

# rural roads

Summer 2015 National Rural Health Association



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An uphill battle	7
Health care on the other side of the mountain	
Experts tailor diabetes, childhood obesity programs to rural	15
NRHA honors rural health's finest	17
Memory Lane	24
Rural health leaders flock to Philadelphia	
Mobile mammography fills gap in rural care	29
Using technology to expand rural behavioral health care	32
Beginnings and Passages	36
Innovative rookies and seasoned professionals share their experiences	
Rural schools drop lunch programs	38
Federal funding doesn't address rural challenges	
HIV outbreak calls for improved public health in rural America	41
Mile Markers	42
Former NRHA member takes No. 2 spot at HHS	
Shortcuts	47
The doctor is in... your Netflix queue	

Cover photo: Richard Sandor, 65, took the hour-long bus ride to the Mad River clinic to pick up his medication for chronic pain.  
Photo by Heidi de Marco

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## IT'S TIME TO PUT AWAY THE CRYSTAL BALL MEDICARE SETTLEMENTS SHOULD BE MORE THAN A "BEST GUESS"

**Brian Bertsch**  
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Jodi Schmidt

## Building bizarre bridges

Navigating today's changing health care environment has been described as straddling two canoes while running the rapids.

Driving through the Flint Hills of rural Kansas recently, I was struck by a metaphor of my own. There I found the "Bazaar Cattle Crossing." It is a highway bridge constructed like any other. This bridge, however, exists only for the cattle, allowing them to safely cross from one range to another.

I believe the sign painters meant "bizarre" – unless they truly believe the cattle are planning an annual cake walk and carnival! Our current path, moving from historic models of care and reimbursement across a bridge toward a challenging new future, is equally bizarre.

But just as we rely upon the solid foundation of a good bridge, we must be willing to invest the time and energy to assure a rural health care infrastructure that supports safe crossing. Please do all you can to be heard during this critical transition, expanding the National Rural Health Association's "Your voice. Louder." motto to "More voices. Even louder."

Jodi Schmidt  
2015 NRHA president

## pit stop

### things I picked up in this issue:

1. Rural towns across America experience higher rates of hunger and poverty, but often do not receive full federal reimbursement for school lunches. *page 38*
2. A three-room mobile mammography unit has screened more than 15,000 women since 2010 in Arkansas counties that lack mammography facilities. *page 29*
3. 5.7 percent of rural residents 18 and older experienced "serious psychological distress within the past 30 days" during 2010-11 compared to 4.7 percent of urban residents. *page 32*
4. Being a rural doctor requires becoming savvy and resourceful, honest and holistic about the care you provide. *page 36*
5. The biggest barrier to treatment for residents of tiny towns is not insurance coverage, but geography, poverty, unemployment and lack of infrastructure. *page 7*

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# An uphill battle

Health care on the other side of the mountain

By Daniela Hernandez

*Jeff Clarke lives in a two-bedroom trailer near the Hayfork Cemetery. Photo by Heidi de Marco*

It's Tuesday morning, half past eight and already hot, when the small bus pulls up to the community clinic. Most of the passengers are waiting in front — an old man with a cane, two mothers with four kids between them, packed lunches in hand.

Two more arrive. A gray-bearded man with a pirate bandana steps from the shelter of his Subaru. A sunken-cheeked woman rushes up on her bike.

“Woohoo! We have a full car!” the driver says brightly after they’ve all climbed aboard.

The riders smile back, some with a hint of resignation.

*continues*

It's time for the weekly trip to the clinic in Mad River, Calif., about 30 miles down a winding mountain road in the Trinity National Forest. The tight twists and turns are hard on the stomach, but even harder on the joints – especially if you have chronic Lyme disease, as more than a few of these riders do.

Jeff Clarke, the 58-year-old in the black bandana, has Lyme, acquired long ago from deer ticks that dwell in the region's sprawling forests. But today he's going to ask about a lump that's been growing in his left breast. It's starting to hurt, and he's worried. His fellow riders list their own ailments matter-of-factly: asthma, dental decay, diabetes, drug addiction, heart disease and much more.

**“We were always 20 years behind everything. We were all just fine with that. Now it's different.”**

**Shannon Barnett, lifelong Hayfork, Calif., resident**

They wouldn't be making this trip if they didn't have to.

In Hayfork, “we're down to the remnants of the medical personnel,” says Clarke, a well-spoken musician with a love for science, cats and NPR. “It just came to the point where if I needed to deal with anything important I just felt much more comfortable going over to Mad River.”

Like so many isolated American towns, Hayfork has lost its vitality and much of its youth to bigger places. For all its tree-lined ridges and breathtaking views, Hayfork is well beyond the tourists' byways – more than an hour from the city of Eureka on the west and Redding on the east. It's a 45-minute drive just to Weaverville, the tiny Trinity County seat.

Whether they're too poor to leave or charmed by the star-filled skies, Hayforkers have mostly made their peace with isolation: No retail stores, theaters, museums, fancy restaurants – and Internet access that is iffy at best.

“We were always 20 years behind everything,” says Shannon Barnett, a 41-year-old former school teacher who grew up here. “We were all just fine with that. Now it's different.”

She's referring to the exodus of basic health services.



*Jeff Clarke, 58, at his trailer in Hayfork, Calif. Clarke says the lack of health care in Hayfork makes it hard to treat his high blood pressure, hepatitis C and Lyme disease. Photo by Heidi de Marco*



*Stormy Clarke, 23, chooses to smoke medical marijuana to cope with her bouts of schizophrenia and bipolar depression instead of taking any prescribed pills. Photo by Heidi de Marco*

For decades, Hayfork had been fortunate. Well after the rise of urban health systems and their intricate business models, it had a tight-knit local “system” founded on the simple, generous commitment of two people: a general practitioner and a pharmacist.

“He was everybody's doctor,” Barnett says of Earl Mercill, MD, a GP who moved up from the Central Valley almost 50 years ago. “You never thought about going to anyone else.”

But it's been years since Mercill retired. Now his clinic is staffed by doctors who rotate in from Weaverville once or twice a week, and otherwise it's run by physician assistants. There are no hospitals for miles, though helicopters swoop in for emergencies when needed.

The Mad River clinic isn't an ideal alternative. It's bigger than Hayfork's





Pharmacist Gerry Reichelderfer, 81, waits for customers at the Hayfork Drug Store last June. He owned the pharmacy for more than 30 years. Photo by Heidi de Marco



Ernie Hall, 77, is a long-time customer and friend of pharmacist Gerry Reichelderfer. Photo by Heidi de Marco



South Trinity Health Services in Mad River, Calif., serves the residents of Hayfork and surrounding areas. Photo by Heidi de Marco

and offers a wider array of services, but it's about an hour away by bus. It's so backed up with patients it can take weeks to get an appointment, Clarke says.

In these tiny towns of California's far north, lacking insurance is not the biggest obstacle to care. Even before Obamacare took effect, about four of five people were insured, roughly the same as in the rest of the state. A good number are on Medi-Cal.

What's ailing these people is geography – that, and poverty. The median household income in Hayfork is about \$34,000 a year, well below the statewide figure of about \$60,000, according to the American Community Survey. Unemployment is extraordinarily high – estimates range between 9 and 26 percent. Many people lack a sturdy car to drive, or even money for gas.

**“It’s a real hardship for people who are severely mentally ill to live out here because there’s not a lot of resources.”**

**Julie Bussman, a former Mad River clinic psychologist**

In the federal government's parlance, Hayfork is a “medically underserved” community – one of roughly 3,500 in the country and 170 in California. By definition, these areas have too few primary care providers, high infant mortality, pervasive poverty and/or a significant elderly population. Some are islands of deprivation within otherwise well-stocked urban areas. Others are dots on the map like Hayfork, far from where doctors and medical services are clustered. According to the National Rural Health Association, only about 10 percent of physicians practice in rural America, where nearly a quarter of the population lives.

Health care is available on the other side of the mountain, says Greg Schneider, a 65-year-old writer and band mate of Clarke's. “The problem,” he says, “is getting there.”

## Lumberjacks and Janes

In 1967, long after its rise and fall as a gold-mining town, Hayfork struck it rich. That's when a friend told

*continues on page 11*



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Mercill, then practicing in tiny Arvin, Calif., that an even tinier town south of Oregon badly needed a doctor.

Mercill was intrigued. He visited a few times with his large and growing family. (He and his wife Marianne eventually raised eight kids, four of them adopted.)

Hayfork was still a mill town then, filled with lumberjacks and Janes, as the women were known. It had restaurants, shops and even a thriving art and music scene.

After praying on the decision, the family moved up north, built a house and settled on 40 acres outside town. A few months afterward, Mercill opened his clinic downtown.

He was beloved almost from the beginning. He made house calls in the middle of the night – sometimes walking over precariously narrow log bridges or shuttling to his patients' homes by snowmobile.

He delivered babies by flashlight after storms knocked out power and waited by his patients' bedsides for hours until they felt better, sometimes charging little more than a slice of cake.

"If they didn't have any money, I saw them," Mercill recalls, frail now, but with a keen long-term memory. "If they could pay later, fine. If they didn't, they didn't. I never went hungry."

Mercill couldn't do everything, of course. If a patient needed a specialist or surgery, he sent them to colleagues in Redding or Weaverville. Sometimes he drove along with them and assisted in the operating room.

