rural roads

Spring 2013 National Rural Health Association

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Physician, professor uses storytelling to engage students

Focus on rural mental health

Telehealth barriers, benefits

Rural hospital plays vital role when disaster strikes

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Volume 11, No. 2
Spring 2013

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On the cover

Therese Zink got Jimmy from neighbors who thought her horse needed a pal. The miniature donkey inspired a story in her collection, "The Country Doctor Revisited," which this physician and professor uses to engage students in rural medicine.

Please share or recycle this magazine.

RuralRoadsOnline.com

Accolades for article and photo contest

We just received the winter 2013 issue of *Rural Roads*. I love the magazine and especially the article "Comfort close to home" by Lindsey Corey. The article and photos appropriately depict the Cancer Resource Center here at Cannon Memorial Hospital. Maybe this story will inspire other small and rural hospitals and/or communities to establish similar programs.

Lindsey certainly was a joy to work with as she wrote the article.

I also had great fun participating in NRHA's first photo contest. I loved seeing all the photos from across our nation. Hope you do it again!

Looking forward to reading *Rural Roads* from cover to cover. Keep up the great work.

Brenda Hoss
Cannon Memorial Hospital administrative assistant
Linville, N.C.

A favorite read

NRHA's *Rural Roads* magazine is one of my favorite reads!

I enjoy reading about the successes of the state association members and the hot topics facing our rural communities.

Thank you, Lindsey Corey, for keeping us informed as we strive together to improve the health of rural people.

Tina Elliott
Indiana Rural Health Association community relations director

Write us

Rural Roads is interested in the opinions of readers. Letters to the editor must be signed and may be edited for space and style.

Send your letter to editor@NRHArural.org or *Rural Roads* editor, NRHA, 521 E. 63rd St., Kansas City, Mo., 64110.

More discussion equals more protection

Thank you so much for the article you published on black lung (winter 2013). Lindsey Corey did a great job of putting together what both David and I said. I so appreciate how she did the article.

And I appreciate that *Rural Roads* is helping bring attention to this disease and its devastating effects on miners. As we bring out more public discussion on black lung, the industry will feel more pressure to protect miners from the disease.

This is a completely preventable disease and we need to eliminate it altogether.

Debbie Wills
Valley Health's Black Lung Program director
Cedar Grove, W.Va.

Using *Rural Roads* to make an impact on Capitol Hill

"Black lung still exists?" is a question I often hear when meeting people who learn I work in a Black Lung Clinics Program. Unfortunately, black lung disease is still affecting our nation's coal miners.

Lindsey Corey's article (winter 2013) reminds us that men and women across our coal mining communities have a story, a life, a face and a name.

Members of the National Coalition of Black Lung and Respiratory Disease Clinics travel to D.C. each spring to educate our congressional leaders on black lung disease, and this year we are proud to provide copies of this article.

Many thanks to NRHA's *Rural Roads* for reminding its readers that in 2013 this disease is relevant and help is available.

Stacy Redinger
Shawnee Health Service Respiratory Disease Program director
Carbondale, Ill.

See what all the fuss is about

To read these and other articles from the *Rural Roads* archives, visit RuralRoadsOnline.com/archive.php.

Come together in Kentucky

One of the best things about the National Rural Health Association is the people it brings together.

And one of the best times to come together is NRHA's Annual Rural Health Conference.

Interested in and passionate about rural health? Join me – and 900 or so rural health professionals – May 7-10 in Louisville, Ky.

We'll meet new colleagues, reunite with friends and experts from across the country and reignite our excitement for improving rural health care.

This year's conference agenda is packed with innovative solutions that have worked in other rural parts of the country. There really is something for everyone from students to veteran rural health pros.

Don't miss out on this once-a-year opportunity to make new cross-country connections and learn about pioneering rural health programs.

Most importantly, take home new experiences, a re-energized perspective and valuable insight to better your community right away.

Looking forward to meeting you at the conference,

Sandra Durick
2013 NRHA president

5 things I picked up in this issue:

1. New this issue, you can take a walk down Memory Lane with friendly faces from NRHA's latest big event. *page 40*
2. Therese Zink's stories are inspiring future rural docs. *page 8*
3. People are four times more likely to go to a minister in times of crisis than all other mental health professionals combined. Four times. *page 22*
4. Louisville, Ky., is the only place you can zipline inside a cave. *page 49*
5. Another nonprofit organization is using *Rural Roads* to advocate on Capitol Hill. *page 4*

Pack your bag.

Plan now to attend these upcoming events.

Rural Medical Educators Conference
May 7
Louisville, Ky.

Annual Rural Health Conference
May 7-10
Louisville, Ky.

Rural Quality and Clinical Conference
July 17-19
Chicago, Ill.

Rural Health Clinic Conference
Oct. 1-2
Austin, Texas

Critical Access Hospital Conference
Oct. 2-4
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Rural Multiracial and Multicultural Health Conference
Dec. 3-5
San Antonio, Texas

Rural Health Policy Institute
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Therese Zink, who grew up on a farm, cares for a horse, a miniature donkey, chickens, cats and a dog.

Tales of a country doc

Physician and professor uses storytelling to engage students in rural family medicine

Story by J. Trout Lowen
Photographs by Sara Rubinstein

A full moon floods the southeastern Minnesota landscape in a pale, wintry light as Therese Zink, MD, pulls away from her small farm and bounces down the gravel road past fields of broken cornstalks. She turns onto Highway 52 and then down a dark, empty road that crosses the middle fork of the Zumbro River before emptying onto Pine Island's main street. Zink parks her Prius in front of the butcher shop, slantwise, the way it's done in small towns, and heads for the Rainbow Cafe.

The hybrid car is just the first indication that Zink is not the stereotypical country doctor who resides in the collective American imagination: the kindly white-haired gentleman practitioner with a worn leather medical bag and comforting smile. A family physician at the nearby Fairview Zumbrota Clinic and associate director of the University of Minnesota Medical School's Rural Physician Associate Program (RPAP), Zink knows firsthand how the role of the country doctor has changed over the past three decades.

It's Friday evening and the restaurant is filling up. The fish fry is popular, but Zink chooses the more healthful salmon entrée. Between bites she talks about her life, where she grew up, what it's like practicing medicine in Zumbrota, and what she hopes to teach the next generation of rural docs. She speaks with the authority of someone used to getting to the crux of a matter – and of someone who knows the power of stories.

In 2010, she edited "The Country Doctor Revisited:

Therese Zink takes a break with her running buddy Maxx, who enjoys swimming and following her on her horse, Indy.

A Twenty-First Century Reader," an anthology of essays, stories and poems describing in sometimes heart-wrenching detail the daily rewards and challenges of practicing family medicine in rural America, one of the largest underserved populations. Since then, she's been in the media spotlight often. But she's not entirely comfortable with all of the attention the book has shone, like the bright moon outside, on her somewhat solitary, if hectic, life.

Zink says solitude is one of the things she treasures most about living on a farm, coming home at night to the quiet and the simple demands of caring for her menagerie: a horse, a miniature donkey, chickens, a dog and an assortment of cats. The farm offers a buffer between herself and her patients – many of whom are friends, neighbors and even members of her book club.

"I've been married and divorced and I don't have a significant other, so I think I've gotten more comfortable with my solitude, and I've also realized what a gift the farm has been as this incredible space to write," Zink says. "My writing has really grown these past years."

Zink has written a memoir, a medical-adventure novel and several essays about her experiences as a doctor. And she is now using writing and stories as a way to engage medical students, especially the next generation of rural physicians.

Zink has put 160,000 miles on her Prius since she purchased it in 2006, many of them commuting from Zumbrota to the university where, as a faculty member in the Department of Family Medicine and Community Health, she teaches third-year medical students in RPAP. Founded 40 years ago to help recruit and retain rural primary care physicians, RPAP places 30 to 40 medical students a year in rural community clinics and medical centers for nine-month apprenticeships. Zink also works part time at the Fairview Red Wing Medical Center, is a preceptor at St. John's Hospital in Maplewood, Minn., and serves as director of the medical school's Global Family Medicine Pathway, which aims to give family medicine residents international experience.

> "I always felt like one of the real gifts that my parents gave me is that all of my sisters and I can talk to anybody, whether they're homeless or from the country club."
> Therese Zink, family physician and professor

But Zink has never been content with being "just" a physician.

In the 1980s, while director of the Family Tree Clinic in St. Paul, she became involved in efforts to reform Minnesota's health care system. That experience motivated her to return to school, to the University of Minnesota, for her master's in public health.

"I wanted to be able to do some bigger picture things," Zink says.

She has. During her career, Zink has published research on a broad array of topics, including intimate partner violence, death and dying, electronic medical records, school-based health centers, health care delivery, and health disparities. In 2008, the Minnesota Academy of Family Physicians awarded her its Researcher of the Year award. She received the 2011 Rural Health Hero Award from the Minnesota Department of Health and the 2012 Distinguished Educator of the Year Award from the National Rural Health Association. And in 2011, Minnesota Gov. Mark Dayton appointed her to serve on his Health Care Reform Task Force, charged with developing strategies to reduce costs, improve access and lessen disparities in health care.

