent of the population of southwest New Mexico as a fully integrated primary care network with 10 locations. In recognition of the importance of policy and resource allocation, HMS created the Southwest Center for Health Innovation in Silver City, N.M. Look us up.

Charlie Alfero is executive director of the Southwest Center for Health Innovation. He joined the National Rural Health Association in 1982 and received NRHA’s Louis Gorin Award for Outstanding Achievement in Rural Health in 2013.

*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.*

Members on the move

NRHA member represents rural health clinics on committee



Jennifer Dunn

Jennifer Dunn, Colorado Rural Health Center director of programs, was recently appointed to the Medicaid Provider Rate Review Advisory Committee.

The committee was enacted in June to assist the Colorado Department of Health Care Policy and Financing in the review of provider rate reimbursements in Medicaid.

Dunn says the Colorado Rural Health Center was contacted by Colorado Senate President

Bill Cadman's office to represent rural health clinics on the committee. Colorado has more than 50 federally designated rural health clinics in addition to 50 other rural clinics.

"As the state authority on rural health, our organization is honored to be the trusted and informed voice for rural health facilities on this committee," Dunn says. "NRHA has been a great resource for education and information on issues impacting rural facilities."

Dunn joined the National Rural Health Association in 2009.



Rachel Ruddock

NRHA member focuses on recruitment, retention in new role

After working for two years at the Michigan Department of Health and Human Services in the Bureau of EMS, Rachel Ruddock recently accepted a position as recruitment and retention services manager at the Michigan Center for Rural Health following the retirement of Steve Shotwell.

In her new role, Ruddock will work to match clinicians with health care facilities in rural Michigan. She will also host events for students to generate interest in rural health careers and give

presentations on loan repayment programs through the National Health Service Corps and the Michigan State Loan Repayment Program.

"I'm looking forward to using NRHA's vast network of resources to expand my knowledge and understanding of issues affecting rural health care in America," Ruddock says.

She joined the National Rural Health Association in 2015.

Longtime rural health educator aims to help rural, underserved women with research



Joellen Edwards

Longtime rural health educator Joellen Edwards, PhD, has joined the faculty at the University of Central Florida College of Nursing.

In her position as professor and Hugh F. and Jeanette McKean endowed chair, Edwards teaches health policy

and research courses and will continue her research on improving cancer screenings and promoting health for rural and underserved women.

Edwards previously served in a variety of roles at East Tennessee State University for 25 years.

"NRHA has been an integral and critical part of my career," Edwards says. "The organization offered opportunities to present research, publish and network with others dedicated to improving rural health across the country. I've also been privileged to be connected with NRHA through policy work on the National Advisory Committee on Rural Health and Human Services, through my term as president of the Rural Health Association of Tennessee, and currently as a member of the editorial board for NRHA's *Journal of Rural Health*."

Edwards joined the National Rural Health Association in 2011.

Clinical background helps fellow in new role



Ann Turner

Ann Turner recently accepted a position as a consultant at Accenture's Health Management Services.

In her new role, Turner is working on projects to improve health care delivery

in New York, such as the Medicaid Delivery System Reform Incentive Payment program.

Turner previously worked as a program manager at the Center for Rural Emergency Services and Trauma (CREST) at Dartmouth-Hitchcock Medical Center in Lebanon, N.H. CREST is a collaborative program of 17 critical access and community hospitals that support the extension of population health-focused emergency services and provider outreach/educational efforts.

"Much of my career has been working with vulnerable and underserved populations in rural areas and trying to make a difference," Turner says. "NRHA, particularly its Rural Health Fellows program, has given me a greater depth and breadth of understanding of the issues and provided me with opportunities to grow professionally so that I can better advocate for improvement."

Turner joined the National Rural Health Association in 2014 and is a 2015 NRHA Rural Health Fellow.

30 NRHA members among '50 critical access hospitals to know'

Many National Rural Health Association members made *Becker's Healthcare* latest list of "50 critical access hospitals to know."

Becker's used standards from the Department of Health and Human Services to define critical access hospitals as having no more than 25 inpatient beds, an

annual average length of stay of no more than 96 hours for acute care, 24/7 emergency care and a location at least 35 miles from another hospital.