In 1982, pharmacist Gerry Reichelderfer came to Hayfork, also on a friend's recommendation. He fell in love with mountain life and took over the drug store next to Mercill's clinic.

Reichelderfer lived just seven minutes and a single stop sign away from his shop. He'd drive over and open up anytime people needed a prescription. If they couldn't pay right then, he'd put it on an I.O.U. or let it slide.

The men joined forces, talking daily by intercom. The partnership would last nearly two decades.

## A turn of fortune

In the late 1980s, the logging industry started to crumble. Partly because of pressure from conservation groups, the mills in Northern California dominoed shut. By the time Hayfork's mill closed in the early



*Hayfork's timber mill, no longer in use, still stands at the edge of small town. Sierra Pacific Industries closed the mill in 1991, leaving more than 150 people out of work. Photo by Heidi de Marco*



*Earl Mercill was honored for his years of service as Hayfork's sole physician with a 13-foot clock on Main Street. Photo by Heidi de Marco*

1990s, the population – never higher than the low thousands – had dwindled.

"When all the workers left, they took all the families and young children," says Rick Simmons of the Trinity County Historical Society. "What was left over was people unable to go anywhere."

Homelessness, poverty and drug addiction took hold. An underground market began to sprout around marijuana – bringing drifters, seasonal trimmers and unofficial security forces to town. The forests became a dangerous place to wander.

Clarke, a runaway and hitchhiker in his youth, was in some ways typical of Hayfork's new generation. He arrived in the 1980s, in the clutches of methamphetamine addiction, a habit he picked up in the bars where he played guitar. For years, he landed jobs and lost them – working as a wood chopper, sandwich maker and cabinet craftsman. He started seeing a woman he met in rehab, then split with her, but not before they had a daughter. They named her Stormy Brooke. He gained custody and lost it more than once.

*continues*





Earl Mercill, now 91 and retired, was Hayfork's only doctor for more than 50 years. Photo by Heidi de Marco



A plaque accompanies Earl Mercill's clock. Photo by Heidi de Marco

He wanted to get sober for her, if not himself. Seeing no hope for professional help locally, he drove to a clinic in Weaverville. His first need, he told the counselor at the desk, was housing – a roof over his head.

"He repeatedly said, 'that's not my job,'" Clarke says.

Clarke stopped trying to seek addiction treatment after that.

"Most of the progress I've made in the last few years

has been behind the 12-step stuff I do," he says.

The meetings at Hayfork's Solid Rock Church saved his life, he says. He goes every Monday and has been sober 10 years.

His health is OK, considering. He lost his teeth. His bottom denture wore out long ago, and his top one is breaking. He has high blood pressure, a detached bicep and hepatitis C from a jailhouse tattoo. He developed chronic Lyme disease because he wasn't treated right away with antibiotics.

Nowadays, Clarke lives behind the Trinity County Fairgrounds, in a two-room trailer next to the town cemetery. Supported by \$889 a month in disability insurance, he spends his time organizing 12-step meetings, reading library books and science magazines, and volunteering as a sound engineer for gigs at the local coffee shop. On good nights, he gets paid a little. Most important to him, he says, is staying as healthy as possible so he can look after 23-year-old Stormy and her 2-year-old son, Tony, who lives with his dad.

Stormy, a tall beauty too insecure to know it, cuts herself and has made several attempts at suicide. Her porcelain arms bear the scars.

"She has no self-esteem," Clarke says. "She has no faith in love, or trust for any other human beings. She has some real darkness inside her, you know? I'm sure I'm responsible for a majority of that."

In June, during a fight with her father, she had what her dad thought was a stroke. En route to Redding in an ambulance, she started seizing so they put her on a chopper. At the hospital, the doctors said she'd had a stress-induced seizure.

After three hours, her doctors released her with a prescription for klonopin to control her seizures and panic attacks, and told her to follow up with her primary care physician.

"I had to laugh," Clarke says. "We're in Hayfork!"

## Like losing a limb

Mercill hung onto his clinic as long as he could, finally selling it to a doctor based in Weaverville. That doctor recently sold it to Trinity Hospital, part of the Mountain Communities Healthcare District, also based in the city.

The saddened community dedicated a clock to Mercill in the town center.

"It was like a limb being cut off," Barnett says. "I know at first I didn't have another doctor for a long time. Other people didn't either. They bounced around for a long time."

Every once in a while, Mercill treated people who asked, but he's 91 now, and hasn't done that in years.

Two of Mercill's kids grew up to be medical professionals – one a dentist, another a physical therapist – but they live and practice in bigger towns. The other children also moved away. One son, Steve, moved back from Southern California 21 years ago to care for his mother before she died. Now he's caring for his dad.

Reichelderfer carried on at his pharmacy after Mercill retired, lending credit to Clarke and others when he could. But the economics of health care shifted under his feet. His business began to struggle. The reimbursements from insurers were too low, he said, and the clinic next door – a long-time ally – began referring patients to bigger stores in Weaverville.

In Trinity County, where Hayfork is located, medical services overall became hard to find. In 2012, according to the Office of Statewide Health Planning and Development, there were 11 medical doctors currently practicing, roughly one per 1,200 residents. Statewide, the ratio is roughly one per 300.

Specialists like dentists and psychiatrists are nearly non-existent here. That lack of specialty care – particularly in mental health – wears on some residents. Stormy Clarke says that when she feels a panic attack or depression coming on, she simply tries to breathe deeply and distract herself by keeping busy. She also has a medical marijuana card and smokes regularly.

A county behavioral office offers counseling in Hayfork, but a counselor isn't there every day, and in-person visits are by appointment only. Sometimes the most expedient treatment comes in jail – Clarke calls it the “nudge from the judge.”

He mentions an acquaintance named Robbie, who suffers from paranoid schizophrenia. Since being released from jail, he's been off his meds, Clarke says. He walks up and down Hayfork's main strip along Highway 3, muttering to passers-by about the many people who are after him.

“In cities, you have places like outpatient programs for these types of people to go to every single day,” said Julie Bussman, PhD, a psychologist at the Mad River clinic. “It's a real hardship for people who are severely mentally ill to live out here because there's not a lot of resources.”

Bussman recently quit and moved back to Minnesota, leaving no psychologist for miles.

After the bus pulls into the Mad River clinic – a remodeled blue cottage that used to serve as the local forest service office – the riders start their wait. They are used to it by now: The kids pull out games and books; the adults chat in the waiting room or by a weathered picnic table on the back lawn.

Everybody has to be seen before the bus can head back.

On this day, Clarke is among the first in line. The physician assistant on duty examines his chest lump and advises against a biopsy, an invasive procedure, because he wants to run more tests. Clarke takes the news with some concern.

“I was pretty freaked out. I went in there with the agenda of the biopsy. They wanted to explore other options,” he says afterward.

By the time the bus gets back to Hayfork, it's mid-afternoon. He drives back to his trailer, frustrated and spent.

A few Tuesdays later, he takes the bus back to Mad River and is referred

to a specialist in Weaverville.

It is another two months before he learns the lump is a side effect of the medications he's taking – a hypothesis Clarke says he'd mentioned earlier to clinicians in Hayfork and Mad River.

Now he has to start thinking about replacing those dentures, which means another bus trip – or several – around the mountain.


## The final loss

Reichelderfer, 81 and in failing health, began looking last year for someone to buy his store. He tried for months. Even the independents weren't interested, in part because pharmacists' family members weren't keen on moving to Hayfork.

With great sadness, he shut his doors in September. “I wish I could have been able to sell it to somebody,” he said, “for the convenience of the people.”

From now on, Hayforkers will have to get a ride to Owens Pharmacy in Weaverville or to Walmart or CVS in Redding.

It took only a few days to board up a drug store open for 32 years.

It's a relic now, standing just yards from the clock the town dedicated to Mercill, with his years of service gratefully memorialized on a plaque. 

*This article originally appeared in Kaiser Health News, an editorially independent program of the Kaiser Family Foundation. Heidi de Marco and Carol Eisenberg contributed reporting.*

## In their own words

Get to know the residents of Hayfork, Calif., in these videos detailing their experiences living in a rural town with little access to health care:

- “Taking care of Earl: Story of a caregiver”  
[bcove.me/s8zu4244](https://bcove.me/s8zu4244)
- “Town pharmacist considers retirement”  
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- “Nowhere to go: Mental health in Hayfork”  
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# Experts tailor diabetes, childhood obesity programs to rural

By Angela Lutz



*Bryant Smalley (standing) and Jacob Warren developed initiatives to help manage childhood obesity and diabetes using telehealth.*

**Childhood obesity has been recognized as a public health crisis in the United States, and the problem is often most severe in rural communities.**

According to Bryant Smalley, PhD, PsyD, executive director of the Rural Health Research Institute at Georgia Southern University, childhood obesity-related health concerns often become chronic or deadly in adulthood.

“Children who grow up overweight are much more likely to face significant health problems ranging from hypertension to cancers once they are adults, and sadly we are starting to see increased rates of ‘adult’ diseases such as type II diabetes even within children themselves,” Smalley says. “Obesity also has well-documented impacts on mental health, self-esteem and even future income potential.

“Unless we focus consistently and heavily on childhood obesity, we may see the first generation of children who have shorter life expectancies than their parents,” he adds.

