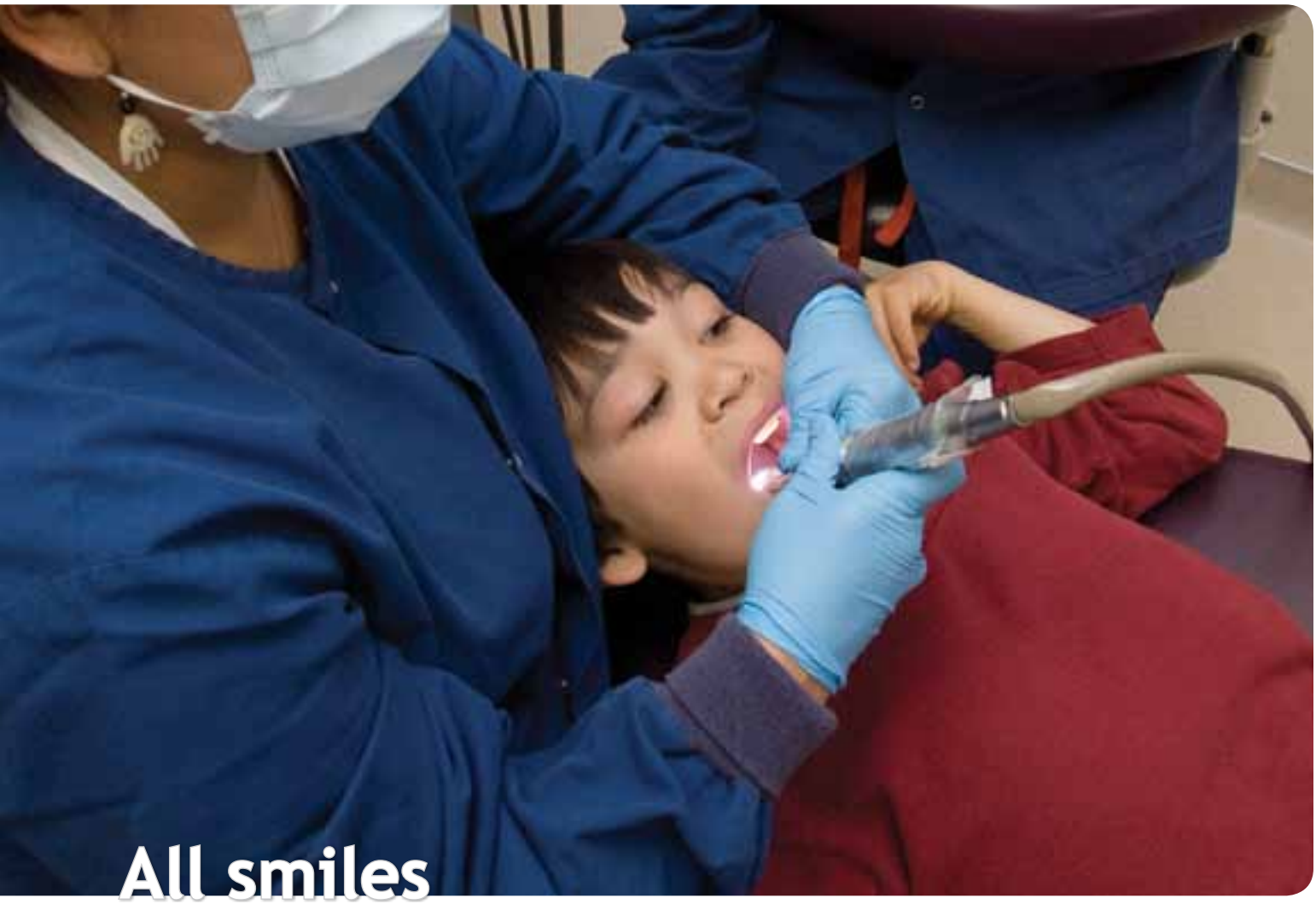
rural roads

Winter 2011 National Rural Health Association



All smiles

Dental therapists take care home

Hospital donation helps college train nurses

Border health advocates share experiences

Delivery comes full circle for rural med student

NextGen's fully Web-based Inpatient Clinicals. Works everywhere you do.*

If you work in community healthcare, you can count on NextGen Healthcare to be there with the industry's premier fully Web-based inpatient clinical solutions. Now, hospitals in all locations can link inpatient and ambulatory data into one robust, easy-to-use platform. Best of all, no matter your location, you'll always receive NextGen Healthcare's exceptional customer service.

Learn more @nextgen.com/rural.

Here.

NEXTGEN HEALTHCARE Ahead.

Get the free mobile app at http://gettag.mobi

**Yes, NextGen® Inpatient Clinicals can run on an iPad right out of the box.*

Volume 9, No. 1

Rural Roads *is a quarterly publication of the National Rural Health Association, a nonprofit association with 20,000 members who share a common interest in the advancement of rural health.*

Advertise

For information on advertising in NRHA publications, e-mail ads@NRHArural.org or call 913-269-1199.

Subscribe

Domestic *Rural Roads* subscriptions are $20 per year. To subscribe, e-mail editor@NRHArural.org or send a check to *Rural Roads* editor, NRHA, 521 E. 63rd St., Kansas City, Mo., 64110.

Rural Roads was awarded a KC IABC 2009 Bronze Quill Award for most improved publication.

NRHA Kansas City office
816-756-3140

NRHA D.C. office
202-639-0550

National Rural Health Association

RuralHealthWeb.org

contents

On the cover

Dental health aide therapists have provided oral health care to rural and remote Alaskan communities since 2006.

Write us

Rural Roads is interested in the opinions of readers regarding articles published. 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.

RuralRoadsonline.com

Rural roots

Nurture. Grow. Branch out.

Connect to innovations and opportunities at these 2011 NRHA events.

Rural Medical Educators Conference
May 3
Austin, Texas

Annual Rural Health Conference
May 3-6
Austin, Texas

Quality and Clinical Conference
July 20-22
Rapid City, S.D.