The following NRHA member hospitals (in alphabetical order) were recognized by the industry publication for going above and beyond to care for their patients:

- Abraham Lincoln Memorial Hospital, Lincoln, Ill.
- Aspirus Grand View Hospital, Ironwood, Mich.
- Avera Holy Family Hospital, Estherville, Iowa
- Boone County Health Center, Albion, Neb.
- Brodstone Memorial Hospital, Superior, Neb.
- Calumet Medical Center, Chilton, Wis.
- Elizabethtown (N.Y.) Community Hospital
- Fairview Hospital, Great Barrington, Mass.
- Grant Regional Health Center, Lancaster, Wis.
- Hudson (Wis.) Hospital
- Kittitas Valley Healthcare Hospital, Ellensburg, Wash.
- Madison (S.D.) Community Hospital
- Martha's Vineyard Hospital, Oak Bluffs, Mass.
- Mayo Clinic Health System-Red Cedar, Menomonie, Wis.
- Memorial Health Care Systems, Seward, Neb.
- Ministry Door County Medical Center, Sturgeon Bay, Wis.
- Mount Desert Island Hospital, Bar Harbor, Maine
- Myrtue Medical Center, Harlan, Iowa
- New Ulm (Minn.) Medical Center
- Orange City (Iowa) Area Health System
- Pike County Memorial Hospital, Louisiana, Mo.
- Redington-Fairview General Hospital, Skowhegan, Maine
- Richland Hospital, Richland Center, Wis.
- Shenandoah (Iowa) Medical Center
- Speare Memorial Hospital, Plymouth, N.H.
- Steele Memorial Medical Center, Salmon, Idaho
- Tahoe Forest Hospital, Truckee, Calif.
- Transylvania Regional Hospital, Brevard, N.C.
- Waldo County General Hospital, Belfast, Maine
- West River Regional Medical Center, Hettinger, N.D.

NRHA member hospitals among top in nation

Each year, iVantage Health Analytics names its top 100 critical access hospitals (CAHs) based on market, value-based and financial indicators.

The National Rural Health Association honored the overall top 20 among those hospitals, as well as the top performers in each of three

continues

Send your career updates to editor@NRHArural.org.

continued

categories – quality, patient satisfaction and financial stability – during its annual Critical Access Hospital Conference in the fall.

These NRHA members (in alphabetical order) achieved the top 20 distinction for 2015:

Overall category:

- Aspirus Grand View Hospital, Ironwood, Mich.
- Aspirus Medford (Wisc.) Hospital and Clinics
- Avera Holy Family Hospital, Estherville, Iowa
- Madison (S.D.) Community Hospital
- Martha's Vineyard Hospital, Oak Bluffs, Mass.
- Memorial Health Care Systems, Seward, Neb.
- Myrtue Medical Center, Harlan, Iowa
- New Ulm (Minn.) Medical Center
- Orange City (Iowa) Area Health System
- Phillips County Medical Center, Malta, Mont.
- Pike County Memorial Hospital, Louisiana, Mo.
- Redington Fairview General Hospital, Skowhegan, Maine
- Speare Memorial Hospital, Plymouth, N.H.
- Steele Memorial Medical Center, Salmon, Idaho
- Transylvania Regional Hospital, Brevard, N.C.
- Waldo County General Hospital, Belfast, Maine

Quality category:

- Calumet Medical Center, Chilton, Wis.
- Iowa Specialty Hospital Belmont (Iowa)
- Lawrence Memorial Hospital, Walnut Ridge, Ark.
- Memorial Health Care Systems, Seward, Neb.
- Pike County Memorial Hospital, Louisiana, Mo.
- Towner County Medical Center, Cando, N.D.
- Trinity Hospital Twin City, Dennison, Ohio

Patient satisfaction category:

- Ashley (N.D.) Medical Center
- Battle Mountain (Nev.) General Hospital Battle Mountain
- Fairview Hospital, Great Barrington, Mass.
- Hansford County Hospital, Spearman, Texas
- Marengo (Iowa) Memorial Hospital
- Meade (Kan.) District Hospital
- Orange City (Iowa) Area Health System
- Reeves Memorial Medical Center, Bernice, La.
- Santa Ynez Valley Cottage Hospital, Solvang, Calif.
- Tioga (N.D.) Medical Center

Financial stability category:

- Battle Mountain (Nev.) General Hospital

- Humboldt General Hospital, Winnemucca, Nev.
- Kiowa (Kan.) District Hospital
- Memorial Medical Center, Ashland, Wis.