In order to address the problem in Georgia’s 16-county Southeast Health District, Smalley’s institute teamed up with the Georgia State Office of Rural Health and Mercer University’s Center for Rural Health and Health Disparities to create the South Georgia Network to End Childhood Obesity (SGNECO), a Federal Office of Rural Health Policy (FORHP)-funded initiative aimed at developing community-wide interventions to address childhood obesity.

After completing a region-wide needs assessment last year, Smalley began working with other community stakeholders to formulate a strategic, rural-specific plan to

develop resources to combat the problem. Jacob Warren, PhD, Mercer University Center for Rural Health and Health Disparities director, who co-created the initiative with Smalley, says SGNECO has been well received because it was generated by community interest.

“By being responsive to the needs of the communities we work in – that is, taking the time to really seek out and listen to what people are wanting to partner to address – programs can be developed that have a much higher likelihood both of initial success and of sustainable impact,” Warren says. “Another important consideration is the need to tailor programs to the realities of rural living; simply importing a program that was developed and evaluated in an urban setting into a rural community won’t always have the same impact, and doing a thorough review of the program to see where rural-specific adaptations are needed (such as exploring ways to minimize transportation burden) can help programs have a higher likelihood of success.”

In addition to childhood obesity, Smalley and Warren are also tackling diabetes, a common complication of obesity in adults. Through a collaborative effort between Georgia Southern University’s Rural Health Research Institute, East Georgia Healthcare Center and the Center for Rural Health and Health Disparities, Project ADEPT (Applied Diabetes Education Program using Telehealth) emerged from years of working in rural communities.

Also funded by the FORHP, Project ADEPT uses telehealth to connect rural diabetics with “a comprehensive, multi-session, evidence-based diabetes education program with the goal of helping patients learn how they can better self-manage their diabetes,” Smalley says.

In the sessions, patients learn about their condition and the importance of glucose monitoring, taking medications, routine medical care, diet and exercise, as well as motivational strategies. Services are provided at four rural clinic locations in East Georgia Healthcare Center’s service region, with a centralized diabetes educator who connects to the other three locations using telehealth.

“Within less than six months of operation, we had already enrolled nearly 80 patients into the multi-session education program and are currently operating on a waitlist,” Smalley says. “Physicians have been highly supportive of the program, and we are eager to see how it will continue to grow and expand.”


As SGNECO and Project ADEPT continue to

gain momentum, Warren is proud of the way these southern Georgia communities have worked together to challenge issues threatening their health – and he’s confident similar initiatives could work in other rural communities.

**“Unless we focus consistently and heavily on childhood obesity, we may see the first generation of children who have shorter life expectancies than their parents.”**

**Bryant Smalley, Georgia Southern University Rural Health Research Institute executive director**

“The thing I am most proud about with both initiatives is seeing the rural communities we work in coming together to tackle a problem that many would describe as so large as to almost be unsolvable,” he says.

“Rural communities are resilient, resourceful and dedicated, and I believe that programs like SGNECO and ADEPT in essence tap into those positive and uplifting qualities of rural communities to address very large – but very important – issues.” 

*Bryant Smalley received NRHA’s 2015 Outstanding Educator Award. Read more about him on page 21.*



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# NRHA honors rural health's finest



2015 Rural Health Award winners

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The 2015 recipients have used technology, teamwork and dedication to forge innovative programs and services, improving the lives of patients everywhere from frontier Kansas to the Mississippi Delta. NRHA celebrates the following rural health organizations, professionals and students who were honored at the 38th Annual Rural Health Conference in April.

*continues*



## Outstanding Rural Health Organization

**Sakakawea Medical Center** *Hazen, N.D.*

**and Coal Country Community Health Center** *Beulah, N.D.*

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In rural western North Dakota, the rivalry between Sakakawea Medical Center (SMC) in Hazen and Coal Country Community Health Center (CCCHC) in Beulah ran deep. Facing a changing health care climate, the two feuding organizations soon realized they would have to collaborate in order to survive.

Under the leadership of Darrold Bertsch, who serves as CEO of both organizations, SMC and CCCHC implemented a novel, cooperative model that puts the 11,000 residents in their service areas first. This cohesiveness resulted in improved quality of care and a brighter financial outlook, with the combined net margin for SMC and CCCHC going from negative to positive double digits in only a few years.

“We are passionate about improving the health and wellness of our area residents and visitors,” says Bertsch. “By working together and alongside our health care partners, we’ve identified the health needs of our communities and

are cooperatively planning for the future. Together, we are better able to improve the lives of our families, friends, neighbors and coworkers who are privileged to call our rural area home.”



## Outstanding Rural Health Program

**Innovative Readiness Training Collaboration**

**Delta Regional Authority and U.S. Department of Defense** *Little Rock, Ark.*

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The Innovative Readiness Training (IRT) Collaboration could be a game-changer for rural communities nationwide. The IRT program seeks to leverage medical training exercises for military reservists to provide free medical, dental and optical care from licensed medical professionals to medically underserved populations in rural America.

In six years, the collaboration has delivered free medical care to nearly 50,000 patients, with an estimated 12,000 additional people expected to receive care this summer. In Arkansas alone, an IRT mission last summer reached more than 2,000 patients.

“Patients are seen who have never seen a dentist or been fitted for glasses,” says David Stewart, mayor of rural Newport, Ark. “Inevitably, patients are diagnosed with chronic diseases that threaten not only their family’s stability, but the productivity of our local workforce. These individuals are often connected to the medical homes necessary to treat and improve their quality of life. The Delta Regional Authority-Department of Defense partnership effectively addresses the urgent medical needs of the region.”

## Outstanding Rural Health Program

### Rural Behavioral Health Primary Care Collaborative

Western Montana Area Health Education Center *Missoula, Mont.*



caption



Many rural communities struggle with a dearth of mental health providers, but the Western Montana Area Health Education Center (AHEC) Rural Behavioral Health-Primary Care Collaborative has made it possible for physicians to refer patients to a behavioral health specialist just down the hall.

Through the partnership of three critical access hospitals, pre-licensed post-doctorate psychologists and pre-licensed social workers were hired to provide services in rural Montana communities while receiving distance supervision from university faculty. Initially funded by a three-year HRSA Rural Health Services Outreach grant, the project has helped reduce profes-

sional isolation for providers and decrease stigma associated with mental health treatment for patients.

"Montana is vastly rural with wide-open spaces and very low population," says Kaye Norris, PhD, Rural Behavioral Health-Primary Care Collaborative project director. "Its rural heritage sets the tone for the entire state. Keeping our rural citizens healthy, with access to quality health care, and thus improving their quality of life is Western Montana AHEC's greatest passion."

## Louis Gorin Award for Outstanding Achievement in Rural Health

**Steven R. Shelton, Texas Area Health Education Center East assistant vice president for community outreach and program director** *Galveston, Texas*

Twenty-five years ago, Steven Shelton planted the seed for the Texas Area Health Education Center East (TAE). His passion and determination have ensured the vitality of the program ever since. An influential leader and faculty member at University of Texas Medical Branch since 1981, Shelton has championed rural-relevant educational programs and trained a generation of health professionals. In his role with TAE, he has worked with students and preceptors to encourage rural practice.

Throughout his 40-year career, Shelton's history of leadership on national and regional rural health efforts has impacted rural health policy, legislation and outreach. He has worked tirelessly to establish nine regional programs serving 111 counties, building strong community relationships and establishing professional mentorships.

"I have tremendous respect for so many individuals who have distinguished themselves as champions of rural health," Shelton says. "I have learned much from each of them. To be recognized in their midst is just overwhelming. I am deeply honored and humbled to be the 2015 Louis Gorin Award recipient."



## Rural Health Practitioner of the Year

**Wendel Ellis, DO, Greeley County Health Services family practitioner** *Sharon Springs, Kan.*



Wendel Ellis' lifetime of work in rural, frontier Kansas is a testament to his commitment to rural health care. Ellis believes that each patient has a right to compassionate, professional care, and he works hard to ensure each patient feels respected and valued.

He also has a passion for teaching, having worked with students from junior high through medical school. In his 21-year career, Ellis has worked as an obstetrician, provided free school physicals, and served as county medical director, nursing home director, EMS director, and deputy district coroner for two counties.

It is the chance to make a difference that fuels Ellis' love of rural health care.

"It is rewarding for us to work to improve health and access to health care in our small community, knowing that other like-minded individuals, groups and systems are doing the same," Ellis says. "With the combination of our efforts, we make a large-scale, meaningful difference, in addition to the significant opportunity we have to benefit an individual patient, family and community."



## Outstanding Educator

**K. Bryant Smalley, PhD, PsyD, Georgia Southern University**  
**Rural Health Research Institute executive director** *Statesboro, Ga.*

After identifying health care needs within his rural Georgia community, Bryant Smalley worked to develop a broad range of initiatives that engage faculty and students at multiple universities, as well as more than 50 community partners. His programs include a six-week rural health research immersion program for students; a telehealth-based

diabetes self-management education program; and a network to provide resources to combat childhood obesity.

Additionally, Smalley is a Georgia Southern University Department of Psychology faculty member. He has supported the independent, rural-focused research of many students and developed a doctoral-level course on rural mental health.

Smalley views his work as a chance to give back.