In Zumbrota, Zink has started a violence prevention committee, bringing together police, community members, mental health professionals and health care providers to improve coordination of services, and she helped raise funds for a peace garden honoring victims of family violence. Zink has also taken her medical skills into the international arena, volunteering in Russia, Chechnya, Honduras, Brazil and Nicaragua.

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Bridging Healthcare Connections

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Therese Zink treats patients presenting with a breadth of health concerns at the Fairview Zumbrota Clinic.

What ties all of Zink's seemingly disparate pursuits together is her interest in how the daily practice of medicine informs the bigger picture, says Vincent Hunt, MD, who served as Zink's residency director at Regions Hospital in St. Paul.

For example, according to Zink's research, 10 percent or fewer of adult family providers screen patients for intimate partner violence and screening among older women is even less frequent. Intimate partner violence can result in chronic pain issues, unintended pregnancy, sexually transmitted diseases, depression and even suicide. Zink suggests physicians help patients see the link between living with violence and their health, not just provide sutures and prescriptions.

"These are the types of issues that are of significant concern to those of us in primary care and family medicine," Hunt says. "And she goes after them with her enthusiasm, her inquisitiveness . . . and translates that into her teaching, her research and her scholarly activities."

According to RPAP director Kathleen Brooks, MD, Zink's commitment to scholarship has inspired other RPAP faculty to publish more about the program and its success. And her passion for teaching and writing has opened new avenues for students to use writing to reflect on their experiences. Last summer, the university, with the Minnesota Medical Association, published a second volume of stories, essays and poetry written by medical students and edited by Zink. "Becoming a Doctor: Reflections" has become a part of the curriculum for medical students in Minnesota and elsewhere, and student essays have appeared in established journals, including *The Journal of the American Medical Association (JAMA), Family Medicine and Minnesota Medicine.*

Zink has kept a journal since high school. But her writing became more focused in 2001, after a volunteer medical assignment in Chechnya went dramatically awry. Her colleague, Kenneth Gluck, head of the Doctors Without Borders mission there, was kidnapped at gunpoint just a month after Zink arrived. During the tumultuous 26 days that Gluck was held hostage, Zink became the major source of support for local staff. He was eventually released unharmed. Zink used writing to process the ordeal.

"It's taken me 10 years to figure out what I learned from that," Zink says. "Ten years of writing."

Her experience in Chechnya also shaped her views on how international aid agencies should operate: building community and focusing on local priorities rather than a employing a top-down agenda.

Zink's advocacy for a community-building approach is playing out in Nicaragua, where she volunteers each January with the St. Paul-based Interfaith Service to Latin America (ISLA). Cervical cancer is a major women's health issue in Nicaragua, and ISLA conducts screening and provides follow-up care in the northern mountain community of Jalapa. While the conventional test is a Pap smear, it's a luxury by Nicaraguan standards, and treatment is delayed since the tests have to be read in the United States. The local government urges the use of a less costly, albeit slightly less accurate, procedure, and Zink has been a vocal advocate in support of the change, sometimes butting heads with colleagues.

In early January, the sky outside the recruitment center for Fairview Health Services in St. Paul is a blank slate of gray. Zink sits at the end of a long conference room table. She peers over the narrow oval glasses perched halfway down her nose at the eager faces of a dozen pre-med students from St. Olaf College. With one exception, all are women. And they're all here to find out more about what it means to be a rural family physician today.

Once homogenous communities anchored by families of German and

continues

continued

Therese Zink discusses "The Country Doctor Revisited" with a group of University of Minnesota medical students.

Scandinavian descent, rural Minnesota today is more often defined by large-scale factory farms and struggling main streets – but with a diverse population that includes immigrants from Latin America, East Africa and Southeast Asia.

Before she tells her story, Zink invites the students to talk about their own interest in medicine. As the conversation moves around the table, she listens intently. Most are from Minnesota, many from rural areas or small towns. Their desire to become doctors stems from a family member in the healing professions or a personal or family health problem. Their stories are not unlike Zink's own, although she tells the students her journey has taken "a more circuitous route."

> "I hear this from students today. They're discouraged away from family medicine by the specialists saying 'you're too smart for it.'"
>
> Therese Zink, professor and family physician

The oldest of six kids, Zink's family moved when she was 10 from suburban Dayton, Ohio, to the farm where her mother grew up and where her grandfather still lived. Caring for the farm animals was "kind of one biology project after another," she says.

Two of Zink's younger siblings were born with Down syndrome. She helped out in her father's office; he was a dentist who devoted much of his time outside of work to building an organization that created group homes for adults with Down's.

Zink remembers often accompanying her father to meetings, doing her homework in the car.

"I always felt like one of the real gifts that my parents gave me is that all of my sisters and I can talk to anybody, whether they're homeless or from the country club," she says.

Zink decided to pursue medicine but dropped out of the pre-med program at Marquette University, "turned off" by the competition, she says, and instead earned degrees in English and theology. After graduation, a job as a clerk in a pediatric hospital emergency room renewed her interest in medicine and an experience there, in which she helped a coworker who was being abused by her husband, cemented her commitment to domestic violence prevention.

When Zink finally enrolled in medical school at Ohio State University, she discovered she loved everything about medicine.

"When I was in surgery, I wanted to be a surgeon. When I was in OB, I wanted to do that. You can't do everything," she says.

Rural family medicine allows her to do nearly everything: prenatal care, pediatrics, geriatric medicine and trauma care. Family practitioners minister to broken arms and sore throats, to AIDS patients and drug abusers. But Zink recalls that her choice of family medicine didn't sit well with some of her professors. Most of them were specialists who suggested she was too smart to waste her time on family practice. She vividly remembers one telling her that, as a family doc, she'd be no more than a "well-trained monkey."

The bias against family medicine persists in many places today, Zink says, and it was one of the catalysts for "The Country Doctor Revisited."

"I hear this from students today," she says. "They're discouraged away from family medicine by the specialists saying 'you're too smart for it.'"

According to a *JAMA* study, despite the well-established need for physicians, in 2010 fewer than 3 percent of all medical school graduates nationally said they intended to practice in rural areas or small towns.

At the turn of this past century, 20 percent of the U.S. population resided in rural areas but just 9 percent of physicians practiced there. Rural Americans tend to be older, poorer and sicker and are more likely to be uninsured.

RPAP is designed to nurture students' interest in and understanding of rural health care. Students work with primary care and family physicians, internists and surgeons at local sites for 36 weeks, immersing themselves in the life and lifestyle of rural practice. One of the oldest programs of its kind in the nation, RPAP has been highly successful; 80 percent of its graduates choose primary care.

"What people do not understand is that specialty medicine is very narrow and very safe, and family medicine is very broad and very encompassing," says Raymond Christensen, MD, RPAP associate director and NRHA's president-elect. "It takes a special person to be able to handle that breadth."

Therese Zink savors the quiet solitude of her farm and the simple demands of caring for her animals.

The essays by Zink and other physicians in "The Country Doctor Revisited" are testimony to those words. In "Everyone Did Their Part, But," Zink describes a frail, 87-year-old retired farmer who hadn't seen a physician in 25 years. Neglected by his family, he was hospitalized twice for infections and broken bones. He became stuck in a quagmire of medical and social service agencies without a family member or primary physician to advocate for him or manage his care.

"Today's high-tech system means there are many more players," Zink writes in the essay, "and if a patient is unable to voice his needs and does not have an advocate, there are no guarantees."

In another essay, "When Hostility Melted for the 'Funny Accent,'" RPAP alumnus Godfrey Onime, a native of Nigeria, describes the challenges of practicing medicine on too little sleep, with too little time, in a community where he's an outsider.

Onime's experience sparked a good deal of discussion during a lunchtime book group for first- and second-year medical students at the University of Minnesota. Ten such book groups are meeting at medical schools around the country, funded by a grant Zink received from the Society of Teachers of Family Medicine.

On this day, nearly two dozen students gather in a meeting room on the sixth floor of the Phillips-Wangensteen Building, eating pizza and discussing Onime's and other stories from "The Country Doctor Revisited." Some have already been accepted into the RPAP program next year. It's clear from the animated burble of voices in the room that the book has grabbed their attention.

"How do you get people to trust you in this situation?" asks Ingrid Anderson, one of the book group's student organizers.

"How do you get rid of your own biases?" counters another student.

Zink sits back, watching the discussion flow. For many of the students in the room, these stories are still just that, stories. Soon, however, they'll have their own to tell, of birth and death, joy and heartache. And with Zink's help, they'll have the tools to help them deal with it all.