NRHA news

NRHA accepting award nominations

The National Rural Health Association will accept nominations for its 2016 Rural Health Awards at RuralHealthWeb.org through Feb. 11.

Winners will be selected by a committee of NRHA members and honored during the 39th Annual Rural Health Conference May 10-13 in Minneapolis.

Each student award winner will also receive complimentary conference registration, a one-year NRHA membership and \$1,000 from John Snow Inc.

Present at NRHA events

The National Rural Health Association is now accepting submissions for three of its conferences. Take advantage of these opportunities to share your knowledge with colleagues from across the country.

For the first time, NRHA is accepting presentation submissions for its annual Rural Quality and Clinical Conference, July 13-15 in Oakland, Calif., at RuralHealthWeb.org/quality through Dec. 17.

And poster submissions are being accepted for NRHA's 39th Annual Rural Health Conference, May 10-13 in Minneapolis, at Ruralhealthweb.org/annual through Jan. 8.

Submit poster presentations for NRHA's Health Equity Conference, formerly known as the Rural Multiracial and Multicultural Health Conference, at Ruralhealthweb.org/equity through Jan. 28.

NRHA forms new interest group, plans ACO summit

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 means alternative payment models (APM) will have increasing influence on the operations

of rural providers.

APMs will create a pressing need for rural providers to look at how they can respond through delivery system reform (DSR) at the local, state and national level.

“As MACRA is implemented, and in light of Health and Human Secretary Sylvia Burwell’s ambitious goals of moving most Medicare payments to APMs and value-based payments, reams of regulation will be promulgated over the next several years that will have profound impact on the rules of game,” explains Brock Slabach, National Rural Health Association member services senior vice president. “It will take the concerted effort of rural providers to ensure the impact of these regulations and programs are tailored for the rural environment.”

So 2015 NRHA president Jodi Schmidt started a special interest group, open to all NRHA members, within the association and dedicated to APM/DSR.

“With this focus and members sharing their experiences and ideas, NRHA will be able to better respond to the flurry of regulations coming out of D.C.,” Slabach says.

NRHA is also hosting a rural accountable care organization (ACO) summit on Feb. 1, just prior to NRHA’s Rural Health Policy Institute in D.C. The one-day ACO meeting will showcase APM/DSR best practices and feature rural health leaders discussing current and future trends. The Policy Institute, introducing attendees to members of the Obama Administration and

continues



Donor corner

Alana Knudson, PhD, has given generously to the National Rural Health Association’s Rural Health Foundation each year since it was established in 2012.

Knudson, co-director of the Walsh Center for Rural Health Analysis, joined NRHA in 2002.

Rural Roads: Why is rural health important to you?

Knudson: Rural is who I am. It’s where I grew up, and it’s where I feel most at home. I was raised on a farm in frontier North Dakota, and our family greatly relied upon the skills of our exceptional primary care provider, Bohdan Hordinsky.

Dr. Hordinsky was a Ukrainian-trained physician who had Sigmund Freud as a professor while studying in Vienna. He fled the Ukraine during WWII. When he was searching for a U.S. community to practice, he was turned away by many urban hospitals because he was mistaken for being German. The only community that welcomed him was Drake, N.D., which had about 650 people in the 1940s. After a few years practicing in Drake, Dr. Hordinsky was recruited by national organizations, but he declined the offers due to his gratitude for the rural community that gave him refuge and an opportunity to practice.

I learned a great deal about rural health from this remarkable individual who practiced until his early 80s – the importance of commitment to place and people, a dedication to the health and wellbeing of the whole person, and that a world-renowned health care provider may just happen to live in your rural community and charge \$14 for an office visit. I am most grateful for my rural roots, for Dr. Hordinsky and for the opportunity to work every day to identify ways to improve the health of rural communities.

Rural Roads: Why do you support the foundation?

Knudson: I believe it is important to invest in the future of rural health, particularly its future leaders. We have been fortunate to have many visionary leaders in rural communities, but many have retired or will in the next five to 10 years. We need to be proactive in creating mentorship opportunities for our up-and-coming rural health leaders to maintain the vitality of rural America.