“I grew up in a town of less than 600 people, and every day I saw (and experienced) the struggles people faced in trying to lead a healthy life,” Smalley says. “Because of the personal connection I have to my work, being selected as Educator of the Year by the National Rural Health Association means a great deal to me and is a very high honor.”

## Outstanding Researcher Award

**Mark Holmes, PhD, University of North Carolina Gillings**  
**School of Global Public Health Department of Health Policy**  
**and Management associate professor and associate chair for**  
**research** *Duluth, Minn.*

Many of Mark Holmes' colleagues view him as an emerging visionary leader, and for good reason: Numerous federal agencies, including the U.S. departments of agriculture and justice, Federal Trade Commission, Congress and the

presented Critical Access Hospital Financial Indicator Report data to the White House Rural Council. He is committed to using his research to improve the lives of rural residents.

“Growing up in rural Michigan, I had not really appreciated how my local health system was different from those in urban settings,” Holmes says. “When I attended college in an urban area and experienced firsthand the different challenges – and opportunities – of rural health care delivery, I became interested in pursuing a career in rural health research ... I have enjoyed all of my 18 years of research on the topic since.”



White House, have used Holmes' research on Medicare hospital reimbursement policy in their decisions.

Additionally, his research on the economic effects of rural hospital closures has led to grants for financially struggling hospitals. Holmes also

## NRHA/John Snow Inc. Student Leadership Award

**Alex Spencer, University of Washington School of Medicine student** *Kalama, Wash.*

As a fourth-year medical student, Alex Spencer is already a dedicated rural health advocate. At the University of Washington, the soon-to-be rural general surgery resident is on the medical school's Targeted Rural and Underserved Track. He also serves as president of NRHA's Student Constituency Group and is a Western Washington Area Health Education Center board member.

With a knack for leadership, Spencer developed NRHA's student liaison program, which helps students connect with each other and share ideas to improve rural health education. His efforts have increased NRHA's student membership. Spencer looks forward to continuing to advocate for rural constituents as he begins his career.

"I've enjoyed the adventure of trying to answer the simple question, 'How can I help the most people, the most?'" Spencer says. "For me, the answer was literally in my backyard and has led me to become a rural general surgeon."



## President's Award

**Pat Schou, Illinois Critical Access Hospital Network executive director** *Princeton, Ill.*



dedicating service to a wide spectrum of rural health causes, all with a spirit of compassion and grace."

Schou was "deeply honored" to receive the award, having been involved with NRHA for more than 20 years.

"I am proud to be associated with NRHA's national

2015 NRHA president Jodi Schmidt selected Pat Schou to receive the President's Award, which was presented in a surprise ceremony at the Annual Rural Health Conference.

"This honor is given to a person who exemplifies the spirit of NRHA," Schmidt said at the awards luncheon. "This year the President's Award goes to a person who has been a lifetime advocate and champion of rural health,

voice," Schou says. "I believe rural communities are the heart of America and the reason we are blessed with good food and so many resources. Our rural communities deserve access to quality health care, and I am committed to helping my family, neighbors and fellow rural communities have these services to keep them safe and healthy."



## Rosemary McKenzie Legacy Award

**Sandra Pope, West Virginia Area Health Education Center director Morgantown, W.V.**

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At NRHA's Rural Multiracial and Multicultural Health Conference, Sandra Pope received the Rosemary McKenzie Legacy Award, which is presented to individuals who have mobilized their communities and dedicated their lives to improving the health of multiracial and multicultural populations.

Since 1983, Pope has enjoyed a career dedicated to serving the underserved. She has written federal grants, managed statewide programs and initiatives benefiting veterans and rural West Virginians, and served on NRHA's Multiracial and Multicultural Council for more than 10 years.

"I had known Rosemary for many years, and I had the utmost love and respect for her as she worked tirelessly to support and address the needs of multiracial and multicultural populations," Pope says. "I do what I do because I understand the need for service and commitment, and I want to do my part, however small, to improve the health of these often under-represented populations and communities."

McKenzie served as NRHA's minority liaison and program services manager for 27 years. She died in 2011 due to complications from pancreatic cancer. The award was created to carry on her legacy, as well



as provide free conference registration and a \$1,000 stipend to the recipient. Pope chose to forego all monetary aspects of the award.

"It was an opportunity to give back to an organization that has given so much to me," she says. "I just knew it was the right thing to do."

## Volunteer of the Year

**John Gale, University of Southern Maine Muskie School of Public Service Rural Health Research Center research associate Portland, Maine**

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Nominated and selected by NRHA staff, John Gale received the Volunteer of the Year award during a surprise ceremony at the Annual Rural Health Conference.

"The attributes of this person include a willingness to be of service whenever needed,

Gale called the award "a complete surprise and an honor."

"My interest in rural health is driven by the commitment and quality of the people working in this area," he says. "I have made good friends and colleagues that generously share their time and knowledge and make a real difference in the lives of rural residents. As a result, I am happy to share my knowledge and to give back to the organization and its members. Attending an NRHA event is like a meeting of old friends."



a commitment to rural health and active participation in NRHA," said NRHA CEO Alan Morgan at the awards luncheon. "In addition, the Volunteer of the Year is one who has been a gracious representative of NRHA in a variety of settings."

## Rural health leaders flock to Philadelphia

The National Rural Health Association's 38th Annual Rural Health Conference brought more than 700 health professionals to Philadelphia to represent rural, network with colleagues, and participate in more than 60 diverse sessions related to rural health progress.

The flagship event was preceded by NRHA's Rural Medical Education and Rural Multicultural and Multiracial Health Conferences.

"There seemed to be something for everyone's taste and desire for adventure," wrote one attendee. "As always, an excellent event."

The April conference kicked off with a presentation by Glenn Steele Jr., MD, CEO of Geisinger Health System, a nationally recognized health system that started as a small rural facility.

Attendees heard directly from insiders at the Federal Office of Rural Health Policy, Centers for Medicare and Medicaid Services, Veterans Health Administration (VHA), the Office of the National Coordinator for Health Information Technology, and multiple rural health associations from across the country.

"Mr. Reilly would be pleased to know NRHA is still a force to be reckoned with," said Uchenna S. Uchendu, MD, VHA Office of Health Equity director.

"I'm delighted to be in your midst," she added during the 2015 Reilly Memorial Address, named after 1983 NRHA president Terry B. Reilly.

NRHA launched NRHApp at the event, a new mobile application allowing participants to access presentations, create their own agenda and interact with other attendees.

"First Twitter in Miami, now apps in Philly. Thanks for keeping us baby boomers current, NRHA staff," Patricia Crawford, West Virginia School of Osteopathic Medicine rural outreach director, commented via the eco-friendly option.

NRHA also honored its 2015 Rural Health Award recipients during a conference luncheon. (Learn more about this year's honorees on pages 17-23.)

NRHA's 39th Annual Rural Health Conference will be May 10-13 in Minneapolis. The Rural Medical Education and Rural Multicultural and Multiracial Health Conferences will be May 10.



FORHP associate administrator Tom Morris, HRSA Office of Planning, Analysis and Evaluation director Becky Slifkin, NRHA president Jodi Schmidt and NRHA CEO Alan Morgan kick off the 38th Annual Rural Health Conference.



NRHA Rural Health Fellows Erin Gregg and Justin Stokes pose for a selfie station photo to share with other attendees via NRHApp.





*Clockwise: NRHA CEO Alan Morgan, 2015 NRHA Volunteer of the Year John Gale and former NRHA president Tim Size catch up during a networking break. Glenn D. Steele Jr., Geisinger Health System president and CEO, gives the keynote address. NRHA Communications Committee members and staff pose for a group photo at the selfie station they developed for the conference. Attendees from North Dakota gather for a photo. Eron Manusov hugs Sandra Pope after presenting her with the Rosemary McKenzie Legacy Award during NRHA's Rural Multicultural and Multiracial Health Conference preceding the Annual Conference.*

## More friendly faces

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



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# Mobile mammography fills gap in rural care

By Katrina Dupins



Physicians Sharp Malak and Ronda Henry-Tillman discuss a treatment plan with patient Mary Vines. Vines discovered she had breast cancer following a mammogram via Arkansas' travelling MammoVan.

For Mary Vines, the glass is always half full. And worry is one feeling she tries to avoid.

Having been diagnosed with cancer in both her breasts, Vines chooses to be grateful the disease was caught in early stages thanks to the University of Arkansas Medical Sciences (UAMS) MammoVan.

Vines had noticed a flyer on the door of a church she was scheduled to clean. A woman of faith, she asked God, "Are you trying to tell me something?"

"I had been feeling twinges in my breasts for two or three years, but I would put it off because I didn't have insurance," she says.

Vines wrote the phone number down and later called to make an appointment. When the van arrived in Hermitage, Ark., population 819, Vines saw mammography technician Heather Buie.

"After she took the first image, Heather said, 'Ms. Mary, I'll have to take another picture because I think you may have moved,'" Vines remembers.

Vines says she knew then that there was something suspicious on the image.

"I know I didn't move," she says. "You can't move on

that thing."

The next day, Vines received a call from Sharp Malak, MD, a radiologist and assistant professor in the Department of Radiology in the College of Medicine and Department of Epidemiology in the College of Public Health.

**"Mammography is a basic component of preventive health. And we have a third of the state where patients don't have access."**

Sharp Malak, MD, University of Arkansas Medical Services radiologist and assistant professor

"He kept apologizing, and I knew his news couldn't be good," Vines remembers. "But I told him I'm OK. I know I will be OK."