This article originally appeared in the spring 2012 issue of Minnesota, *the University of Minnesota Alumni Association magazine.*

Watch, listen, learn

To hear an "Access Minnesota" interview with Therese Zink, MD, and to watch a companion video for "The Country Doctor Revisited," go to minnesotaalumni.org/zink.

For more on her book, visit theresezink.com/country-doctor-revisited.

Zink joined the National Rural Health Association in 2008 and was NRHA's 2012 Distinguished Educator of the Year.

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Telepsychiatry connects communities to care

By Angela Lutz

Telepsychiatry is used in rural and underserved areas to quickly get behavioral health patients the psychiatric care they need.

At Northpoint Behavioral Health in St. Clairsville, Ohio, a 23-year-old man being treated for schizophrenia brought his mother along to an appointment at his psychiatrist's request.

The rural community of 5,166 lacks psychiatric specialists, so the young man met with his doctor via videoconference instead of face-to-face. But it made no difference to him; in fact, the technology was so effective and his experience so positive that he forgot to tell his mom.

"The young man never even told her it was telemedicine, because for him, it didn't make any difference," says Tom Perrone, Northpoint executive director. "People have this impression that it's going to be like Skype – you'll have the pauses and buffering, and it's not like that at all. It's happening at that moment."

Northpoint Behavioral Health serves four Ohio counties with five offices, three of which have been using telepsychiatry since July 2012. According to Perrone, the technology has allowed psychiatrists to provide more effective evaluations and medication management, and it has decreased travel for patients by allowing them to "meet" with their doctor at an office closer to home.

"Having a child psychiatrist, adult psychiatrist and geriatric psychiatrist has never happened in our area," Perrone says. "I can get that specialty service when I

need it."

Due to the national shortage of psychiatrists, the ability to extend services has been vital to communities that sometimes have no mental health providers. According to Geoffrey Boyce, InSight Telepsychiatry executive director, the applications of telemedicine in behavioral health care are "endless," with some of the most common being child, adolescent and geriatric psychiatry and substance abuse.

"Behavioral health care has proven to be the most successful application of telemedicine to date because it is one of the few medical disciplines where a physician can effectively evaluate a patient without being in the same physical space," Boyce says. "Essentially any step of the behavioral health care process can successfully adapt to telemedicine."

> "Having a child psychiatrist, adult psychiatrist and geriatric psychiatrist has never happened in our area. I can get that specialty service when I need it."
>
> Tom Perrone, Northpoint Behavioral Health executive director

Despite telepsychiatry's potential, a number of barriers continue to prevent the technology from being utilized to its full potential. According to Boyce, one of the key challenges facing providers is reimbursement. Medicare will reimburse for telepsychiatry when a community is considered rural or underserved, but legislation differs from one state to the next, and a variety of rules and regulations continue to limit the full adoption of telepsychiatry.

The current system for licensing and credentialing physicians presents additional issues. Boyce says that a national system for licensing and credentialing would be a "huge asset" to the expansion of telemedicine.

"Right now, a physician essentially needs to be licensed in the state he [and his patient are] physically located in," he says. "With the growth of telemedicine, the ability to provide care across state lines will be vitally important."

Despite these barriers, Boyce believes technology will continue to evolve to provide affordable, high-quality mental and behavioral health care closer to patients' homes.

"Telepsychiatry will soon be commonly available to consumers in their homes and other easily accessible locations like their primary care facilities, local health clinics, mobile service providers and more," Boyce says. "Telemedicine is a viable part of the solution for improving behavioral health care, and as reimbursement policies and health care reform increasingly acknowledge this fact, care will continue to grow."

Telepsychiatry tools

For more information on reimbursement guidelines, visit the Center for Telehealth and e-Health Law at ctel.org.

To determine whether your community is considered rural under Medicaid, check out the Rural Assistance Center's "Am I Rural?" tool at raconline.org/amirural.

To find out if your community is in a health professional shortage area (HPSA), check out the Health Resources and Services Administration's HPSA finder at hpsafind.hrsa.gov.

Expert assistance

Telehealth will be a hot topic at the National Rural Health Association's 36th Annual Rural Health Conference May 7-10 in Louisville, Ky.

Experts will explore how telemedicine can address the increasing behavior health needs of rural areas in a cost-effective manner at all levels of care.

Another session will outline innovative telemedicine approaches using simulations and clinician immersion to instruct rural mental health issues to medical students.

Visit Ruralhealthweb.org/annual for the full agenda and to register.

Mental Health First Aid offers new rural-focused curriculum

Ria Muttukumara, Mental Health First Aid training and referral coordinator

Mental Health First Aid (MHFA) is an early intervention program that educates the public on how to assist someone experiencing a behavioral health crisis.

The program, created in Australia in 2001 and managed in the United States by the National Council for Behavioral Health, teaches the skills needed to identify, understand and respond to individuals who may be experiencing signs of a mental illness or substance use disorder. And first aid is administered to help individuals connect with appropriate care.

The Substance Abuse and Mental Health Services Administration/ Health Resources and Services Administration Center for Integrated Health Solutions recently tailored its training program for rural populations, and the University of North Dakota Center for Rural Health and Atlas Research are conducting outreach and technical assistance for rural MHFA training nationwide throughout 2013.

The training is especially useful in rural communities where access to mental health services may be limited, explains Ria Muttukumaru, MHFA training and referral coordinator with Atlas Research.

"Rural MHFA is a way to build community-level capacity to identify mental health and substance abuse concerns early and for rural residents to increase their confidence to intervene and refer people to the resources that do exist," she says. "MHFA is a way to increase the level of baseline knowledge about mental health and substance abuse and to decrease the negative perceptions often associated with these disorders."

Rural Roads magazine asked Muttukumaru about the program.

What does MHFA training consist of?

To become a certified mental health first aider, individuals complete an interactive 12-hour course that presents an overview of mental illnesses and substance use disorders and introduces participants to risk factors and warning signs of mental health problems. Participants learn a five-step action plan to help individuals in crisis connect with appropriate professional, peer, social, and self-help care.

How does the rural curriculum differ from the standard curriculum?

The rural curriculum features discussions on what rural communities can do with a lack of or limited resources and services, and the practice sessions include rural-relevant scenarios such as farming-related situations and long-distance travel to health care.

Who might want to take the training?

The training is appropriate for just about anyone. Examples of training participants include non-clinical primary care, mental health, and substance abuse staff; school and counseling personnel; social and human services providers; local law enforcement; corrections officers; nursing home staff; outreach workers; volunteers; clergy and members of faith communities; young people; families; and the general public.

How can our readers learn more?

The Quick Start Guide helps to make organizing a Rural Mental Health First Aid training in your community straightforward and simple. Additional resources are available at mentalhealthfirstaid.org.

How can readers bring the training to their rural communities?

The training is easy to organize and is relatively low-cost per person (the cost varies per trainer). I can connect you with a Rural Mental Health First Aid trainer for your community or region, or you can learn how to become a certified instructor to teach the 12-hour course. *Rural Roads* readers can contact me at rmuttukumaru@atlasresearch.us or 202-717-8725, or visit mentalhealthfirstaid.org.

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The Right Strategies for Rural Healthcare

Rural pastors learn to help veterans

By Lindsey V. Corey

Chaplain John Oliver facilitates a discussion with rural clergy from the Beckley, W.V., area.

Military veterans are accustomed to being the first line of defense.

And when they need help – when anyone does – they're four times more likely to seek out a pastor than all other mental health providers combined.

"What we know is that pastors are often sort of the first line of defense," says Jeni Cook, National Veterans Affairs (VA) Chaplain Center associate director. "They're the people that veterans are more likely to go to initially than psychiatrists, psychologists or social workers."

Four times more likely. About 25 percent of people seeking mental health care make their first contact with a clergy member, and post-traumatic stress disorder has been identified as a significant predictor of those seeking help from ministers, according to a Harvard Medical School study led by Philip S. Wang, MD.

Chaplain John Oliver says those facts triggered an "aha moment."

Before a soldier is on the front line, he or she goes through rigorous training. But pastors aren't as equipped.

"It's vitally important that our pastors understand who's coming to them and what they're coming to them seeking," says the Durham VA Medical Center chaplain service chief.

Recognizing nearly 40 percent of veterans live in rural areas, the Veterans Health Administration (VHA) Office of Rural Health funded a project to help rural clergy understand and respond to vets' unique needs.

"The goal is to get information about services for veterans further out into the rural communities," Cook says.

In 2012, Oliver led one-day workshops in eight rural communities in the Southeast to educate small-town ministers about:

1. veteran and military culture,
2. the spiritual, mental and physical effects of combat trauma,
3. the impact of the mental health stigma in rural areas,
4. the needs of service members, veterans and their families, and
5. a referral process to help veterans access VA benefits and health care.

"Not only do we want them to have really good pastoral skills that are adapted somewhat for veterans and the veteran's unique experiences, but

Jeni Cook, National Veterans Affairs Chaplain Center associate director, leads a training exercise with rural clergy and Veteran Service Organization representatives from the Beckley, W.V., area.

also we want them to have a variety of ways to refer an individual into mental health care and physical health care provided by VA," Cook says.