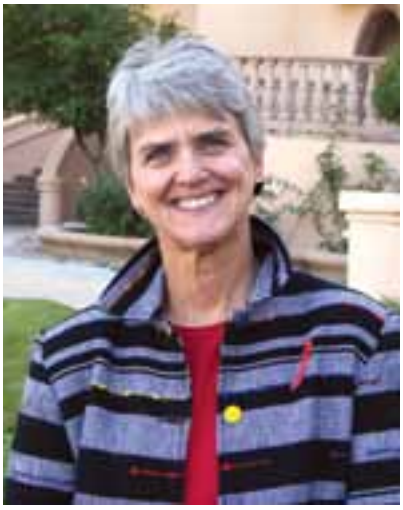
Rural Health Clinic Conference
Sept. 27-28
Kansas City, Mo.

Critical Access Hospital Conference
Sept. 28-30
Kansas City, Mo.

Rural Multiracial and Multicultural Health Conference
Dec. 7-9
Daytona Beach, Fla.

RuralHealthWeb.org

Big tasks for rural health



1/1/11: what a great date to start my responsibilities as president of the National Rural Health Association.

I look forward to the exciting year ahead. My most recent predecessors, Dennis Berens and Beth Landon, have worked to strengthen rural economies and communities. With the guidance and hard work of CEO Alan Morgan and our staff, NRHA is seen as the national leader for rural health. Our association is stronger than ever.

My goal as president is to work with all of you to successfully implement health reform. I know not everyone thinks the health reform law is a good one. But regardless of your position, I believe more rural Americans should have access to affordable health insurance, a strong rural health workforce and quality health care services. We need to support our rural safety-net programs.

None of these are small tasks. I look forward to working together to achieve these goals and make this year another great one.

Kris Sparks
2011 NRHA president

pit stop

5 things I picked up in this issue:

1. A South Dakota med student completed a rotation under the doc who delivered him. *page 16*
2. A donated former hospital building was the catalyst for a college to develop a nursing program. *page 11*
3. Every winter, Paul Dulin treats friends and neighbors to a Mexican feast of posole. *page 24*
4. Before 2006, 25,000 Alaskans had no access to oral health care. The dental health aide therapist program changed that. *page 6*
5. Three of the 10 poorest American counties are on the U.S.-Mexico border. *page 14*

All smiles

Dental therapists take care home

By Angela Lutz

In Alaska Native populations, 60 percent of children ages two to five have untreated dental decay.

For many Americans, requesting time off work, excusing the kids from school, booking a hotel room and reserving $400 plane tickets sounds like preparation for a much-needed vacation.

But for rural and remote populations in Alaska, such travel plans often mean someone in the family has gone too long without seeing a dentist.

With many villages accessible only by snowmobile, boat or plane and the majority of dental providers located in large cities, thousands of Alaska Natives have not seen a dentist in decades.

As a result, dental decay in Alaska Native communities is widespread – 60 percent of children ages two to five have untreated decay, and 20 percent of adults over 55 are completely toothless.

"We have two-and-a-half times the rate of decay in children in Alaska Native populations than in other areas and races across the country," says Mary Willard, DDS, Alaska Native Tribal Health Consortium (ANTHC) Dental Health Aide Therapist Program clinical director. "And it doesn't just affect kids – we also see dental caries and lost teeth in the adult population."

Until recently, there was not much isolated Alaskans could do to combat the ravages of tooth decay. Faced with insurmountable transportation costs, lack of insurance and loss of income, many were left with one choice: live with the pain.

Community solutions

But beginning in 2003, ANTHC began implementing the dental health aide therapist (DHAT) model, which has been utilized for 80 years to provide safe and effective care in more than 54 countries worldwide, including Great Britain, Canada and New Zealand, where the first therapists began practicing in 1921.

Certified dental therapists are mid-level providers working as part of the dental team. They work remotely under the general supervision of a dentist to extend the reach of services to populations in need. They are able to provide the full scope of preventive care, including cleanings, fillings, sealants, simple extractions and referrals.

And according to Willard, since 14 dental therapists began practicing in Alaskan communities in 2006, more than 25,000 residents have direct access to dental care that they didn't have before.

"One of the things we hear is that it's nice to get the care at home and not have to travel far away," Willard says. "Patients talk about how nice it is to be treated by someone who looks familiar or is familiar within the community. Often our therapists are the first native people who have worked on their teeth, and they're proud and happy about that."

In fact, one of the main reasons for the longevity and success of the DHAT program is the trainees' connection to the communities they serve. While many past recruitment efforts have focused on getting providers to rural areas by offering loan forgiveness, the incentives turned out to be ineffective as long-term solutions.

> "Often our therapists are the first native people who have worked on their teeth, and they're proud and happy about that."
> Mary Willard, DDS, Alaska Native Tribal Health Consortium Dental Health Aide Therapist Program clinical director

"As soon as the loans were repaid, the providers were gone," says Alice Warner, PhD, program officer at the W.K. Kellogg Foundation, a national philanthropic organization dedicated to improving the lives of vulnerable children and families. "This is why rural areas are starved for providers. But when someone comes from the community and is trained and educated to become a therapist, they generally return home and

continues

Dentists return home

As executive director of New Mexico Health Resources (NMHR), a nonprofit dedicated to recruiting and retaining health professionals in rural areas, Jerry Harrison knows firsthand the challenges of getting dentists to come to small towns.

"We have one of the oldest dentist populations in the country, and as they retire there's no one to take their place," he says. "We have a severe shortage of dentists to begin with, and we're one of the few states that doesn't have a dental school."

To combat this shortage, Harrison and NMHR work with the pre-dental society at the University of New Mexico to prepare students for admission to dental schools as well as for dental hygiene work.

On average, 10 New Mexican students per year graduate from dental programs across the country. Many of these students are eligible for loan repayments due to poverty, as well as through the National Health Service Corps and the Western Interstate on Higher Education, which offers funding for students living in states where health professional training programs aren't available. Ten more students graduate each year without state supplemental financing.