"She had cancer in both breasts," Malak says. "It's good that we have the MammoVan to help address the unmet need of so many women going without mammograms."

The MammoVan screens about 2,000 patients a year. Malak says they're hoping to double that number in 2015.

"Mammography is a basic component of preventive health," he says. "And we have a third of the state where patients don't have access. That's why this service is important."

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continued



*The University of Arkansas Medical Sciences MammoVan screens about 2,000 patients each year, most of them in rural areas.*



*Ronda Henry-Tillman*

Ronda Henry-Tillman, MD, is a breast cancer surgeon and a professor in UAMS Department of Surgery in the College of Medicine. Every day she sees patients who are in the advanced stages of cancer.

"I thought, 'We need to do better,'" Henry-Tillman says. "When we started evaluating what the biggest problem was 15 years ago, we found that it was the fact that women didn't have a place to get a mammography. Since then, we have been able to provide the MammoVan service. It has made a big difference."

**"I had been feeling twinges in my breasts for two or three years, but I would put it off because I didn't have insurance."**


*Mary Vines, MammoVan patient*

For Vines, the difference is personal.

"Instead of coming in with a tumor she could feel, Dr. Malak was able to see it through the mammogram images. That wouldn't have happened if the MammoVan hadn't rolled into her county offering the service," Henry-Tillman says.

Vines says she's grateful the mobile mammography unit made a stop in Hermitage last fall.

"We're in the middle of nowhere, 100 miles from Little Rock and 100 miles from Monroe," Vines

explains. "I wouldn't be here if I hadn't seen that flyer. I just thank God for it. You couldn't ask anyone to treat you any nicer than the way people have treated me at UAMS. Everyone has gone out of their way to help us." 

*Katrina Dupins is the University of Arkansas Medical Sciences media relations manager.*

## Help on wheels

A three-room mobile mammography unit, the University of Arkansas Medical Sciences MammoVan regularly travels to 26 Arkansas counties that lack FDA-approved certified mammography facilities.

Since it started in February 2010, more than 15,000 women have been screened on the MammoVan.

The MammoVan is outfitted with the most advanced digital mammography equipment and is staffed by a certified mammography technologist and a technical assistant.

Patients receive their test results within two to three weeks. Results are also sent to each patient's primary care physician. If the mammogram shows a potential abnormality, the patient is referred for follow-up to the appropriate services.

If a patient has insurance, MammoVan will bill insurance. Grant funds are also available to pay for services or assist with payment.

The unit is handicap accessible, with a wheelchair lift entering directly into the mammography suite. And it's designed to accommodate women in a standing or seated position.

The MammoVan is paid for in part by the Arkansas Cancer Coalition, State Legislature and support from the Walmart Foundation, Komen Foundation and private donors including Ashley County Cares.



# Partnerships use technology to expand rural behavioral health care

By Christina Villalobos



*Northeast Kingdom Human Services (NKHS) in Derby, Vt., is a community mental health center that serves clients in rural Vermont. The Vermont Department of Mental Health designated NKHS with the responsibility of ensuring needed services are available through local planning, service coordination and monitoring outcomes within the region. In 2012, NKHS built a new clinical outpatient facility.*

The World Health Organization calls behavioral health illnesses the biggest health burden in North America.

Approximately one in five U.S. adults 18 and older has a mental illness, and approximately 22.7 million people 12 and older needed treatment for an illicit drug or alcohol use problem in 2013, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).

Behavioral health issues, such as depression and substance use disorders, tend to impede a person's positive health behaviors like healthy eating and exercising, and likewise, chronic diseases often impact a person's mental health.

"Coordinating care across providers, particularly through the use of health information technology

(IT) and sharing of patient information and data, is essential to delivery of patient-centered, high-quality health care that addresses the 'whole' person," says Sahira Rafiullah, Federal Office of Rural Health Policy (FORHP) deputy associate administrator.

Health IT involves the secure exchange of health and other personal information between a patient and his or her provider and other entities, such as insurance companies and government agencies. Health IT also encompasses health systems integration, health information exchange (HIE), and the use of electronic health records (EHR).

"Health IT can also be a critical tool for prevention, wellness and recovery support," adds Aaron Fischbach, FORHP policy coordinator.

The Affordable Care Act (ACA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act are propelling an increase in health IT use with pay-for-performance models and EHR incentive programs.

"We know ACA and the HITECH Act will expand both insurance

coverage and access to health IT for both patients and providers,” says Laura Rosas, SAMHSA lead public health advisor. “Access to physical and behavioral health care is critical to the patients we serve, and the integration of behavioral health and primary care will improve outcomes. That is one of the reasons we developed Consent to Share, an open-source software that allows patients to choose which parts of their health information they want to share, which facilitates compliance with the substance abuse confidentiality regulations.”

**“Smaller systems can be nimble in making the kind of changes necessary to succeed in the new health care environment. Novel delivery arrangements may be pursued more easily among stakeholders who know and trust one another and who have a collective interest in improving community wellbeing.”**

Sue Deitz, Critical Access Hospital Network executive director

Compared to the general health care sector, adoption rates of EHRs and health IT are significantly lower among behavioral health care providers due to a lack of resources and the necessary expertise, as well as the ineligibility of most behavioral health care providers for EHR meaningful use incentives. In addition to the Health Insurance Portability and Accountability (HIPAA) requirements, stringent confidentiality restrictions for alcohol and drug abuse patient records and data further compound the health IT adoption challenges for behavioral health providers.

“Considering these factors, the challenge becomes more complex for rural behavioral health providers,” Fischbach says.

Health IT adoption among small, rural providers also currently lags behind larger providers. When taking into account the three distinct burdens to adequate rural behavioral health care – 1) accessibility: patients may have to travel great distances to access care; 2) availability: there is a limited availability of rural behavioral health providers; and 3) acceptability: there is a greater stigma associated with seeking behavioral health services in rural areas due to lack of anonymity – providing coordinated quality health care through the use of health IT and sharing of patient information is problematic for rural behavioral health care providers.

FORHP grantees are leveraging Rural Health Network Development grant funds to successfully integrate behavioral health care into primary care and provide high-quality coordinated health care through the use of health IT to confidentially share patient information and data.

## Vermont partnerships

The Behavioral Health Network of Vermont, which does business as Vermont Care Network (VCN), has partnered with the Vermont Council of Developmental and Mental Health Services to create Vermont Care Partners (VCP). VCP enables Vermont’s community mental health centers (CMHC) and specialized service agencies (SSA) to collaborate with local and state partners.

VCP is seeking to build upon network relationships and initiatives that use integrated efforts and technology to ensure data quality, enhanced reporting, population

*continues*

## Rural rates and resources

According to the *2014 Rural-Urban Chartbook*, compiled by the University of North Dakota Center for Rural Health and NORC Walsh Center for Rural Health Analysis:

- 5.7 percent of rural residents 18 and older experienced “serious psychological distress” within the past 30 days during 2010-11 compared to 4.7 percent of urban residents.
- 24 percent of women 18 and older in non-metro counties reported having “any mental illness (AMI) in the past year” from 2010-11, compared to 20 percent in central counties of large metro areas. Among men, the urban-rural gap for AMI was hardly discernable.
- Adolescent major depressive episode (MDE) in the past year ranged from 4-5 percent across urbanization levels for males and 11-13 percent among females. The highest percentages were found in non-metro counties. Across all regions, the largest percentage of adolescent males reporting MDE in the past year resided in non-metro counties with a city, while the largest percentage of females were located in the most rural counties in the West.

The free *Rural Mental Health and Substance Abuse Toolkit* was designed to help develop and implement programs to improve community mental health using proven approaches and strategies. It was funded by the Federal Office of Rural Health Policy and is available at [raconline.org/communityhealth/mental-health](http://raconline.org/communityhealth/mental-health).

continued



*Newport Hospital and Health Services in Newport, Wash., is an active member of the Critical Access Hospital Network. It is a 25-bed hospital providing integrated and comprehensive health care services for individuals living in eastern Washington and northern Idaho.*



*Sue Dietz*

and individual health management and improvement, and connectivity to the statewide Vermont HIE.

Vermont's 10 CMHCs currently use different EHR platforms, which are all at varying levels of implementation and functionality. And only one of the state's six SSAs has an EHR in place. As a result, the CMHCs and SSAs have been unable to engage with each other in quality improvement and benchmarking activities using real-time data.

VCP's Advancing Care through Technology project supports consistent and efficient reporting from all 16 CMHCs and SSAs to ensure high-quality clinical data and outcome reporting by aggregating data through the adoption of a unified data repository for individual agency and network-wide analysis; working with accountable care organizations to improve health outcomes and decrease costs through common protocols and patient engagement; and electronically transmitting patient care summaries across multiple settings to inform and enhance care across the health care continuum.

"Until the state develops a methodology to work within federal confidentiality restrictions for sharing alcohol and drug abuse patient information or federal regulations change, our data repository will serve as an

alternative to the Vermont HIE," explains Simone Rueschemeyer, VCP/VCN executive director.

The data repository will conform to the strictest privacy standards, and all member agencies have signed business associate agreements (BAA) and qualified service organization agreements.

"This project will also enable the CMHC/SSA system of care to demonstrate its value in a rapidly changing health care landscape," Rueschemeyer says.