VHA understands that rural clergy, in addition to being congregants' go-to person, are often community leaders who can influence public opinion and behavior, explains James Goalder, PhD, retired VA psychologist and clergy training program coordinator.

> "Pastors are often sort of the first line of defense."
>
> Jeni Cook, National Veterans Affairs Chaplain Center associate director

"Veterans need supportive communities to assist them with reintegration into civilian life so matching their needs with faith-group resources is of great benefit, particularly in rural and highly rural areas," he adds.

Oliver was pleased with the number of clergy who participated in the free trainings and with their motivation to better serve veteran and active duty service members. About one-third of participating ministers were also military vets.

"As a pastor and a Vietnam veteran I still was unaware of a lot of things that the VA could do in partnership and that we could work together to provide a lot more resources to the veterans," says Rev. Donald Bradley, who leads a United Methodist church in rural Indiana.

The referrals Bradley can now make are evidence of the program's importance, according to Oliver.

"We're trying to help veterans get the care they need, and veterans don't always know about the services that are available to them," Oliver adds. "And clergy don't always know what the VAs are doing. So my role here has been to try to bring two groups of people together – the clergy and the VA – to help them talk to each other."

Clergy were given direct lines to VA medical center personnel in their areas as well as other resources to aid veterans.

Future rural workshops will include information about traumatic brain injury, military sexual trauma, and specific mechanisms for referrals to non-VA mental health providers.

Help our heroes

Of the more than 8 million veterans enrolled in the Veterans Health Administration nearly 40 percent live in rural areas.

The National Rural Health Association's 36th Annual Rural Health Conference will put an emphasis on veterans' health with relevant sessions including one on the rural clergy training program.

To better serve veterans in your area, plan now to attend additional sessions on:

- Honoring rural veterans at the end of life
- Combining community-based and VA care to best serve veterans
- Veteran outreach programs to assist in benefit access
- Veterans' health-centered training and education
- Survey results on veteran culture competence of rural health providers

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Visit Ruralhealthweb.org/annual to view the full agenda and register for the largest gathering of rural health professionals in the country from May 7-10 in Louisville, Ky.

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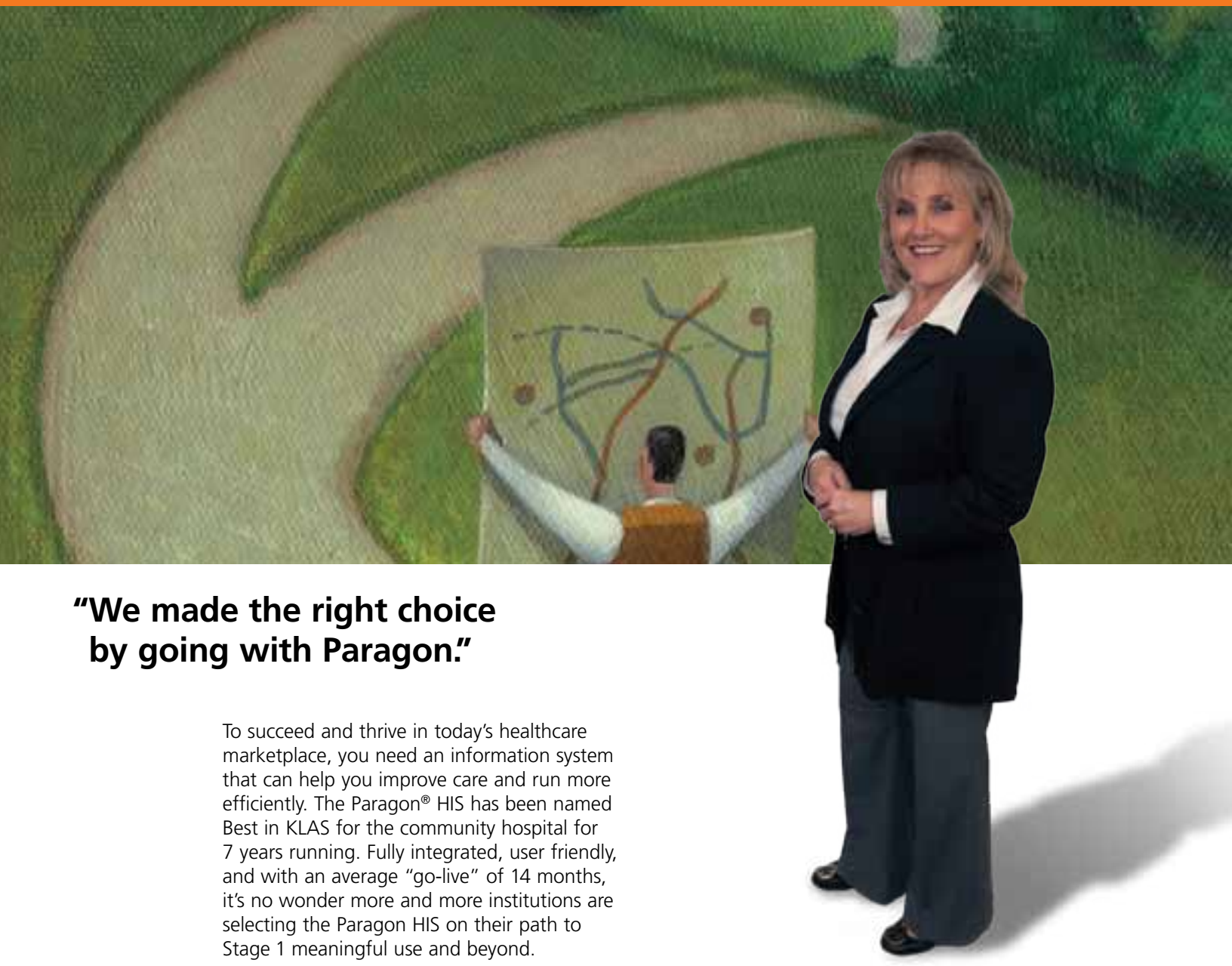

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[1]*Source: 2006-2012 'Best in KLAS Awards: Software & Professional Services',* www.KLASresearch.com.

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Telehealth experts explore benefits and barriers

By Angela Lutz

Karen Rheuban and Andy Southerland communicate with a patient via telehealth from their network's hub at the University of Virginia.

Across the country, telehealth is changing the delivery of rural health care for the better.

In the Northeast, tele-intensive care unit services helped medical responders provide disaster support in the aftermath of Hurricane Sandy. Following the storm, flooding and impassable roads isolated many rural communities, but telehealth allowed patients to remotely receive specialty care.

Further south in rural Arkansas, the University of Arkansas for Medical Sciences' Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) program gives high-risk pregnant women access to maternal-fetal medicine specialists via call centers and videoconferencing.

A replica of the ANGELS program at the University of Virginia has reduced preterm delivery by 25 percent in the populations they serve.

"We connect to six rural sites where high-risk pregnant women can come to either a health department or federally qualified health center and see a high-risk obstetrician via telemedicine," says Karen Rheuban, MD, University of Virginia continuing medical education and external affairs senior associate dean and Center for Telehealth director. "That has made a huge impact."

And telehealth helps first responders save lives every day. According to Sherilyn Pruitt, Office of Rural Health Policy Office for the Advancement of Telehealth director, when a child at the scene of an accident needed to be

continues on page 28

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caring for the future of rural America

continued from page 25

transported to a trauma center by helicopter, wireless devices allowed paramedics to communicate with nurses and specialists en route to determine the extent of the child's injuries.

"It actually increased the rate of survival for the child," Pruitt says.

Because of telehealth's significant benefits to rural patients and providers, last year the Health Resources and Services Administration contracted with the Institute of Medicine (IOM) to explore the growing importance of telehealth in rural and underserved communities. The two-day meeting included many experts from the federal sector, private sector and associations.

One of the primary goals of the meeting was to examine how telehealth can extend limited resources to provide affordable, high quality services to geographically isolated individuals, as well as identify barriers that still need to be addressed. According to Pruitt, telehealth benefits millions of people nationwide, so these discussions are vital.

"About 10 million patients receive telehealth services," Pruitt says. "Telehealth is considered to lower cost while improving quality of care. Providers enjoy the additional expertise that is provided through telehealth consultations."

The first IOM report on telehealth was issued the same year Congress passed the Telecommunications Act of 1996, which led to the establishment of the Universal Service Rural Health Care Program and provided discounts on telecommunications services. According to Rheuban, who chaired the most recent IOM meeting, telehealth has grown considerably since the first networks were established 17 years ago.

"In our network, we have supported more than 30,000 telemedicine encounters," Rheuban says. "I would say more than 90 percent of those patients stay in their own community and don't have to travel or require transfer."