Investing in the Rural Health Foundation is a way to pay it forward. The contributions made to the foundation make a positive, lasting difference in the long-term health of rural communities.

NRHA thanks Alana Knudson for her ongoing contributions to the Rural Health Foundation.

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

All those who give by Dec. 31 will be recognized in an upcoming Rural Roads.

caring for the future of rural America

continued

Congress, will also feature a session with Center for Medicare and Medicaid Innovation officials continuing the discussion of ACOs, APMs and DSRs on Feb. 4.

To join the special interest group, email membership@NRHArural.org, and register for the ACO summit and Policy Institute, taking place Feb. 2-4, at RuralHealthWeb.org/pi.

NRHA introduces new event for hospital leaders

The National Rural Health Association is planning its first Rural Hospital Innovation Summit in conjunction with its 39th Annual Rural Health Conference May 10-13 in Minneapolis.

“Health care and change have become synonymous, whether it’s new and expensive treatment modalities, the challenge of managing the health of populations or shifting financing schemes that confound the best of hospital operators,” says Brock Slabach, NRHA member services senior vice president. “We wanted to create an event to bring together rural hospital CEOs and CFOs tasked with managing these changes so that they can adapt as well as prepare their hospitals to thrive amidst these challenges with confidence.”

This interactive event will convene rural hospitals leaders to discuss what has worked well and what hasn’t and to share insights and innovations. It has been designed for teams from the same facility, including board members, executives, medical staff leaders and emerging leaders.

Interactive sessions will focus on developing and ensuring positive patient experiences, managing the health of populations, reducing costs of care, exploring alternative payment models and their fit for rural hospitals and delivery system transformation in a rural context.

Register today at RuralHealthWeb.org to save \$100.

Rural training track program enters sixth year

The Rural Training Track Technical Assistance (RTT TA) Demonstration Program recently entered its sixth year.

The program, funded by the Federal Office of Rural Health Policy (FORHP) and administered by the National Rural Health Association, is focused on supporting and developing “1-2” rural training track family medicine residency programs. The program provides RTT medical students with travel support for rural rotation opportunities and for their significant others to join them during on-site interviews. In addition to providing direct technical assistance to current and developing programs, NRHA’s RTT TA program also conducts research surrounding the impact of these residencies and their residents.

“NRHA is thrilled to continue its work with FORHP on this important project,” says NRHA program services coordinator and RTT TA staff liaison

Laura Hudson. “This program supports not only the primary care residencies programs and their staffs, faculty members, organizations and rural communities, but it also directly supports and encourages medical students to train and remain in rural America. NRHA remains committed to providing access to care to rural America.”

For more information on the program, including its research policy papers, visit raconline.org/RTT.

To learn more about RTT programs, read student reflections about their rural rotations and apply for travel support, visit the student site at traindocsrural.org.

NRHA internships prove valuable to students

Did you know the National Rural Health Association offers internships?

Because of NRHA’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.

Two interns recently joined NRHA at its D.C. office.

A senior at Sewanee University majoring in international and global studies, Briana Ehret came to NRHA to focus on health policy and advocacy. Her work included meeting coordination, legislation updates and developing NRHA’s chronic disease policy paper.

“I have never learned as much during a summer as I did while working at NRHA,” Ehret says.

Originally from rural Kentucky and Utah, University of Miami Miller School of Medicine MD-MPH candidate Sterling Haws joined NRHA to focus on rural health and immigration. His internship included developing an NRHA policy paper and brief on immigration in conjunction with NRHA member experts. Haws will also work with Florida Rural Health Association leaders to further develop its immigration policy information.

NRHA offers internships every semester in its Kansas and D.C. offices and works with students to meet their internship requirements.

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

NRHA hosts Rural Primary Care Issue Group meeting

The National Rural Health Association brought together 12 primary care experts including physicians, physician assistants, nurses, researchers and rural health clinic, community health center and state office of rural health leaders for the first Rural Primary Care Issue Group meeting in Washington D.C. in July.