## Washington network

The Critical Access Hospital Network's (CAHN) Eastern Washington Rural Integration Project will address rural primary and behavioral health care challenges by leveraging local collaboration with an innovative behavioral and primary health care integration model, as well as focusing on effective care coordination through continued development of patient-centered medical home models, established disease registries and integrated health information; using collaborative partnerships to pursue health care improvement opportunities and strategic rural health solutions; engaging state policymakers; and sharing the program's best practices and results.

The newly established public-private partnership organizations, called Rural County Coalitions, will use local population health indicators to establish health priorities and align strategic directions across agencies.

"This project supports the belief that rural communities have enormous potential for achieving the objectives of a high-performance rural health system," says Sue Dietz, CAHN executive director. "While there are




limitations related to scalability in rural health system development, there are also advantages that come with smaller scale. Smaller systems can be nimble in making the kind of changes necessary to succeed in the new health care environment. Novel delivery arrangements may be pursued more easily among stakeholders who know and trust one another and who have a collective interest in improving community wellbeing.”

**“Our rural network is encouraging of members to work with other community stakeholders to collaborate, share limited resources and reduce duplication. Value-based models are going to forge new relationships with those that have skin in the game. We are just trying to get ahead of that wave.”**

**Sue Deitz, Critical Access Hospital Network executive director**

For example, CAHN was able to create an HIE among network members using a virtual private network for the secure exchange of health information. The HIE harnesses and leverages the existing health IT capabilities in five CAH members and their respective nine rural health clinics. CAHN’s HIE is also positioned to connect with Washington’s HIE, OneHealthPort.

To address the initial challenge to confidentiality of behavioral health patient records, two network members retained legal counsel to draw up BAAs and a memorandum of understanding, which were an effective solution to privacy concerns and implemented by the rest of the members.

“Population health is not just a clinical/medical issue,” Deitz says. “It is a community issue involving behavioral health, public health, oral health, schools, transportation, food banks and the like. In creating new models of delivery, our rural network is encouraging of members to work with other community stakeholders to collaborate, share limited resources and reduce duplication. Value-based models are going to forge new relationships with those that have skin in the game. We are just trying to get ahead of that wave.” 

**Christina Villalobos is a public health analyst for the Federal Office of Rural Health Policy.**



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# Beginnings & Passages



Savita Fanta with her husband  
Stefan and son Asher

“Many of our patients do so much with so little and push me daily to stretch my limits to do the same.”

## Never a dull day: Why I love my job as a rural doc

By Savita Fanta

I love my job as an internist and pediatrician in Lyles, Tenn., population 734, for so many reasons.

I grew up in a small town in Middle Tennessee, so I knew the rural lifestyle was rewarding.

I participated in several rural health experiences during my time in medical school at the University of Missouri. I particularly remember a home visit to a very complex patient who was desperate to find “a doctor who would just doctor.” He wanted someone to help with diseases that, though complex, had several options for treatment if he were just able to access the physicians, facilities and pharmacies to provide them.

This patient’s prognosis would be different simply because he was rural. I had a hard time with that idea, and I work daily not to accept that inequality.

I took a job at a federally qualified health center in rural Tennessee to do just that. I have learned the \$4 drug lists by heart and have exhausted all our possibilities for free or reduced-cost medical care for our patients.

But that’s not all: I’ve learned how to identify whether the cows in the field behind our clinic belong to one of our patients or to his neighbor, why the skunks were so prolific a month ago, and even a few new terms I did not realize existed for medical symptoms. (I’ll spare you the definition of “skowers.”)

My experience here has been rich and rewarding. I am not only an internist, but at times also rheumatologist, a pulmonologist, a therapist, and, if I’m lucky, a student and friend.

Many of our patients do so much with so little and push me daily to stretch my limits to do the same.

Most of all, they’ve taught me that being rural doesn’t mean being uneducated or underprivileged. Quite the contrary: It means becoming savvy and resourceful, honest and holistic about the care you provide, all while dodging the cows in the parking lot and the skunk smell in the office. There is never a dull day as a rural doc.

*Savita Fanta, MD, is the only physician serving Three Rivers Community Health, a federally qualified rural health center in Lyles, Tenn. She found the position, her first as an attending, through the Tennessee Rural Partnership (TRP) in 2014. TRP is a National Rural Health Association member.*



Innovative rookies and seasoned professionals share their experiences.

“The look in the eyes of someone for whom you have made a difference is a true reward.”



Steven Shelton with his son Kevin on a West Texas ranch

## How many blessings can I count?

By Steven Shelton

How many blessings can I count among the experiences I have gained by my link to rural life and rural health? Preparing this column sparks great memories and realizations.

My work as a physician assistant in rural family medicine in the pioneering days of the PA profession created memories still vivid after 40 years. I learned the art of medicine from Bill Rollo, the esteemed town doc, who showed me what it meant to be “of the community.”

I learned to infuse compassion in my care of hurting families. I learned that helping as patients and loved ones faced the certainty of death was as important as healing in other ways.

I felt the reward of health care as the school board chairman came up to me at my oldest daughter’s graduation from high school. He asked if I remembered him, more than 20 years later, as he held up the finger I had repaired from a meat market injury when he was a youth. The look in the eyes of someone for whom you have made a difference is a true reward.

My career evolved to teaching PA students, then also medical students and others. I love to share the stories that help those students envision what they will face, who they will become, and what opportunities they may seize to find ways of making a difference for others.

As my career has progressed, mainly by being drafted by leadership to take on new and different roles, I have discovered that working at the Texas Area Health Education Center lets me get out and meet people, listen to them, learn from them, define their needs, and become a partner in problem solving to address those needs or strengthen their rural or underserved community. Such a role is a far cry from the kid who had trouble talking to classmates when growing up.

When it gets to the bottom line, I believe nothing is better than loving family, living in faith, serving others, and being willing to do what it takes to make a difference in life.

*Steven Shelton is assistant vice president for community outreach and program director at the University of Texas Medical Branch of Texas Area Health Education Center East. He joined NRHA in 2004 and received NRHA’s Louis Gorin Award for Outstanding Achievement in Rural Health in 2015. Learn more about Shelton’s career on page 20.*

*Are you relatively new to rural health or looking back on years of serving rural America?  
Email [editor@NRHArural.org](mailto:editor@NRHArural.org) if you’d like to share your story.*

## Rural Oregon schools drop lunch program

Federal funding doesn't address rural challenges

By Robin Stephenson



Photo by Joseph Molier, Bread for the World

**We have a problem in Oregon:  
We have one of the highest rates  
of hunger in the nation.**

*Oregonian* columnist David Sarasohn wrote that if there was a town called poverty it would be the largest city in Oregon.

That town would look a lot like Jordan Valley in rural Malheur County. The beauty of the high desert landscape belies a hidden reality of hunger and poverty; one in four residents live below the poverty line. In 2010, 24.3 percent of residents utilized food stamps, compared to 14.6 percent in the Portland metropolitan area. Malheur County has a 30.1 percent rate of child food insecurity – meaning kids are skipping meals.

Like jobs, resources in Jordan Valley, population 175, are limited; the nearest full-service grocery store is nearly 100 miles away. Approximately

80 students are bused to school each day from remote ranches, and 50 percent qualify for free or reduced-price lunch based on family income.

So, hearing that Jordan Valley dropped its free and reduced-price lunch program made my jaw drop. This makes no sense.

Kids learn better, graduate at higher rates, and are healthier when they have access to a nutritious lunch. There is a lot at stake here. The United States has a federal program that subsidizes school lunch, but the program is optional.

The problem is that the program isn't working for Jordan Valley.

Sharon Thornberry, a Bread for the World board member,

sees the urban-rural hunger divide in her work as the community food systems manager at the Oregon Food Bank. She views hunger at the community level. Thornberry says Jordan Valley exposes a policy issue that needs attention. She told Oregon Public Broadcasting that the lunch program no longer works for rural communities.

**“Rural towns across America  
experience higher rates of hunger  
and poverty.”**

“I can remember them telling me in Jordan Valley that each meal cost them a dollar more than the federal reimbursement,” she said.



Photos by Joseph Molieri, Bread for the World


Economically depressed districts need full reimbursement for school lunches or other policy interventions that are specific to the circumstances rural communities face today.

**“Economically depressed districts need full reimbursement for school lunches or other policy interventions that are specific to the circumstances rural communities face today.”**

Jordan Valley is not unique – rural towns across America experience higher rates of hunger and poverty. Of course, the permanent solution to our hunger problem is a job that pays enough to support a family. In the meantime, the school lunch program is a critical

tool to combat child hunger.


I grew up in a town similar to Jordan Valley and bused to school from our small family farm. I am thankful for the free lunch I received that took the pressure off my parents during some tough economic times. Sometimes, we all need a little help.

The program that authorizes the national school lunch program expires Sept. 30. In the reauthorization process, members of Congress have an opportunity to strengthen the program so it works for rural communities. 



*Robin Stephenson is Bread for the World's national lead for social media and senior regional organizer. This article was originally published Dec. 3, 2014, on Bread for the World's blog at [bread.org](http://bread.org). Bread for the World is a nonprofit organization working to end hunger.*





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### Karen Heck

A/R Analyst, Patient Financial Services  
Boca Raton Regional Hospital

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# HIV outbreak calls for improved public health in rural America

By Michael Meit and Brock Slabach



Michael Meit



Brock Slabach

The HIV outbreak in rural Scott County, Ind., took many by surprise this spring. For others, the news was sad but not so surprising.