The types of specialty services available in rural areas has also increased

Talking telehealth

The panel of experts, convened last year by the Health Resources and Services Administration and the Institute of Medicine, identified these key themes to ensure the continued growth and evolution of telehealth in rural America:

- Technology should not be seen as a barrier but as something that allows more patients to interact with their providers.
- The focus should be on the patient, not the technology.
- There should be a more systematic way to implement telehealth across the country so every person can get appropriate care no matter where they are.
- Growing evidence that demonstrates the efficacy of telehealth should be disseminated more widely.
- Reimbursement should be increased to encourage more participation.
- Barriers such as broadband availability, licensure, credentialing and privileging and scope of practice need to be addressed.

Learn more about the federal meeting directly from its chair Karen Rheuban, MD, and participant Sherilyn Pruitt at the National Rural Health Assoication's 36th Annual Rural Health Conference May 7-10 in Louisville, Ky.

Sessions that will examine the evolution of telehealth, its current evidence base, and how technological developments are changing the delivery of health care.

Representatives from pilot programs funded by the Office of the National Coordinator for Health Information Technology will share lessons learned in expanding telehealth, federal plans for sustainability and strategies to overcome barriers.

And you'll have the chance to meet with directors from telehealth resource centers across the country to explore services that can be delivered to rural hospitals, clinics and providers including available care specialties, critical access hospital benefits and no-fee services.

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thanks to telehealth; according to Rheuban, telehealth has the potential to encompass virtually "all of health care." Without telehealth, many rural areas wouldn't have access to specialists in radiology, psychiatry, stroke neurology, dermatology, cardiology or dentistry.

Unfortunately, barriers still remain. One of the main challenges providers face is securing reimbursement for telehealth services. According to Rheuban, the Benefits Improvement and Protection Act of 2000 increased telehealth reimbursement under Medicare significantly, and 16 states have since passed legislative mandates for reimbursement.

But 34 states still lack reimbursement mandates, and health care providers in communities that don't fit under the Medicare definition of rural struggle as well. According to Rheuban, many so-called urban communities "effectively are rural because of specialty health professional shortages." For example, she says she knows of several Appalachian communities with no hospital that are considered urban under the federal definition.

"In some of these counties, it's just a family medicine physician or an internal medicine physician and that's it," Rheuban says. "There are some inequities with the definition [of rural] that could be resolved by a broadening of the eligibility criteria by CMS [Centers for Medicare and Medicaid Services]."

Another barrier many rural communities face is limited cell coverage and broadband access. The Federal Communications Commission has helped to tackle this issue through its Rural Health Care Program, established in the Telecommunications Act of 1996, which recently announced an expansion of funding for telecommunications and broadband services for health care. Rheuban is grateful for this development, as she has experienced the drawbacks of substandard cell coverage firsthand.

"I live in Charlottesville, Virginia, and unfortunately there are still locations in Virginia where my cell phone just doesn't work," Rheuban says. "We still have a long way to go."

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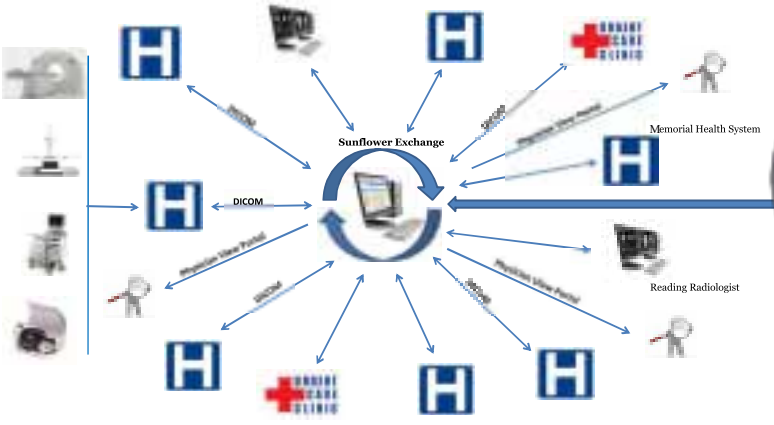

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Rural hospitals play vital role when tragedy strikes

By Tim Putnam

Henryville, Ind., 2012 tornado destruction.

Tim Putnam

On March 2, 2012, communities throughout the Midwest and South were ravaged by the first tornados of the season. This storm proved deadly, taking 14 lives in Indiana alone and devastating the tiny towns of Henryville, Holton and Marysville.

After suffering the trauma of having their town destroyed around them and seeing members of their family and friends killed or injured, many people faced life threatening injuries of their own.

Our rural hospital went into mass casualty mode and helped multiple victims as they were brought to our emergency department. We triaged, treated and when necessary, stabilized and coordinated transfer for the most critical patients to regional trauma centers. It was a long and emotion-filled night as people faced fear and loss they had never before imagined.

Throughout my career in rural health care I have experienced the effect of tornadoes, devastating ice storms, school bus crashes and other disasters both natural and manmade. During each disaster, I was reminded what an honor it was to work with our hospital's team of dedicated professionals. Each situation was also a vivid reminder of what would have happened to my friends and neighbors if our hospital had suffered the fate of many of the rural hospitals in the 1980s and '90s and closed our doors permanently.

Our function in the health care system is much more than the care we provide on a daily basis. It is also the responsibility we have when our region experiences unforeseen devastation. In no way do I wish to minimize the challenge urban hospitals experience when faced with similar circumstances, but rural hospitals generally stand alone and are figuratively the first on the scene and the first place of refuge. Rural hospitals are never more valued than when there is a communitywide emergency.

> "When it comes to disasters, there are two kinds of communities: those that have faced this type of devastation and those that will."

It is clear that we will continue to face funding cuts and other challenges from state and federal officials. Rural hospitals will have to fight to maintain vital services, and many will be fighting for their very existence. Over the coming months we must clearly articulate our need to exist.

We need to make it clear to decision-makers in Washington and our statehouses the vital role rural hospitals play when tragedies hit our communities. We have made our case for survival on concepts like the importance of health care to the economy of small towns and the efficiency of health care provided close to home, but our role when disaster strikes is a

story that is not told enough.

When it comes to disasters, there are two kinds of communities: those that have faced this type of devastation and those that will. As rural health leaders, we need to plan accordingly and be well prepared for this eventuality.

We also need to make our case to decision-makers whose actions threaten to weaken rural health care. The impact of leaving many Americans without a local hospital deprives them of a vital resource when their communities need to respond to widespread tragedies.

Tim Putnam, DHA, is president and CEO of Margaret Mary Health in Batesville, Ind. He has led critical access hospitals for 10 years. Putnam joined the National Rural Health Association in 2009 and was a 2011 NRHA Rural Health Fellow.

3 ways to become a rural health advocate

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You can "like" NRHA's Facebook page and follow NRHA on Twitter for updates on rural health happenings. Subscribing to NRHA's Rural Health Voices blog (blog.RuralHealthWeb.org) will keep you informed on important updates from Capitol Hill.

2. **Start at the grassroots.** NRHA's grassroots mailing list enables you to participate in rural advocacy efforts and campaigns to contact state and national representatives. Hear the latest from NRHA's advocacy staff during calls on the last Wednesday of each month at noon ET. Send a blank email to join-grassroots@lists.wisc.edu.

3. **Make connections.** As always, attending NRHA events and participating in our free interactive webinars are the best ways to meet with rural health leaders and decision-makers and advocate for rural patients and providers. NRHA's member-driven social network, NRHA Connect (connect.NRHArural.org), helps you keep in touch with colleagues between NRHA conferences and make your voice louder through NRHA.

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Beginnings & Passages

Cristina Miller

"A world-renowned economic historian, gave me, a young researcher, the best advice. She said, 'seek the truth and tell it.'"

Seeking and sharing the truth about rural health

By Cristina Miller

My grandfather was a Wisconsin farmer, as was his father and father's father and so on.

My Wisconsin relatives still operate dairy farms. In 2001, I made a pilgrimage to Trassem, Germany, where my family comes from, and met my relatives who still live on the family farm and in the family house built in 1691.

My grandfather was always intrigued by flight. When he was little, he made a set of wings to put on his arms and then jumped out of the hayloft in hopes of truly flying. Needless to say, he fell straight down – luckily onto bales of hay. His love of flight was transferred to my father, who became a corporate pilot. We moved around the country a lot, so I didn't grow up in a rural community. But my dad's family and relatives still live in that small town in Wisconsin, and as a child I treasured visiting. My uncle is the rural town's family physician. My cousins are rural firefighters and EMTs. Rural health care is very important in my family.

My defining moment, where my passion for rural health research really surfaced, was as a graduate student at the University of Illinois at Urbana-Champaign. I was a research assistant for Robert Aherin, PhD, in agriculture safety and health and the National AgrAbility Project (providing assistance to farmers with disabilities). I learned about the severity of farm injuries and accidents through my research on farmers with disabilities and training in ag medicine with Kelley Donham, DVM, of the University of Iowa, and on farm safety with the Illinois Fire Institute and as a National Institute for Occupational Safety and Health ag safety and health trainee and a USDA Public Service Leaders Scholar. It made me think about rural access to hospitals, EMS and 911 services and how I took those services for granted.