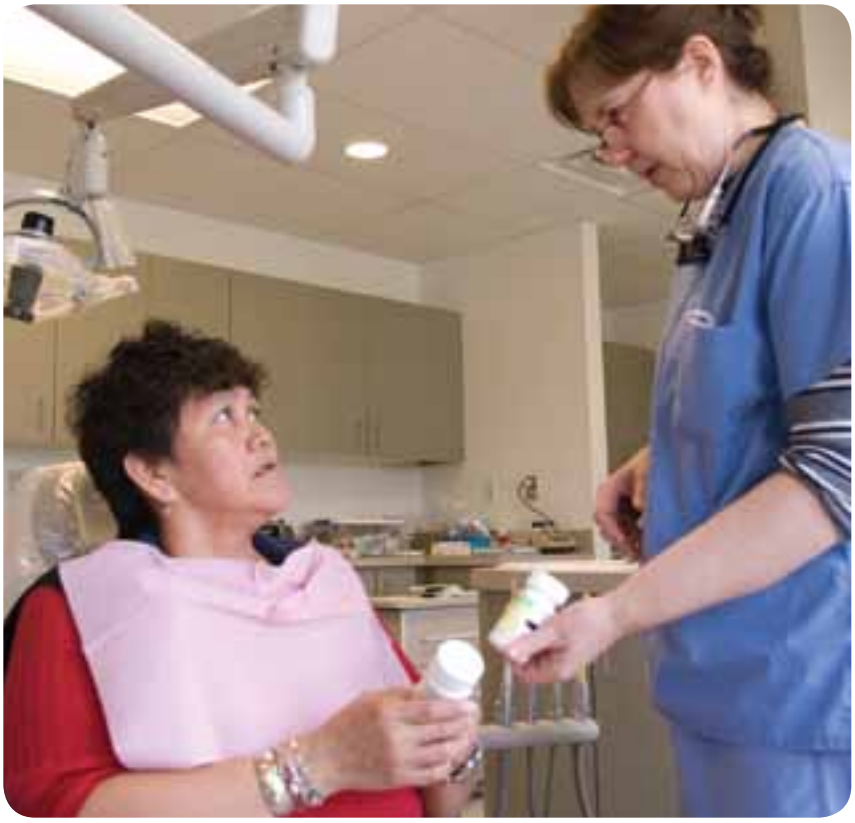
And because the students have rural community connections, 95 percent of them return home to practice after graduation.

"It's very different than moving someone in from urban Albuquerque and having them go to work in a town of 2,500," Harrison explains.

Going forward, he says the dental health aide therapist model currently utilized in Alaska could have "tremendous potential" in expanding care.

"One of my dreams would be that dental education programs would integrate training programs for mid-level providers the way medical schools have implemented nurse practitioner, physician assistant and clinical nurse specialist training," he says. "I'd like to see dental schools integrate training for mid-levels along with dentists and hygienists, or community colleges affiliated with dental institutions."

continued



Dental therapists serve many communities that haven't had a regular oral health care provider in decades.

practice there. They're invested in the community in ways others are not."

For the last two years, the Kellogg Foundation has been evaluating the effectiveness of the DHAT program in five communities in Alaska, the only state where dental therapists are legally allowed to practice other than Minnesota as of May 2009. So far, the results of the study have been positive and encouraging.

"The major findings were that the program in Alaska has shown that the therapists are providing safe, competent and appropriate care," says Kathy Reincke, Kellogg Foundation communications manager. "And the patients are highly satisfied with that care."

One of the factors contributing to patient satisfaction is the extensive training dental therapists receive, plus their daily communication with their supervising dentist. Before they even begin training, candidates must complete a two-part interview – first with their tribal health organization, then with ANTHC partners at the University of Washington. Once candidates have been selected, they complete two years of intensive, hands-on training, with the first year in Anchorage and the second year at the Yuut Elitnaurviat People's Learning Center in Bethel.

After this training is finished, candidates complete a six-month preceptorship with a supervising dentist before they receive certification and can begin practicing in their communities. Even after they return home to work solo, they are in daily contact with their supervisor via phone, e-mail and telehealth technology, including digital imaging and X-rays.

"Dental therapists are part of a dentist-led team," Reincke explains. "They are not independent practitioners. They have a limited scope of practice, and they are in contact with their supervisor multiple times a day. The therapists know their scope and don't exceed it."

The lower 48

While Alaska's DHAT program has made strides toward solving the oral health care crisis in the nation's largest state, many low-income rural populations in the lower 48 states are still suffering with unaddressed dental disease. Nearly 50 million Americans live in the 4,000 federally designated dental shortage areas, 60 percent of which are rural.

According to Warner, the consequences of neglecting dental health issues can be severe and long-term, especially for children.

"Oral health is essential to good physical and emotional well-being," she says. "A lot of kids are living in pain. When people are denied that care for a lifetime, it affects a significant aspect of every part of human development."

> "You'll hear we don't have a shortage; we have a distribution problem. But regardless, in too many rural communities there are no dentists or not enough."
> David Jordan, Community Catalyst Dental Access Project director

But with many rural areas facing recruitment and retention issues similar to those in Alaska, their ability to bring dental providers to their communities is limited.

To address this challenge, the Kellogg Foundation has partnered with Community Catalyst, a national nonprofit working to expand health care access, to explore whether the DHAT model is a viable option to

expand care in five states with some of the greatest disparities: Kansas, New Mexico, Ohio, Vermont and Washington. By 2014, the Kellogg Foundation will have invested more than $16 million to increase access to oral health care.

In its partnering role, Community Catalyst is spearheading community-led efforts to establish coalitions to educate lawmakers and the public on the roles of dental therapists.