The purpose of this group and its meeting is to help rural communities:

- move toward the improvement and expansion of access to health;
- build and maintain its primary care workforce;
- build partnerships with other organizations;
- expand and improve access to culturally competent, quality health care;
- ensure primary care, preventive and enabling services are available to rural and frontier patients;
- and monitor the landscape under expanded insurance coverage.

Facilitated by NRHA board member Dave Schmitz, MD, a rural training track program director from Idaho, the meeting was coordinated in conjunction with the Federal Office of Rural Health Policy (FORHP) as part of its cooperative agreement with NRHA and included agenda items

such as the physician fee schedule, rural pharmacy, telehealth services, and accountable care organizations.

“Primary care is the linchpin of the future health care structure. Being able to bring together a group of primary care health professionals from across disciplines informs NRHA on true, real-time primary care successes and challenges in this new era of rural primary care. In turn, NRHA can continue to take that message back to our partners and Capitol Hill,” says NRHA program services coordinator Laura Hudson.

The experts who attended will serve as a rapid response group for NRHA and will meet annually for the next four years to discuss rural primary care with NRHA and FORHP leadership.

NRHA leads rural veterans health meeting

The National Rural Health Association hosted the inaugural Veterans Rural Health Initiative meeting in

continues on page 41



NRHA's Rural Health Foundation

The National Rural Health Association has championed for rural health for more than 35 years.

NRHA's purpose is more relevant and vital today than ever.

Together, we can continue to protect and advance rural health through NRHA's Rural Health Foundation.

Like the people it serves, the foundation is focused on partnerships and promise, connections and community.

That's what it's all about.

Give back, move forward.

Send your tax-deductible donations to NRHA's Rural Health Foundation, 4501 College Blvd., Ste. 225, Leawood, KS, 66211, or contribute online at RuralHealthWeb.org/donate.

Donors who give by Dec. 31 will be recognized in *Rural Roads* magazine.

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continues from page 39

Washington D.C. in August.

Twenty-five participants discussed barriers and best practices impacting access to care for rural veterans.

“NRHA is proud to have launched the Rural Veterans Health Initiative to continue to provide leadership on access to health care services for rural veterans,” says program services vice president Amy Elizondo. “It is through this initiative that NRHA intends to highlight and develop successful strategies for improving the quality of care for those who have served our country.”

NRHA members representing veterans advocacy groups, community health centers, state office of rural health and rural hospitals as well as retired military personnel and leadership from the Veterans Health Administration Office of Rural Health and the Federal Office of Rural Health Policy (FORHP) participated in the two-day meeting. They will serve as a rapid response group for NRHA and will meet annually for four years to discuss rural veteran health care with NRHA and FORHP leadership.

Topics included the Veterans Choice Act, coordination of care between the VA and rural providers, transitioning military service personnel with health care skills training into rural positions, rural homelessness and opportunities for collaboration.

NRHA revamps social network for members

The National Rural Health Association has redesigned NRHA Connect, an exclusive, online member benefit for advocacy and networking, to be more intuitive and user friendly.

Join the conversation by activating your account to connect with colleagues and NRHA staff at Connect. NRHArural.org.

A mobile version of NRHA Connect, MemberCentric, is available on the app store of your mobile device. Select NRHA from the list of organizations.

For more information on accessing NRHA Connect and its features, including your initial password, email membership@NRHArural.org.

NRHA staff member earns award

Brock Slabach, National Rural Health Association member services senior vice president, received the 2015 Calico Leadership Award.

The award is presented annually to an outstanding rural health leader by Technical Assistance and Services Center (TASC), a program of the National Rural Health Resource Center.

Slabach joined NRHA's staff in 2008. He is a former NRHA member and rural hospital administrator.

accelerating advocacy

Participate in policy-making process to protect rural

Help shape the agenda on health care in rural America by joining the National Rural Health Association and colleagues from across the nation Feb. 2-4 in D.C.

NRHA will introduce you to members of the Administration, Congress, key public health officials and health care experts and give you the tools to effectively advocate on behalf of rural patients and providers.

The 27th annual Rural Health Policy Institute is also your opportunity to participate in the policy-making process through coordinated visits with your elected officials on Capitol Hill.