A world-renowned economic historian, Deirdre McCloskey, PhD, gave me, a young researcher, the best advice. She said, "seek the truth and tell it." This advice guides me as I conduct research on rural and farmer health, rural access to health care and rural health care provision links with community development.

Cristina Miller, PhD, is an agricultural economist with USDA Economic Research Service. She joined the National Rural Health Association in 2012 and is a 2013 NRHA Rural Health Fellow.

Innovative rookies and seasoned professionals share their experiences.

"The more familiar I became with the community, the more compelled I felt to stretch my ability to help address unmet needs."

Susan Kunz with Corinne Redhorn, a Tohono O'odham tribal member and early mentor to Kunz.

Working myself out of a job

By Susan Kunz

Thinking back to 1981, I recall sipping strong coffee in rural Colombia (South America), pondering future employment in my native Arizona once my already-extended Peace Corps service ended. What could possibly be as exciting and rewarding as wandering the countryside with a social worker and an agronomist teaching basic public health?

Thank heavens for the friend that sent me a job announcement for a nutritionist position with the Tohono O'odham Nation. During the job interview, I was asked about my experience with fundraising. I confidently responded that I had managed successful bake sales. The polite chuckles across the table seemed to limit my prospects, but they hired me anyway, saying that I had potential.

My first job in a tribal community continued to teach me to recognize potential. My knowledgeable and compassionate colleagues also taught me the spirit of mentorship. In return, I mastered many roles. The more familiar I became with the community, the more compelled I felt to stretch my ability to help address unmet needs.

So I decided to write grant applications (on a typewriter, no less).

While on business in D.C., I visited several federal agencies to sniff out opportunities for funding. One federal employee was surprised by my visit, stating, "…we have never funded an Indian tribe because they don't submit competitive proposals." I left that day highly resolved to prove her wrong. Our grant application was indeed funded, and I later successfully petitioned to have her removed from our grant as the project officer for lack of cultural competence and respect.

That turning point ignited my professional passion to match community needs with funding resources through program development and grants. While doing so, I have tried to pass on my early lessons from the Tohono O'odham Nation.

My efforts to increase funding are wed to building the potential and capacity of community members through mentorship. Although I expanded my partnerships beyond Indian Country to also include Hispanic/Latino communities along the U.S.-México border, my goal is still the same: to work myself out of a job. It has been great fun.

Susan Kunz is the Mariposa Community Health Center's health promotion and disease prevention director. She received the inaugural Rosemary McKenzie Legacy Award during the National Rural Health Association's 18th annual Rural Multiracial and Multicultural Health Conference in December for dedicating her career to improving health equity for American Indians and Hispanics in Arizona.

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Rural health advocates gather in D.C.

The National Rural Health Association's Rural Health Policy Institute brought nearly 400 rural health advocates together in D.C. in February.

United States Department of Agriculture Secretary and White House Rural Council chair Tom Vilsack reminded attendees in his keynote address, "Rural America matters. And for far too long rural issues have not received the attention they deserve."

Mary Wakefield, PhD, U.S. Health Resources and Services Administration administrator told participants from every state, "I'm pleased the Office of Rural Health Policy is working with NRHA and focusing like a laser to increase the rural health workforce."

Spurred by NRHA staff and members on the Hill, Senators Amy Klobuchar, D-Minn., and Jerry Moran, R-Kan., introduced S.R. 26, which aims to recognize and preserve the important contributions rural hospitals and providers make to their communities. The release of the resolution during the event gave grassroots advocates the opportunity to rally support and encourage their members of Congress to support this legislation.

Sen. Pat Roberts, R-Kan., referred to the many rural health professionals and students attending the 24th annual event from Kansas as "my eyes and ears on the ground" and thanked rural health advocates from across the country for gathering in Washington to share their stories with members of Congress.

The 2014 Policy Institute will be Feb. 4-6.

Agriculture Secretary Tom Vilsack stopped to speak with Sen. Tom Harkin, D-Iowa, after delivering the NRHA Rural Health Policy Institute keynote address. Above: NRHA CEO Alan Morgan and 2013 NRHA President Sandra Durick thanked Vilsack for taking the time to answer NRHA members' questions. Left: NRHA members Patricia Crawford, Sandra Pope, Norma Bowyer and Annie Barnes caught up during the Policy Institute Congressional Reception in the Dirksen Senate Office Building.

Clockwise: Republican Sen. John Thune met with NRHA members from South Dakota during NRHA's Congressional Reception. Future NRHA Rural Health Fellow Isaiah, 5, accompanied his mom, Nalo Johnson, from South Dakota to D.C. to watch her presentation as a graduating Rural Health Fellow at the beginning of the Policy Institute. They also took the time to be tourists. Rep. Ron Kind, D-Wis., spoke with NRHA members about rural health needs in his home state. Oklahoma State University Student Osteopathic Rural Medicine Club officers Melanie Hutchinson, Kassandra Guthmueller, Carissa Kulczycki and James Hensel met with their elected leaders on Capitol Hill. HRSA Administrator Mary Wakefield answers media questions after speaking with Policy Institute attendees.

More friendly faces

Continue your trip down Memory Lane or see what you missed with more photos from the Rural Health Policy Institute and other NRHA events at flickr.com/nrha.

And learn more about and become involved in NRHA's advocacy efforts on pages 32 and 48.

A Windy City welcome
from NRHA member Pat Schou

Side trip

Pat Schou

Chicago's Millennium Park

From its skyline on the shores of Lake Michigan to its shops on the streets of Michigan Avenue, don't miss your chance to see Chicago this summer with rural health colleagues.

Entertainment

A Chi-town summer will not disappoint the sports enthusiast or the theater patron. While you're in the Windy City for the National Rural Health Association's 9th annual Rural Quality and Clinical Conference, you can see the Blue Man Group and even catch the White Sox as they take on the Braves.

Must-see sites

This historic hub city offers many sites from our nation's past as well as plenty of chances to learn something new.

You'll want to visit Navy Pier, the Art Institute of Chicago, Adler Planetarium, Shedd Aquarium, the Old Water Tower (which survived the fire in 1871), the Lyric Opera of Chicago and, of course, Wrigley Field.

Dining

Chicago has pub for every taste – and taste bud – from elegant dining experiences to legendary deep-dish pizza or nightlife.

Make sure to stop by the Signature Room at the top of John Hancock Center and to view the city from 95 stories up.

For detailed information on more Chicago attractions and activities, visit choosechicago.com.

In short, this windy city will blow you away!

Pat Schou is executive director of the Illinois Critical Access Hospital Network. She joined the National Rural Health Association in 2007.

Keys to quality

Join rural health colleagues and national experts for the National Rural Health Association's 9th annual Rural Quality and Clinical Conference July 17-19 in Chicago.

Plan now to connect and collaborate with professionals practicing on the frontlines of rural health. And take what you learn home to improve care right away.

Go to RuralHealthWeb.org/quality for event details, scholarship opportunities and discounted rates.

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Set up a video chat. Or schedule a brief get-to-know-you intro at the May NRHA conference in Louisville by calling **Mike Milligan**, President, Legato Healthcare Marketing, **920.544.8102**.

NATIONAL RURAL HEALTH ASSOCIATION
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Members on the move

Journal of Rural Health editor accepts new positions

Ty Borders

The National Rural Health Association's *Journal of Rural Health (JRH)* editor is now a University of Kentucky (UK) faculty member.

Ty Borders, PhD, became a professor and chair of the Department of Health Services Management in the university's College of Public Health in November.

And to further support the development of rural health research at the university, he also became the Foundation for a Healthy Kentucky endowed chair in rural health policy and co-director of a new Institute for Rural Health Policy in February.

Borders has been editor of NRHA's peer-reviewed scholarly publication since 2009 and will continue in that role.

"My service as editor of *JRH* has greatly contributed to my career development by expanding my knowledge of the breadth of social, economic, behavioral and health system determinants of rural residents' health services use and population health as well as by raising my own national reputation within the field of rural health research," Borders says. "I'm quite certain that my role as editor contributed to the University of Kentucky's decision to select me as a department chair and endowed chair in rural health policy, and my continued role as editor of *JRH* will further enable me and our university to generate new knowledge that will inform rural health policy, management and health care delivery."

Prior to joining the UK faculty, Borders was a professor of health policy and management and director of the PhD in Health Systems Research Program at the University of Arkansas for Medical Sciences for seven years.

Borders joined NRHA in 2004.

Former NRHA president retires

Kris Sparks recently retired from her position as manager of rural health programs for the Washington Department of Health.

She held the position since 1999 and worked for the state office since 1990.

Kris Sparks

"I miss working with rural communities and my colleagues across the country working to improve rural health," she says. "But I'm enjoying time on our little farm and with family and friends."

Sparks joined the National Rural Health Association in 1990 and served as president in 2011.