"We need over 10,000 new providers to meet the needs of our current system," says David Jordan, Community Catalyst Dental Access Project director. "Dental therapists enter communities that may not have had a provider in over a decade. You'll hear we don't have a shortage; we have a distribution problem. But regardless, in too many rural communities there are no dentists or not enough."

One of the state-level organizations working with Community Catalyst is Health Action New Mexico (HANM), a nonprofit bringing affordable health care to New Mexicans since 1995. In New Mexico, 69 percent of dentists practice in urban areas, but the majority of the two million people living in the nation's fifth

continues

Care for kids

In low-income populations, oral health care tends to be low on the list of a family's priorities.

"We see so many families without heat, transportation or phones," says Robert Howard, dental hygienist and owner of Grinovations, a mobile dental clinic providing care to students across the state of Washington. "It's a low priority, and maybe rightly so."

But under the SSB 6020 legislation, which passed in 2001, dental hygienists are legally allowed to practice in schools. This has allowed Howard to overcome financial barriers by taking his clinic on wheels, which is owned and operated by hygienists, directly to kids regardless of their ability to pay.

"When services are provided in schools, the number of children who receive services increases dramatically," he says.

Howard has been operating Grinovations since 2005, when he purchased the RV-turned-clinic from founder Kerry Warden. On his first day, he realized providing care in impoverished rural communities was vastly different from what he experienced on an average day in a dentist's office.

"Every once in a while in the dentist's office we'd have a kid with rampant decay who would be the talk of the break room," he says. "But that would be every couple of months. In these schools, 60 to 70 percent of these kids would put tears in your eyes. After my first day, I pulled over on the way home and cried. My passion had been sparked."

In 2009, Grinovations staff took their two RVs, which are fully outfitted with exam rooms, to 85 schools across the state and provided need-based care to nearly 10,000 children. Of these children, approximately 27 percent were uninsured. Stamped on these fee-for-service bills are the words "please pay what you can." Many patients who still cannot afford to pay show their gratitude in other ways.

Grinovations staff brings care to kids at Washington schools with two mobile dental clinics.

"One day a little grandmother knocked on the door of the RV, and she handed me a bag of tamales," Howard recalls. "Another little kid ran up to me in Wal-Mart and hugged my leg. His parents didn't speak much English, but they were very humble, thankful folks. "

Grinovations sees many of the same children every year, some of whom they've been treating since kindergarten who are now entering high school with perfect teeth. But Howard still sees a significant portion of the referrals he makes each year go unfulfilled.

"We do what we can to get every child hooked up with a family dentist, but in the population we deal with, oftentimes it just doesn't happen," he says.

To extend the scope of services available, Howard says adding a dental therapist to their team could "eliminate a tremendous amount of pain and suffering."

"Of 3,000 referrals last year, 70 to 80 percent could have been addressed by a dental therapist," he explains. "For low-income folks, these issues usually end up being addressed in the emergency room. Addressing these problems preventatively could save potentially millions of tax dollars."

continued

The 2010 class of dental therapy students (with graduates wearing white lab coats) at the Alaska Native Tribal Health Consortium in Anchorage.

largest state are poor and rural.

According to Pamela Blackwell, HANM project director for oral health access, this has created a crisis-level epidemic of dental disparities and disease. In October, she witnessed the dire need for care firsthand in Albuquerque, N.M., when she volunteered at the Mission of Mercy mobile dental clinic, which has brought oral health care to underserved and uninsured residents in some of the nation's poorest communities since 1994.

"There were over 2,000 people from all over the state who camped outside for days to get care," she says. "You would ask them, 'Are you in pain?' And so many of them said, 'Only when I eat,' which to most of us means all the time. It was really sad and striking, and they were extremely grateful for the opportunity to be there."

A promising approach

Blackwell is thankful for the many providers who volunteer to make Mission of Mercy clinics happen, but she recognizes that it doesn't provide a 365-day, close-to-home solution the way dental therapists could.

"We're working with communities and talking to them about whether dental therapists would work for them," she says. "We don't want to force it on anyone, and we want to make sure it has support at the community level. The students who would go into the program would be chosen by the community. They would be homegrown, culturally competent providers."

Through HANM's research, Blackwell has discovered that most communities are interested in the DHAT model for both access and career opportunities. And vacant dentists' offices are ready and waiting – there are 42 unused operatories at New Mexico's federally qualified health centers and community health centers. School-based clinics have also been considered as future dental homes further utilizing a central location within the community. Later this year, HANM plans to apply for a $4 million federal grant authorized by the Affordable Care Act to train new providers.

"If we can spend the Affordable Care Act demonstration project funding for training therapists rather than building infrastructures, we would prefer it," Blackwell says. "If possible, we prefer to use resources that are already available."

But before New Mexico – or any other state – can begin implementing the DHAT model, laws would need to change allowing therapists to provide care. According to Warner, the law change is a slow process because it happens state-by-state, not federally. And if the laws change, there are then training, curriculum and reimbursement issues to tackle.

> "When people are denied that care for a lifetime, it affects a significant aspect of every part of human development and well-being."
> Alice Warner, W.K. Kellogg Foundation program director

Warner says educating citizens and lawmakers on the roles of dental therapists is a vital first step toward changing state laws.

"Most of the general public doesn't know about this level of provider," she says. "If you went to the grocery store and started asking around, most people probably wouldn't know about dental therapists."

And that's why Blackwell says spreading the word about the need for accessible, affordable oral health care in rural and remote communities is so necessary.

"A lot of times we don't see [the need], so we forget it's there," she says. "But we're already at a crisis. We'd love for New Mexico to give this promising approach a try."

Community property

Hospital donation helps college train nurses

By Angela Lutz

Even before the Mother Teresa Center for Nursing and Health Education at Benedictine College in Atchison, Kan., opened, many students already felt a connection to its namesake.

One group was planning to spend the summer volunteering with the Missionaries of Charity organization founded by Mother Teresa in Calcutta, India, before the building was named.

Another student was volunteering as a nurse's aide caring for the elderly, and when faced with the task of bathing her patients she began questioning her vocational choice: was she really cut out to be a nurse?