“This year, the rural health care delivery system faced its greatest challenge,” says Maggie Elehwany, NRHA's government affairs vice president. “Fifty-nine rural hospitals have closed; 283 more are on the brink of closure. Continued cuts in hospital payments have taken their toll, forcing far too many closures and leaving some of our nation's most vulnerable populations without timely access to care.”

NRHA asks you to stand up and protect the rural health care safety net and join us in Washington in February.

Register now at RuralHealthWeb.org/pi to save \$100.

All the news that's fit to archive

Pennsylvania Avenue is best known as home to the White House and its famous residents. But did you know that Newseum, a museum dedicated to archiving decades of media and journalistic activity, is located just blocks away and 1.5 miles from the National Rural Health Association's Policy Institute hotel?

Historians and tourists will find international headlines and artifacts spanning 80 years. These compelling exhibits and comprehensive collections portray some of the world's most significant historical moments, representing how they were reported in an interactive setting. And – like many museums in the area – Newseum is free.

So when you're in town for the Policy Institute in February, make time to join the more than 2.25 million visitors who have already experienced Newseum.

Off the beaten path

Winter wonderland

More than a little off the beaten path and a bit farther than “over the river and through the woods,” travelers will discover North Pole, Alaska (formerly known as Davis), population **2,117**.

Not just Christmas legend, this town is home to the world's largest Santa. Installed in its current location in **1978** and arriving in four pieces, the **42**-foot tall statue weighs in at **900** pounds. This fiberglass icon greets passersby and customers of the Santa Claus House, a classic trading post store on Saint Nicholas Drive.

The store was first constructed in **1952** by Con and Nellie Miller and served as a meeting place for locals, a grocery store, wedding destination and North Pole's first post office. While it has been renovated (and even relocated) in the decades that would follow, Santa Claus House is a lasting icon heralding the holidays season after season. Proving there are more than **12** days of Christmas for this tiny town, the Santa statue and Santa Claus House bring holiday joy to locals and thousands of tourists **12** months a year.

North Pole, Alaska, isn't so far off the beaten path that it doesn't have its own U.S. ZIP code. Thousands upon thousands of letters addressed to “1 Santa Claus Lane” are received and answered by a group of locals each Christmas season.



Newseum photo by Rob Crandall via Shutterstock

up to speed

Work well

To stay healthy at the office we all know to avoid the vending machine for our afternoon snack and keep moving throughout the day. But did you know that rest is also an important part of the equation? No, unfortunately we aren't recommending you nap on the job. While we should all keep moving and stretching throughout the day (aka “desk-exercise”), it's important to remember that we also need our rest.

Show up rested: Getting adequate sleep the night before a shift could cut down on those vending machine trips, unhealthy lunches, caffeinated refills and even give you the energy you need for pre- or post-work exercise.

Rest your eyes: Computer screens can stress our sight throughout the day. Make sure you take time to look away from the electronics in your daily routine at regular intervals to avoid strain.

R&R: You've worked hard, so don't let those vacation days go unused. Many studies have demonstrated that by taking time for yourself throughout the year, your physical health and emotional wellbeing can dramatically improve, making you an even better and more productive employee.



Partner with Premier to reduce supply chain expense

Facing the pressures similar to those of large hospitals and health systems, rural hospitals, like you, are looking to reduce its supply chain spend and standardize products. Premier's partnership with NRHA gives you access to Premier's GPO contract portfolio. Take cost out of your organization, improve safety and support clinical processes.

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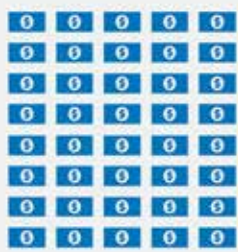
BY HEALTHCARE
SYSTEMS

LEVEL OF INFLUENCE:



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Feb. 2-4
Washington, D.C.
- Rural Hospital Innovation Summit**
May 10-13
Minneapolis, Minn.
- Health Equity Conference**
May 10
Minneapolis, Minn.
- Rural Quality and Clinical Conference**
July 13-15
Oakland, Calif.
- Rural Medical Education Conference**
May 10
Minneapolis, Minn.
- Rural Health Clinic Conference**
Sept. 20-21
Kansas City, Mo.
- 39th Annual Rural Health Conference**
May 10-13
Minneapolis, Minn.
- Critical Access Hospital Conference**
Sept. 21-23
Kansas City, Mo.