"My involvement in NRHA has allowed me to learn how different rural is across the country, but that while the places may look different we all share a commitment and caring for people," Sparks says.

NRHA member leads Kansas CAH

Allen Van Driel

Allen Van Driel recently became CEO of Smith County Memorial Hospital in Smith Center, Kan.

"I am looking forward to the challenges of leading a dynamic health system in Smith Center," he says of the 25-bed critical access hospital with an attached 28-bed long-term care facility and a provider-based rural health clinic.

Van Driel most recently served as chief operating officer at Chadron Community Hospital and Health Services in Chadron, Neb., since 2008. Previously, he was CEO of Harlan County Health System in Alma, Neb., for 16 years.

He also represented Nebraska on the National Rural Health Association's Critical Access Hospital Leadership Group and served as the Nebraska Rural Health Association's 2008 president.

"There are no more dedicated providers of health services anywhere than in small, rural facilities," Van Driel says. "All rural health care providers are facing a daunting future as the health care system in this country is transformed under health reform. NRHA has been and will be an invaluable resource to facilities such as Smith County as they adapt to changes. I look forward to continuing my association with NRHA and actively participating in its efforts."

Van Driel joined NRHA in 2009.

NRHA news

NRHA leads third annual rural training track event

More than 50 participants, representing 16 rural training track (RTT) programs, including six developing RTT programs, gathered in Boise, Idaho, for the 2013 National Rural Health Association RTT Conclave at the end of February.

The Family Medicine Residency of Idaho, led by Ted Epperly, MD, and Dave Schmitz, MD, served as host for this third annual conference.

The event brought together rural medical residency site directors, program coordinators, faculty and other RTT stakeholders for face-to-face meetings with counterparts from across the country to discuss the opportunities and challenges specific to RTTs as well as issues related to graduate medical education and rural health care in general.

"Everyone in the room understood that rural training track programs offer something special to medical residents who are looking for a more in-depth training program," says Amy Elizondo, NRHA program services vice president. "They know because many of them are rural family physicians who serve as the safety net medical provider for obstetrics, mental health care, general surgery and more in their rural areas because it is difficult to see a specialist."

Rural family physicians often treat a wide variety of conditions and patients. Thus, after a resident completes medical school and selects an RTT site for practice, they will have more opportunities to learn different aspects of the role of a family physician, she explains.

"Rural areas desperately need more family physicians, and all of our conclave attendees are working day in and day out to recruit, train and retain these physicians for rural America," Elizondo says. "While the need for dedicated rural physicians is still great, these RTT programs are making a difference in their rural areas one medical resident at a time."

And their impact is growing. Leading RTT expert Randall Longenecker, MD, shared that the RTT programs had the highest match rates (84 percent) between medical residents and their residency positions in the last 10 years.

Mary Wakefield, PhD, Health Resources and Services Administration (HRSA) administrator, commended RTT programs for their success in training and retaining physicians for rural America during her remarks at the 2013 NRHA Rural Health Policy Institute.

HRSA, through its Office of Rural Health Policy, supports these efforts through a cooperative agreement with NRHA to offer technical assistance to current and developing RTT programs.

NRHA welcomes new fellows

Following a competitive review process, 13 fellows were selected to participate in the National Rural Health Association's yearlong, intensive program aimed at developing leaders who can articulate a clear and compelling vision for rural America.

"With the successes achieved by the six previous classes, we look forward to continuing the tradition of building rural health care leaders through this valuable program," NRHA CEO Alan Morgan says.

continues

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The 2013 Rural Health Fellows first met during NRHA's Rural Health Policy Institute in February in Washington, D.C.

The new fellows are:

Judith Austin, Hi-Desert Medical Center chief operating officer and chief nursing officer, Joshua Tree, Calif.

Lynn Barr, Tahoe Forest Health System chief information officer, Truckee, Calif.

Chris Felton, West Texas Area Health Education Center associate director, Lubbock, Texas

Susan Frazier, MD, Memorial Health Clinics/Aspirus physician, Rib Lake, Wis.

Alicia Haywood, Colorado Rural Health Center policy and advocacy manager, Aurora, Colo.

Kelly Humpherys, University of Oklahoma Rural Residency Program assistant director, Bartlesville, Okla.

Chad Jones, PharmD, Chelsea Family Pharmacy pharmacist, Chelsea, Okla.

Cristina Miller, USDA Economic Research Service Public Service Leaders scholar and University of Illinois-Chicago doctoral candidate, Silver Spring, Md.

Stephanie Powers, Regional Health grant services assistant director, Rapid City, S.D.

Hicham Rahmouni, Richard G. Lugar Center for Rural Health associate director, Terre Haute, Ind.

Geoffrey Roche, Pocono Health System community and government relations coordinator, East Stroudsburg, Pa.

Jonathan Wade, Mercy St Francis Hospital president, Mountain View, Mo.

Vicki Weidenbacher-Hoper, National Center for Rural Health Professions assistant director, South Beloit, Ill.

For more information on the Rural Health Fellows, visit RuralHealthWeb.org. Application materials to join the 2014 class will be available online in May.

NRHA congratulates Rural Health Fellows graduates

The National Rural Health Association congratulates the following 2012 Rural Health Fellows for completing the intensive program aimed at developing leaders who can articulate a clear and compelling vision for rural America.

The 2012 fellows presented the results of a year of research and collaboration during their graduation ceremony at this year's NRHA Rural Health Policy Institute in Washington, D.C.

These NRHA members are now alumni of the competitive program:

Anne Braswell, North Carolina Office of Rural Health and Community Care research and development senior analyst, Raleigh, N.C.

Mary DeVany, Great Plains Telehealth Resource and Assistance Center outreach director, Harrisburg, S.D.

Jarod Giger, PhD, University of South Dakota social work assistant professor, Vermillion, S.D.

Rebecca Hartman, Alvernia University doctoral candidate, Wyomissing, Pa.

Nalo Johnson, PhD, Avera Rural Health Institute grant writer, Sioux Falls, S.D.

Lesley LaFile, Good Samaritan Hospital Foundation grants and special project manager, Kearney, Neb.

Lori Larson, Central Minnesota Area Health Education Center regional specialist, Fergus Falls, Minn.

Samantha Lippolis, Children's Hospital Colorado outreach coordinator, Aurora, Co.

Tarik Walker, MD, University of Colorado family medicine instructor, Aurora, Co.

Florence Weierbach, PhD, East Tennessee State University College of Nursing assistant professor, Johnson City, Tenn.

"Having the opportunity to participate as a Rural Health Fellow was a wonderful way to introduce me to the organization. Not only did I receive focused instruction on rural health policy and advocacy, I was able to network with other dynamic individuals focused on sustaining rural health access," Johnson says. "I am very thankful for having had the chance to participate."

As part of the yearlong program, the fellows developed four projects examining oral health and long-term care needs in rural America, streamlining telemedicine licensure and the feasibility of a critical access hospital residency program.

For more information, visit RuralHealthWeb.org.

Speak up: Present at NRHA conferences

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

Submissions for this year's Rural Health Clinic and Critical Access Hospital Conferences will be accepted through April 26. The events will be Oct. 1-4 in Austin, Texas.

Rural Multicultural and Multiracial Health Conference submissions will be accepted through May 31 for the Dec. 3-5 conference in San Antonio, Texas.

And NRHA will take session proposals for its 2014 Annual Rural Health Conference, the nation's largest gathering of rural health professionals, May 1 through July 31. The 2014 event will be in Las Vegas April 22-25.

Constituency group changes name, not focus

The National Rural Health Association's Board of Trustees recently changed the name of the Community-operated Practices Constituency Group (CG) to the Federally Qualified Health Center (FQHC) CG.

The change was made so new and current members may more easily identify this CG and its purpose, particularly in this era of primary care expansion through the FQHC model, explains Scot Graff, the CG's chair.

A federally qualified health center is a facility with a reimbursement designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services. The designation is significant for several health programs funded under the Health Center Consolidation Act.

Members in this CG focus on interests and issues regarding policy, regulation and collaboration with other health care organizations. NRHA members working or interested in rural federally qualified health centers are encouraged to join this group via NRHA Connect.

"Our CG is hoping to increase collaboration with other providers," Graff says. "It makes sense as collaboration is the heart and soul and focus of rural."

NRHA Connect is a private social network available exclusively to NRHA members. If you have not yet utilized your free access to NRHA Connect, or if you are unsure of your membership status, email membership@NRHArural.org.

For more information on the FQHC CG, and to connect with its members, sign up today at connect.NRHArural.org.

NRHA recognizes congressional rural health champions

The National Rural Health Association recently presented its 2013 Legislative Awards, which recognize outstanding leadership on rural health issues by U.S. congressional members and staff.

This year's recipients are:

Sen. Max Baucus, D-Mont.

Sen. Charles Grassley, R-Iowa

Sen. Charles Schumer, D-N.Y.