But then she heard stories about the Catholic nun who dedicated her life to caring for the poor, the ill, the injured, the forgotten. When she discovered the new building would be named for her role model, she says she once again became inspired and confident in her decision to become a nurse.

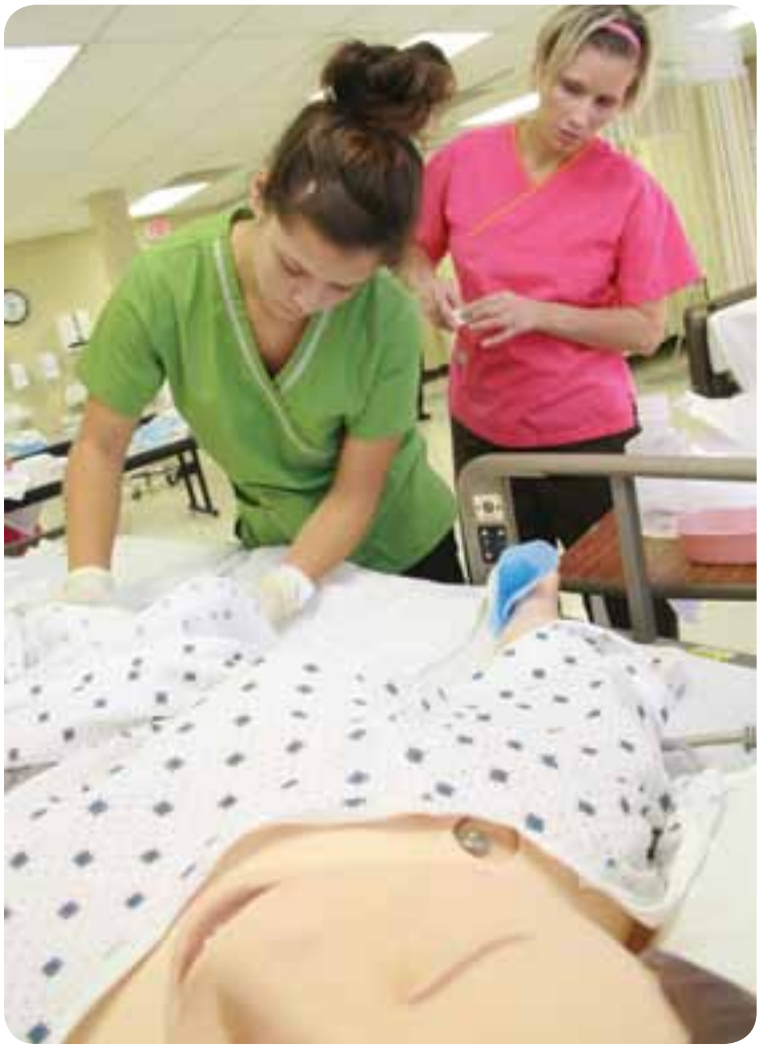
And since the building's dedication on Aug. 26, which would have been Mother Teresa's 100th birthday, students have received daily motivation from one of her most famous quotes, inscribed near the entrance: "Give your hands to serve and your heart to love."

"The students are very excited to be the [nursing school's] inaugural class," says Lynne Connelly, PhD, Benedictine College director of nursing. "The name of the building is very inspiring to them."

continues

Photo: Students, staff and visiting Missionaries of Charity nuns at Benedictine College in Atchison, Kan., celebrate the unveiling and dedication of the new nursing center. The building was donated by Atchison Hospital.

continued



Nursing students practice in the skills lab of the new Mother Teresa Center for Nursing and Health Education at Benedictine College.

Room to grow

Enrollment at Benedictine College, a Catholic liberal arts school with 1,488 students, has grown 85 percent over the last 10 years, according to Stephen D. Minnis, college president. Until recently the school lacked the geographical space to accommodate the growing student body.

"We're landlocked," Minnis explains. "We have a river on one side and neighborhoods on the other."

During his six years as president and 12 years on the board of trustees, Minnis says he dreamt of having a bachelor-level nursing program at the college.

"Many students wanted to go into nursing, but they would have to transfer somewhere else," he says. "We also saw what's going on in America – there's already a nursing shortage, and it's part of our mission to do something about it."

Fortunately, when Atchison Hospital constructed a new facility south of town in early 2010, hospital leaders decided to donate the old facility, which was built in 1912 directly across from the Benedictine campus. Comprising 10 acres of land and valued at $7.8 million, the donation is the largest single gift in the university's 152-year history.

> "We're not just in some little corner trying to eke out a program in a couple of classrooms. It's the perfect size, and we have room to grow."
> Lynne Connelly, PhD, Benedictine College director of nursing

The property will eventually house psychology, sociology/criminology and journalism and mass communication departments, but the donated two-story building, formerly a doctors' office, was able to immediately address the needs of the new nursing program.

"We have a floor of the building, and we got to design it," says Connelly. "We were fortunate that we didn't have to spend much money renovating. We have the space we need, and it's a dedicated space. We're not just in some little corner trying to eke out a program in a couple of classrooms. It's the perfect size, and we have room to grow."

The building is complete with classroom space and a skills lab with six beds donated by Heartland Hospital in nearby St. Joseph, Mo. In addition to Connelly, the nursing program employs one full-time and three part-time faculty members in pediatrics, general medical surgery and pharmacology. There are currently 18 students enrolled. In the fall registration will increase to 25, at which point they also plan to add instructors in intensive care, mental health and community health.

For Connelly, who served 22 years as a nurse in the U.S. Army and previously taught at the University of Texas Health Science Center and the University of Kansas School of Nursing, working at Benedictine has been "exciting but challenging."

"It interested me more and more to start from scratch and leave a legacy," she explains. "In the military you change jobs every three or four years, and I find that

exciting. It makes you stretch."