The combination of rural poverty, lack of rural public health resources and a high uninsured population is manifesting in an epidemic. The devastating truth is it has taken an HIV outbreak to point out these deficiencies.

While rural communities have many assets, some also experience longstanding poverty that results in despair, which can often lead to drug abuse. The record number (158 at the time of printing) of cases of HIV infection in Scott County has been linked to intravenous use of prescription pain medications. The drug of choice in this community was Opana, a long-acting form of Oxymorphone. When altered and injected, it produces a powerful high. Indiana's chief health officer told the *New York Times*: "There's a feeling of hopelessness within this community. They're addicted, and they're getting HIV because they're addicted."

While there is a critical need to address the underlying social conditions that lead to this sense of hopelessness, we also need to ensure our rural communities have the health care, public health and social services resources necessary to prevent substance abuse, treat addiction, and identify and contain infectious and communicable diseases.


Our rural communities bring much to the table in addressing these challenges, including strong social networks, a culture of self-sufficiency, and robust faith communities. At the same time, however, America's rural

community systems need proper investment, training and technical assistance to effectively leverage these assets and ensure the health and wellbeing of the people they serve.

It is heartbreaking that a preventable disease like HIV has to become epidemic before it highlights what the National Rural Health Association and public health professionals have been saying for decades: Investment in both the economic and public health of rural communities is essential.

State and local governments have been slashing public health and social services funds for several years, particularly following the economic recession. At the same time, federal resources have also declined. This results in rural communities being more reliant on federal funds as an overall proportion of their budgets, even as their overall budgets have dwindled.

**"While rural communities have many assets, some also experience longstanding poverty that results in despair, which can often lead to drug abuse."**

Together, these cuts have both decreased available funding to address social and public health issues in our rural communities, while impeding the flexibility rural areas have to address the unique issues they face. Yes, the chickens have come home to roost due to years of neglect. Let's use this tragedy to change policy and ensure that this is the last epidemic we have to endure. 

*Michael Meit is the NORC Walsh Center for Rural Health Analysis co-director and an NRHA board member leading the association's Public Health Constituency Group. Brock Slabach is NRHA's membership services senior vice president.*

## Members on the move



Jodi Schmidt

### NRHA president creating rural network

2015 National Rural Health Association president Jodi Schmidt recently became operations director at the University of Kansas Hospital in Kansas City.

In her new role, Schmidt assists in the implementation of a CMS Innovation Award, creating a rural clinically integrated network comprised of 11 critical access hospitals and their associated rural health clinics, one rural federally qualified health center, one sole community hospital, and a rural outpatient/urgent care center.

Schmidt previously served as CEO of Labette Health in Parsons, Kan. She has 27 years of experience in rural hospital administration.

“My work with NRHA’s Future of Rural Health Task Force and ongoing board, Policy Congress and Government Affairs Committee efforts has strengthened my understanding of the underlying objectives and goals of our Innovation Center project,” Schmidt says. “Most importantly, networking through NRHA’s educational conferences I’ve attended in recent years has assisted me in working through the rural-specific challenges of implementing new payment models.”

Schmidt joined NRHA in 1991.

### Member discovers leadership potential through NRHA

National Rural Health Association member Allison Seigars recently accepted a position as executive director of Rural Health Projects Inc. (RHP)/Northwest Area Health Education Center in Enid, Okla.

In her new role, Seigars helps RHP improve access to quality health care services for rural Oklahomans. The position also includes serving as managing director of the Rural Health Association of Oklahoma.

Seigars, who has worked for RHP for almost seven years, previously served as its associate director.

“I have attended multiple NRHA-sponsored events and trainings that have been enormously helpful for me to attain the executive director position, including a national NRHA conference and the State Rural Health Association Leadership Conference,” Seigars says. “This workshop not only provided me with great information and understanding, but it also made me recognize within myself the potential to attain a leadership position, which until that point had never really occurred to me. Needless to say, I was excited, intimidated and humbled by NRHA and my supervisors’ belief that I could be a leader.”

Seigars joined NRHA in 2010.



Allison Seigars



## NRHA news

### Former NRHA member takes No. 2 spot at HHS



Mary Wakefield at NRHA's Rural Health Policy Institute

Former National Rural Health Association member and longtime rural health advocate Mary Wakefield, PhD, was recently chosen to serve as deputy administrator of the Department of Health and Human Services (HHS).

She had spent five years at the helm of the Health Resources and Services Administration overseeing the government's programs for vulnerable populations.

Wakefield, a nurse from North Dakota with more than a decade of Capitol Hill experience, confirmed that rural health will continue to be one of her priorities.

"We are thrilled to see such a strong rural advocate assume a key position within HHS," said Alan Morgan, NRHA CEO. "Dr. Wakefield is a stalwart champion for rural health within the administration."

Wakefield has spoken at numerous NRHA events and

## Donor Corner



Meg Gravesmill

The Accreditation Association for Hospitals and Health Systems (AAHHS) has given to the Rural Health Foundation each year since it was established by the National Rural Health Association in 2012.

AAHHS' mission is to help hospitals and health systems to better serve in their communities through accreditation, education and research.

**Rural Roads:** Why does AAHHS choose to provide ongoing financial support to NRHA's Rural Health Foundation?

**Meg Gravesmill, AAHHS hospital operations vice president/general manager:** We developed our accreditation program by reaching out to the rural hospital community to seek their input on our standards, the survey process and the pilot surveys, to ensure our accreditation approach was perfectly tailored to small hospitals.

We recognize the valuable role of the Rural Health Foundation in supporting the leaders of these small hospitals.

**Rural Roads:** Why should others consider a donation to this cause?

**Gravesmill:** It is important to support those who are taking leadership roles in their own health care centers. These leaders are in a unique position to speak to the health of rural America and influence policies affecting their patients.

NRHA thanks AAHHS for its ongoing contributions the Rural Health Foundation.

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

## caring for the future of rural America

each year at NRHA's Rural Health Policy Institute in Washington, D.C.

HHS Secretary Sylvia Mathews Burwell praised Wakefield's ability to lead "through a time of marked transformation."

"She has improved access to health for millions of patients, strengthening America's health care workforce," she wrote.

## Apply now to become a Rural Health Fellow

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

The program aims to educate, develop and inspire a networked community of rural health leaders who will step forward to serve key

*continues*

continued



2015 Rural Health Fellows

positions in the association, affiliated rural health advocacy groups and local and state legislative bodies.

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

“It wasn’t until I was selected as an NRHA Rural Health Fellow that I genuinely understood the obstacles, geographical and policy, people residing in rural areas encounter on a daily basis,” says Jarod Thomas Giger, PhD, assistant professor at the University of South Dakota School of Health Science.

Apply at [RuralHealthWeb.org/go/fellows](http://RuralHealthWeb.org/go/fellows) by Aug. 31 to be considered for the 2016 class.

## Present at NRHA conferences

The National Rural Health Association is currently accepting presentation submission proposals for two upcoming educational events.

Submissions for NRHA’s 39th Annual Rural Health Conference, the nation’s largest gathering of rural health professionals, are being accepted through Aug. 31. The 2016 event will be in Minneapolis May 10-13.

Session proposals for NRHA’s Rural Multicultural and Multiracial Health Conference, May 10 in Minneapolis, are being accepted through Sept. 30.

The deadline for poster and research submissions for both Minneapolis events is Jan. 8.

To submit a proposal for review by a panel of NRHA members, visit [RuralHealthWeb.org](http://RuralHealthWeb.org) and complete the online application.

## NRHA hosts summer events in Minneapolis

The National Rural Health Association’s 11th annual Rural Quality and Clinical Conference will demonstrate how to advance quality and clinical care from theory to practice July 15-17 in Minneapolis.

Quality and performance improvement coordinators, researchers, students, hospital administrators, and doctors, physician assistants and nurses practicing on the front lines of rural health are encouraged to participate in this interactive event.

Jennifer Lundblad, PhD, president and CEO of Stratis Health, a Minnesota-based nonprofit dedicated to health care quality and patient safety for more than 40 years, will provide the keynote address.

Attendees will also hear updates from federal partners, rural health and telehealth experts, clinicians and D.C.’s top rural health lobbyist.

“All the NRHA staff and conference speakers are very knowledgeable and approachable,” one past attendee wrote in an evaluation. “I always leave NRHA events more inspired and excited about rural America.”

Scholarships are available and will be reviewed and awarded on a first-come, first-serve basis.

Arrive early for the State Rural Health Association Leadership Conference, an opportunity for state association leaders to enhance their skills and network, on July 14-15.

Register today at [RuralHealthWeb.org/quality](http://RuralHealthWeb.org/quality).

## NRHA journal announces new editorial board members, increases impact

The *Journal of Rural Health* editorial board recently selected six new members who will serve two-year terms.

The quarterly publication published by NRHA is a peer-reviewed, international journal devoted to advancing professional practice, research, theory development and public policy related to rural health.

The journal’s citation impact factor, which is based on



Ty Borders

the number of citations of articles published in the journal, increased to 1.77 in 2013, compared to 1.44 in 2012. Since 2008, the citation impact factor has increased 69 percent.