Rep. Tom Reed, R-N.Y.

Kevin Courtois, Senate Judiciary Committee minority staff

Carla McGarvey, Rep. Mike Thompson staff member

continues

Send your career updates to editor@NRHArural.org.

continued

Meghan Taira, Sen. Charles Schumer staff member

"The winners embody hard work, commitment and a true devotion to rural America," says David Lee, NRHA government affairs and policy manager. "Their efforts to guarantee quality, accessible health care in rural environments are appreciated, and NRHA and all rural advocates are fortunate to have such stalwart champions."

Award winners were honored during NRHA's 24th annual Rural Health Policy Institute, which brought nearly 400 rural health advocates to Washington, D.C., in early February. (See page 40 for more on the event.)

The 2014 Policy Institute will be Feb. 4-6.

Rep. Tom Reed accepts one of seven NRHA 2013 Legislative Awards.

accelerating advocacy

Make sure divided Congress remembers rural needs

By Maggie Elehwany

Fiscal cliff, sequestration, government shutdown, oh my. It's not you're imagination; there actually is one federal crisis after another.

Each chronicle of doom and gloom seems to have consequences more dire than the last. What is our government doing? And how did we get here?

Much can be blamed on the lack of "a middle." That is, that there no longer seems to be moderates on either side of the political aisle in Congress. The middle has been replaced with ideologues and antics of brinksmanship. The value of compromise among moderate voices has all but vanished. Why does this matter to rural America?

Just like a person from the middle of the country can bring common-sense prudence to resolve an argument, it's the political middle that calms the extremes of the left and the right. It's the moderates who bring parties to the table, who broker the deal. It's the moderates who fought to improve health care access for rural patients and for rural health clinic improvements, to create rural hospital designations and to increase health care workforce programs in health professional shortage areas and more. The moderates were often the greatest champions of rural America.

Where once such names as Bob Packwood, Richard Lugar and Ted Kennedy symbolized bipartisan compromise in Congress, today many political party heads and pundits shun the term.

Ironically, voters, in their zeal to get something in Washington done, are eliminating many of the workhorses in Congress. And many recent moderates have retired simply because he or she found Capitol Hill too toxic. The recent list of departing Senate centrists is long: Olympia Snowe, R-Maine, Ben Nelson, D-Neb.; Joe Lieberman, I-Conn.; Jim Webb, D-Va.; Kent Conrad, D-N.D.; and Jeff Bingaman, D-N.M. Each said the polarized bickering in Washington is debilitated the democratic process.

Congress has its lowest approval rate in the history of tracking approval ratings. It seems the nation is weary from the crisis de jour form of government. Nevertheless the threats of cuts to the rural health care delivery system are real and continue to loom. Federal cuts, that may seem minor to a large urban medical facility, will be significant — maybe devastating — for the small rural hospital or provider.

So, you can grow weary of Congress, but not our fight for rural patients and providers. We need your voice. We need you to join the National Rural Health Association's advocacy efforts now.

See page 32 for details on how to become involved and make a difference.

Maggie Elehwany, JD, is the National Rural Health Association's government affairs and advocacy vice president.

By Kacie Fodness

Derby details: Stay on track

Ready, set, race to the 36th Annual Rural Health Conference in Louisville, Ky., May 7-10.

Take advantage of early registration at RuralHealthWeb.org/annual to ensure you won't have to jockey for a spot at this exciting event.

In addition to iconic Churchill Downs, Louisville is the birthplace of bluegrass, home to many bourbon distilleries open for tours, and it's the only place you can zipline *inside* a cave.

Whether it's food or music, relaxation or sports, bourbon or mint juleps, Louisville will not disappoint.

Off the beaten path

A horse of a different color

Comanche

Taxidermy preparation of Comanche.

Made famous for surviving the Battle of Little Bighorn, celebrated war horse Comanche was so important to soldiers and the war efforts of the late 1800s that he was stuffed some 120 years ago, and — due to an unpaid bill — you can still see him today at the University of Kansas Natural History Museum in Lawrence.

His namesake, the town of Comanche, Kan., population 1,891, is where this horse was first deemed a hero, when — after being shot with an arrow — Comanche allowed his rider to finish the battle.

Long thought to be "the only survivor of the Battle of Little Bighorn," Comanche is subject of much legend and posthumous respect. In his "retirement" at Ft. Riley, Comanche befriended yet another solider and reportedly died of a broken heart when Gustave Korn did not make it home from the Battle of Wounded Knee in 1890.

Though he is on display in a museum in Kansas and never set hoof on race tracks in Kentucky, Comanche is a horse for the history books.

shifting gears

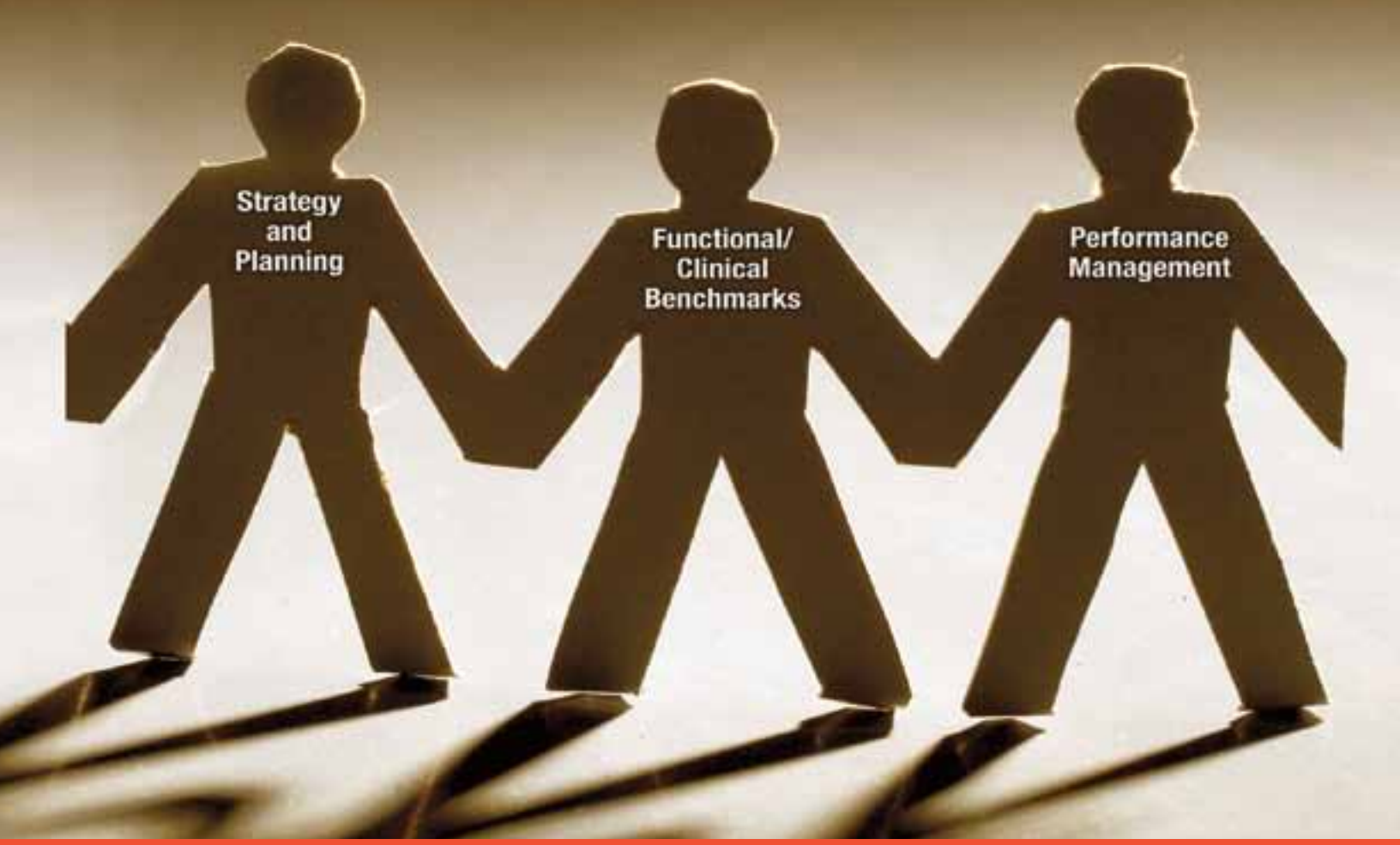
Spring greens: Can you dig it?

Gardens are, not surprisingly, one of the most effective ways to go green both literally and metaphorically.

Plant a garden. Not only will you be rewarded with healthy, local produce and herbs, but you'll contribute to healthier planet and local ecosystem. The act of planting and the exercise of upkeep can also be a nice workout.

Conserve water. Avoid overwatering plants and flowers by doing your homework to find out just how much they need.

Take it inside. Houseplants can serve as a natural indoor filter. Notable examples are chrysanthemums and English ivy, which have each been deemed "living air filters."



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