Shared mission

Donating the space has been beneficial for Atchison Hospital as well, as they now have a new state-of-the-art facility with more centralized services to serve the community of 10,432 people. While the major departments at the old hospital were spread out, now the emergency room, medical surgery, obstetrics and radiology departments are approximate to one another on a single floor, and two offices nearby house the town's specialty physicians.

Also, according to CEO John L. Jacobson, the benefits of having a local nursing program "are nearly self-evident."

"When your local college is able to attract the best and brightest students, it's a win-win for both institutions," he says. "Anytime you have a BSN [bachelor of science in nursing] program adjacent, nearby or even local, it benefits all hospitals in the area."

> "It's really good for the whole community and the communities around us."
> Charlene Clause, Atchison Hospital chief nursing officer

Last semester Benedictine students received fundamentals training at Atchison Hospital, and during the spring semester they will start clinical, obstetrics and medical surgery rotations. They will also be training at other area hospitals, including St. John Hospital in nearby Leavenworth, Kan.

Because students trained in rural areas are more likely to practice in small towns, many area leaders see Benedictine's nursing program as an exciting opportunity to address the rural nursing shortage.

"It's really good for the whole community and the communities around us," says Charlene Clause, Atchison Hospital chief nursing officer. "Many students are from the region, so the likelihood that they will gravitate back to their hometown community hospitals after getting their BSN is very likely."

And in the meantime, students continue following in the footsteps of the woman about whom Minnis says, "You'd be hard-pressed to find a better caregiver."

Lynne Connelly, Benedictine College director of nursing, says she likes the challenge of starting a program from scratch.

"If we can have our students try to emulate Mother Teresa in their care of their future patients, then we've created some pretty great nurses," he says. "She inspires our young people to love their patients and give the best care they can provide, and that's a great service to the profession."

Border health advocates share experiences with conference attendees

By Lindsey V. Corey

Teresa Leal loves an audience.

For her, it's not about ego but necessity.

So the Sonora, Mexico, native and activist jumped at the chance to introduce attendees of the National Rural Health Association's Rural Multiracial and Multicultural Health Conference to the border community of Nogales, Ariz., and a few of its binational programs.

"We're open to anybody. We need it. We demand it. We're not going to stop speaking out or working toward solutions," Leal says. "We don't want pity from outsiders but understanding that we're doing our best not to be victims. It was a bountiful experience to have you [NRHA] come and do that."

About 40 professionals arrived in Tucson before the 16th annual educational conference and watched the desert sunset from a bus headed for the border town of Nogales, population 20,017.

First stop: the Southeast Arizona Area Health Education Center (AHEC), where a staff of seven serve three of the state's four border counties from a metal building just a short walk from the Mariposa border crossing.

"It was a privilege to have NRHA participants visit our center and get a more personal tour of the community as opposed to just arriving at a conference in a big city," says executive director Gail Emerick.

She explained that increased mainstream media coverage in light of Arizona's immigration law (SB1070) has made recruiting health care professionals difficult.

"The media has sensationalized border violence," she says. "Our border communities on the U.S. side are safer than most of the largest cities in the U.S., but coverage has made people skeptical of coming to serve the area, making it a challenge to find providers. If it was a challenge before, it's an even bigger challenge today."

> "Our resources have limits, but that doesn't stop us. It can't."
> Teresa Leal, border health volunteer

So Emerick looks for those who like a challenge to serve the area's close-knit Hispanic and Native American populations.

"We're a great place for health care providers interested in unique cultures," she says. "Some factors that provide challenges also create a unique service environment. We get dedicated professionals when we do get people to serve here, and that's a wonderful thing."

The area also boasts fiercely determined volunteers like Leal, who gathered other health care volunteers from both sides of the U.S.-Mexico border to share their stories and a traditional meal at the Pimeria Alta Historical Society, the former fire station in downtown Nogales where she works two days a week as curator.

NRHA on the border

NRHA's Border Health Initiative began in 2008.

The group includes experts from state offices of rural health, state rural health associations, the U.S. Border Health Commissioners from each state and federal partners including the Office of Rural Health Policy, the Office of Global Health Affairs, the Pan-American Health Organization and other interested stakeholders. Members who developed NRHA's first official policy brief on border health issues meet face-to-face annually in one of the border states and participate in quarterly calls.

The next Border Health Initiative meeting will be in San Diego in August. There will also be a plenary session highlighting border health issues during NRHA's 34th Annual Rural Health Conference May 3-6 in Austin, Texas.

Leal founded Comadres (co-mothers), a group of Mexican and American women, in 1986. Today, three generations of women volunteer to educate, support and protect their peers as part of Comadres. The project has provided information on public health topics from tuberculosis and water contamination through one-on-one or informal and sometimes secret gatherings in homes on both sides of the fence. The Comadres network also includes safe houses for child abuse and domestic violence victims.

"We listen to the communities, and the communities listen to us," Leal says. "We go to them and talk about TB because it's stigmatized, and we go to squatter communities and try to help with the isolation that a battered woman feels. Our resources have limits, but that doesn't stop us. It can't. It's a very personal and dynamic way of doing things, a way of life, not just a project."

She also founded Manos de Mujer (women's hands) to help Mexican and tribal women create and sell traditional products from paper flowers to tamales. The unemployed or underemployed women prepared the meal for the NRHA gathering and took home what was left.

Attendees enjoyed a buffet of corn and flour tortillas, rice, beans, cactus, beef and sweet bread while community members presented on a local ranch offering equine therapy to autistic children, a free clinic for disabled children, a women's shelter, food safety and peer health education.

"The challenges are big here, but we are a good lab for new ideas, research and programs that could be tried in underserved communities," she told attendees. "All these voices, even though they don't have the funding or resources, they keep going to try to address issues that affect them. I'm glad NRHA came here to expand our effort to look at and think about these issues in different ways."

Local Kiwanis president Pete Wise told attendees that teenagers the organization helped in the past are choosing to volunteer today.

"A little act of kindness you give to a child now can change the world," he says. "What's being done here, it's amazing."