“The continued rise in the journal’s citation impact factor reflects its expanding impact on the field of rural health services and policy research,” says *Journal of Rural Health* editor Ty Borders, PhD.

The new editorial board members are:

**Ekta Choudhary, PhD**, CDC National Center for Environmental Health Division of Environmental Hazards and Health Effects epidemiologist

**Joseph S. Coyne, DrPH**, Washington State University Department of Health Policy and Administration professor, Center for International Health Services Research and Policy director

**Ted Epperly, MD**, Family Medicine Health Center Residency of Idaho president and CEO

**Jarod T. Giger, PhD**, University of South Dakota School of Health Sciences Department of Social Work assistant professor

**Martin Lipsky, MD**, University of Illinois College of Medicine at Rockford regional dean

**Cecilia Rosales, MD**, University of Arizona Mel and Enid Zuckerman College of Public Health assistant dean and associate professor

“These members bring a wealth of experience in primary care, public health, environmental health, international health, and research in disparate populations,” says editorial board chair Kevin Bennett. “We look forward to working with this talented group of professionals to continue to bring high-quality scholarship to the pages of the journal.”

Full-text articles are available to NRHA members online at [connect.NRHArural.org/journal](http://connect.NRHArural.org/journal).

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

## accelerating advocacy

### Connect with Congress this summer

With nearly 300 rural hospitals on the brink of closure, congressional support is necessary to ensure access to care for rural Americans.

The National Rural Health Association encourages all rural Americans to engage their elected officials now. They must understand the necessity for robust funding for existing programs in the appropriations process along with the need for new and innovative future models.

“Rural health care providers ensure access to care for hundreds of thousands of vulnerable Americans,” says Maggie Elehwany, NRHA government affairs vice president. “We need action from all levels of government to protect that access and put the health care delivery system in rural America on solid footing.”

NRHA is working with members of the Senate and House on a comprehensive bill to deal with rural hospital closure crisis. This bill

would reverse cuts hurting rural hospitals, make permanent important rural Medicare extenders, provide copay equity for rural beneficiaries, provide regulatory relief, and create a new option for rural communities.

When senators and representatives are home during the August recess, invite them to visit your facility, attend town hall meetings, and write letters to the editors of area media outlets. Let Congress know how vital these programs are to your facility and your community.





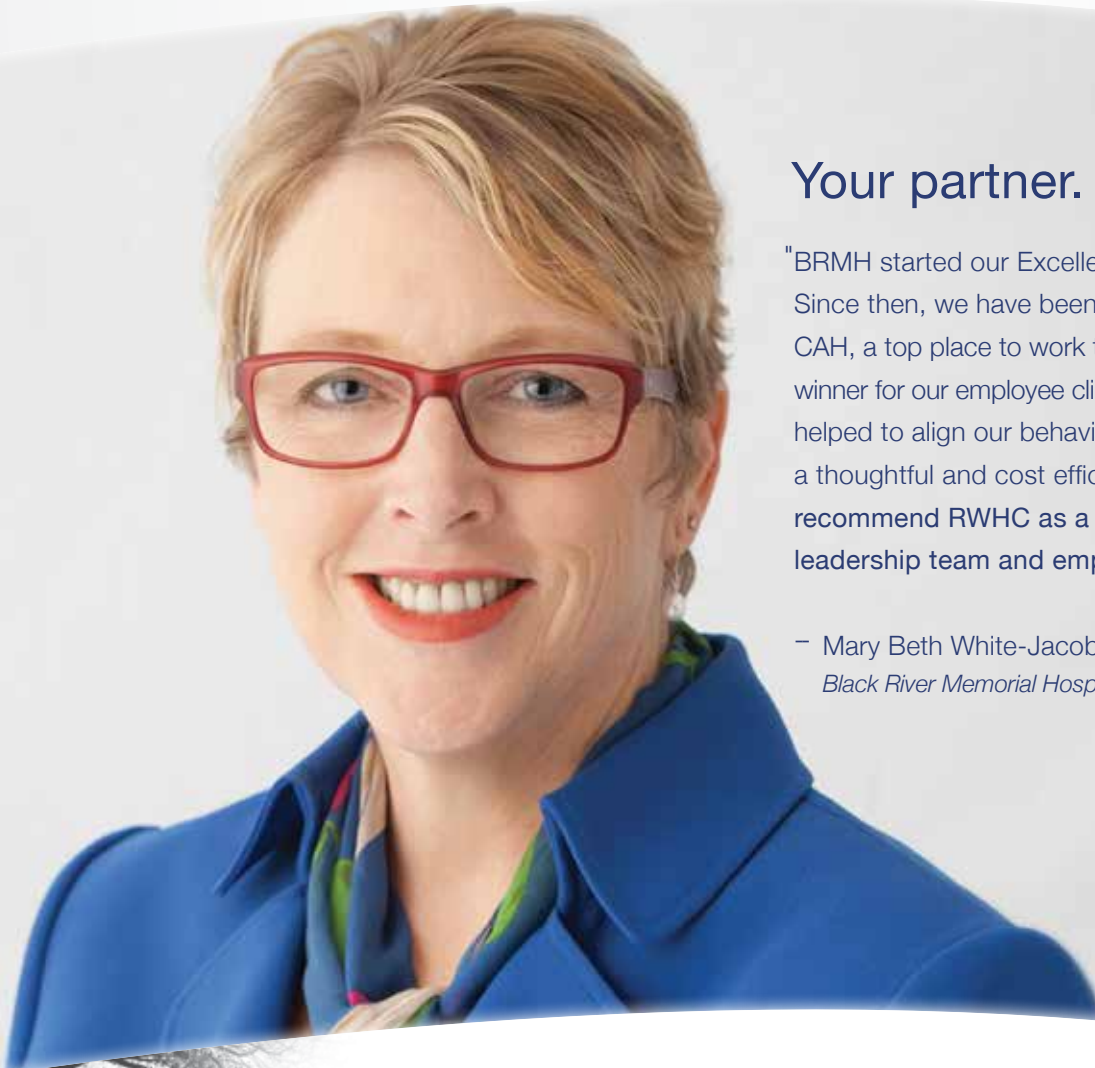
Jo Anne Preston  
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*Black River Memorial Hospital, Black River Falls, WI*



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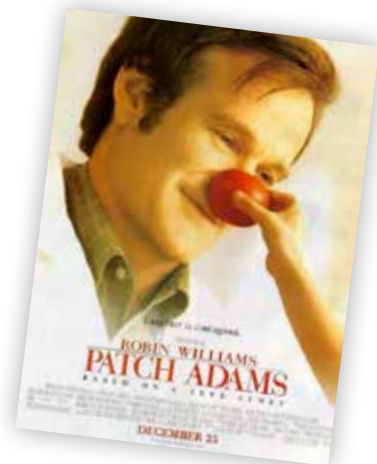
By Kacie Fodness

## The doctor is in... your Netflix queue

Pop some popcorn, grab the Kleenex, and take advantage of one of Netflix's newest additions: "Patch Adams."

While it's been nearly 17 years since the movie's release, many who revisit the film will recall the reasons it was a box office success. But some of the lesser known facts are equally entertaining and heartwarming:

- Robin Williams dropped in on classes at the University of North Carolina-Chapel Hill (a filming location) and treated students to stand-up routines.
- Throughout his film career, Williams was often cast as a doctor. In addition to portraying real-life physician Hunter Patch Adams, MD, he can be seen in this role in "What Dreams are Made Of," "Good Will Hunting," "Nine Months," and "Awakening."
- Cast and crew collaborated with the Make a Wish Foundation, and as a result, nearly all of the children in the movie were, during filming, actually being treated for cancer.



### Off the beaten path

## King of condiments



Photos via catsupbottle.com

## shifting gears

### Green as the day is long

Whether you are already involved in green initiatives or wondering where to start, here are some summer-specific ideas that can make a lasting impact:

- Open windows
- Turn down water heaters
- Ride bikes
- Grow food
- Clean with natural products
- Buy local produce

Summer is right around the corner and, for many of us, that means firing up the grill and backyard barbeques with all the fixings.

Wherever you land in the "catsup"/"ketchup" debate, you won't want to miss one Illinois town's claim to tomato fame.

In **1949**, construction was completed for what was, and still is, the World's Largest Catsup Bottle, a water tower just south of Collinsville, Ill. At **70-feet tall**, the bottle could hold almost **640,000** bottles of catsup.

When the water tower's future was uncertain, a restoration team rallied and raised the **\$80,000** necessary to save it between **1993** and **1995**.

This bottle now not only enjoys a place on the National Register of Historic Places, but is home to the annual World's Largest Catsup Bottle Festival and has its own fan club. This July, festival attendees can complete a **5** or **10K** and maybe even catch Oscar Mayer's Weinermobile.



National Rural Health Association

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## Get smart.

Plan now to attend these NRHA conferences and move to the head of the class.



### SRHA Leadership Conference

July 14-15  
*Minneapolis*

### Rural Quality and Clinical Conference

July 15-17  
*Minneapolis*

### Rural Health Clinic Conference

Sept. 29-30  
*Kansas City*

### Critical Access Hospital Conference

Sept. 30-Oct. 2  
*Kansas City*

### Rural Health Policy Institute

Feb. 2-4, 2016  
*Washington D.C.*

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