Donations can be sent to Teresa Leal, 441 North Grand Ave. Suite 7, Nogales, AZ 85621.

By the numbers

The U.S.-Mexico border extends for **1,952** miles. It includes **44** U.S. counties, the majority of which are rural. Three of the **10** poorest American counties are on the border. **Twenty-one** of the U.S. counties on the border have been designated as economically distressed areas, including **1,200** colonias in Texas and New Mexico.

Coming together

150 professionals and students attended NRHA's 16th annual Rural Multiracial and Multicultural Health Conference in Tucson, Ariz.

Plan now to participate in the 2011 event Dec. 7-9 in Daytona Beach, Fla.

Thank you

NRHA would like to thank the following people for their donations to the 2010 Annual Giving Campaign and their continued support of rural health.

Graham Adams
Tommy Barnhart
Larry Bedell
Gail Bellamy
Dennis Berens
Gabriela Boscan
James Boulger
Becky Conditt
Lindsey Corey
Maggie Elehwany
Amy Elizondo
Danny Fernandez
Michael French
Jonathan Garvin
Scot Graff
Susan Green
Sharon Hutinett
Lance Keilers
Lisa Kilawee
Beth Landon
Angela Lutz
Rosemary McKenzie
Robert McVay
Michael Meit
Carol Miller
Alan Morgan
Gail Nickerson
Debra Phillips
Geno Poarch
Sandra Pope
Rita Salain
Jodi Schmidt
Kathy Siress
Tim Size
Brock Slabach
Kris Sparks
Dustin Summers
James Tyler

NRHA is proud that 100 percent of staff believe in our mission and donated.

Hospital delivery comes full circle for rural med student

By Lindsey V. Corey

Dave Staub and Carl Rasmussen

Twenty-six years after Dave Staub delivered Carl Rasmussen, they met again in the hospital room.

This time it was a four-week rotation.

A second-year med student at the University of South Dakota (USD), Rasmussen went home to Sisseton, S.D., population 2,454, to complete his sophomore rural preceptorship under the direction of Staub, MD, and partners at Coteau de Prairies Hospital and Clinic.

> "You need to have the student understand that they may not know everything, but nobody in medicine ever does."
> Dave Staub, MD

It was his first rotation and chance to see how classroom and lab work translated to patient care.

"I'd been stuck in a classroom, so I was really looking forward to being in a working environment on a daily basis and getting the rhythm and feel of that in my head and to finally start to apply some of the knowledge and to form a more applicable framework to all that book knowledge we'd been tediously working through," Rasmussen says. "It's safe to say it exceeded my expectations."

Day one at Coteau de Prairies, he found himself scrubbing in on a C-section.

"I'd maybe observed a handful of surgeries from a distance, and here I am assisting on my first day," he recalls. "It was kind of a whirlwind. I remember being surprised when all of a sudden they are removing an infant from the uterus. It's like I forgot what we were in there for. My head was taking in all the anatomy and focusing on what I had to do, and then holy smokes, there's a brand new baby."

Rasmussen also spent time in the emergency room and clinic. The closest large hospital is an hour and a half away in Fargo, N.D.

"I feel like I was exposed to the whole gamut of primary care medicine and the way providers have to work with limited resources, and I think that's an important building block," he says. "If you don't have the foundation, I don't think you're going to put together as accurate of a broader picture of how it all fits together."

Staub, USD clinical associate professor of medicine, has been practicing in Sisseton for 34 years and taught about 30 medical students. He says he values the active learning colleagues at his rural hospital and clinic provide.

"You need to have the student understand that they may not know everything, but nobody in medicine ever does," he says. "I have all my students see patients,

and I may not be in the room all the time. They need to get over the fear of meeting somebody, and pretty soon they are comfortable with the process and gain confidence in the human, eye-to-eye humanity part of medicine. Learning isn't watching; it's doing, and Carl is self-motivated, so it didn't take long for him to jump in and do exams."

At first Rasmussen hesitated taking the opportunity to complete his rural rotation in his hometown, but he knew he'd get to work with members of the nearby Sisseton-Wahpeton Oyate tribe, and after being away for eight years, he didn't know many of the Coteau de Prairies patients.

In addition to being able to "enjoy Mom's home cooking," Rasmussen says he appreciated Staub's approach to training.

"That mentoring style is a refreshing way to learn medicine," he says. "You can tell when a doctor enjoys it and when they feel burdened by it, so you definitely value someone like Dr. Staub, who devotes so much time and energy to get you involved in learning."

Rasmussen sought out Staub, his then primary care physician, during his undergraduate education for advice on pursuing a medical career.

"I asked him if he could still recognize the reasons he went into medicine," Rasmussen remembers. "He assured me that he definitely could on a daily basis."

Rasmussen says he could see himself practicing in a small town after his residency.

"I'm trying to remain open-minded so I experience the full scope of each rotation, but at the same time, I definitely feel most strongly drawn to primary care and feel like family medicine would be a good fit for me," Rasmussen says. "I like that you're working with patients of any age and seeing them at the frontlines of care. I also like that it's needed, especially right now."

Grant impact

Rural outreach programs under review

By Angela Lutz

In migrant communities along the U.S.-Mexico border, the first key in reaching out to residents to provide health care and education is earning their trust.

Migrant Health Promotion has been bringing health education and outreach to migrant farm workers in southern Hidalgo County, Texas, for nearly 30 years. One of the first lessons CEO Gayle Lawn-Day learned while working toward this mission is the important role of promotoras de salud, or community health promoters.

"It's all about trust," Lawn-Day explains. "They need someone who has a similar cultural and language background and accessibility within the community. That's the real core of being a promotora."

Coming from the neighborhoods they serve, promotoras aren't required to have a medical background, but they do receive monthly training and certification from their home state. Then they are able to provide leadership, peer education and resources to support community empowerment and remove the cultural barrier to care.

Removing this barrier is especially important in many of the high-poverty colonias, or unincorporated neighborhoods, Migrant Health Promotion serves, where most residents are uninsured and either don't have access to health care or don't follow up on diagnoses due to financial barriers. Transportation is also an issue, as many colonias lack roads and basic services such as water, grocery stores and trash pickup.

"Also, due to recent immigration debates there's a lot of fear generated, and the angst surrounding the issue has created a lot of problems," Lawn-Day adds. "People are afraid to access care."

In border towns where residents have grown more wary of outsiders, promotoras from within the communities who can provide culturally competent care are becoming increasingly valuable.

"[Migrant populations] are not wild about strangers," Lawn-Day says. "But they trust us. We don't have a problem finding leaders, either, because they want to serve their communities and be healthy but need the tools to do so."

In order to provide the necessary tools and resources and educate migrant populations on mental health, chronic illness, and diet and exercise, Migrant Health Promotion has created the Futuros Saludables, or healthy futures, project by utilizing grant funding from the Office of Rural Health Policy's (ORHP) 330A Outreach Authority, which was created as part of the Public Health Services Act of 1991. Futuros Saludables received a three-year grant: $150,000 for the first year, $125,000 for the second and $100,000 for the third.

According to Nisha Patel, ORHP community-based division director, each year ORHP funds approximately 300 grantees out of 330A dedicated to identifying and addressing health disparities in rural communities. Since 1996, the program has distributed approximately$475 million.

> "There's been a growing recognition that we can't continue to fund programs without determining if they work and how we can make them work better."
> Michael Meit, National Opinion Research Center Walsh Center for Rural Health Analysis co-director

"The most successful grant programs have community buy-in from key stakeholders and leaders," Patel explains. "They are collaborating with community organizations to solicit resources, having a clear vision and understanding community needs, and developing a plan around that need to address it."

In order to determine the grantees' impact and sustainability, ORHP arranged a four-year contract with the National Opinion Research Center (NORC) Walsh Center for Rural Health Analysis and the University of Minnesota Rural Health Research Center to evaluate 330A programs and

identify common themes among successful grantees.

"This is an innovative initiative," says Michael Meit, Walsh Center co-director. "There's been a growing recognition that we can't continue to fund programs without determining if they work and how we can make them work better."

Currently in the second year of the evaluation process, Meit says the results and data gathered have been promising.

"We've been interviewing grantees, and a lot of these programs are sustained after the grant funding ends," he says. "The grant funding truly is seed-funding to get these networks up and running. Of the 72 programs we've contacted, 80 percent are still up and running. It's a remarkable example of the programs' impact, and it speaks to the value of partnering and developing networks."

> "The ultimate goal of this evaluation is to develop a gateway of information... rural communities don't have to reinvent the wheel."
> Nisha Patel, ORHP community-based division director

In addition to determining the programs' sustainability, evaluators are also working to develop resources for rural communities around the country hoping to start similar programs.

"We are identifying common themes among grantees and showing their impact," Patel says. "The ultimate goal of this evaluation is to develop a gateway of information including evidence-based models and best practices so other rural communities don't have to reinvent the wheel."

For example, once the evaluations are complete, communities wanting to expand health care knowledge and services in a culturally competent manner will be able to access successful models such as Migrant Health Promotion's Futuros Saludables program on the Rural Assistance Center web site.

According to Lawn-Day, since they began their efforts more colonia residents are accessing health care services, and they have developed strategies to deal with stress and depression, including diet and exercise initiatives. This increase in utilization has largely been achieved through the efforts of promotoras, which is why Lawn-Day says she believes the program will have longevity.

Also contributing to the program's sustainability is the number of organizations with which Migrant Health Promotion has partnered, which has allowed them to open offices serving isolated, underserved and minority populations in five states.

"We have established community leaders, and the community resources will remain in place," she says. "Even after the grant is done, these people will still be there and will have learned what they need to know to provide services."

Overview of Office of Rural Health Policy 330A grants

- Created as part of the Public Health Service Act of **1991**
- More than **$475** million has been awarded since 1996.
- Nearly **300** grantees each year seek to expand rural health care access, coordinate resources and improve rural health care service quality.
- **Five** grant programs operate under the authority of section 330A:
  - Rural Health Care Services Outreach
  - Network Development Planning Rural Health
  - Network Development Small Health Care Provider Quality Improvement
  - Delta States Rural Development Network

Beginnings & Passages

Texas' largest medical center looks out for small towns

By Brian Petter

Brian Petter and family

Though I grew up in Houston, I was always intrigued by the landscape changes as we left southeast Texas on family vacations as a child. I enjoyed the peace that came with the open spaces and nature. But I don't think I really recognized the draw to the rural parts of the state until I left for college and got to visit.

After undergrad, I headed back to Houston to begin working in the world's largest medical center, and I really enjoyed my time there. But graduate school took me back to College Station, and I was fortunate to study at the School of Rural Public Health. I spent my practicum commuting between two critical access hospitals in Brazos Valley. My graduate school focus on state disparities and experience in small town hospitals solidified my desire to serve in rural communities.

After more than 10 years in College Station, I was fortunate to get the opportunity to serve 26 county service areas just outside San Antonio. It has been incredible to work for the largest health care provider in South Texas and to look out for the interests of patients from surrounding areas. Methodist Healthcare System of San Antonio considers it a privilege to serve the region and is forward-thinking enough to ensure we are able to assist facilities that cannot serve their populations in subspecialty areas of medicine.

We not only serve the rural areas of the south hill country, but we are also fortunate to assist with challenges along the Texas-Mexico border. In my role, I am able to partner with administrative teams of large border hospitals or critical access hospitals in towns of less than 3,000. Most months, I log well over 1,000 miles visiting communities and hospitals, and what I find most amazing is the communities may look different, but similar issues remain, and the lack of access to care is common across our huge state.

Communities may look different, but similar issues remain.

One of the most rewarding things I have been a part of was the heart alert program we created with other communities, in which we can auto-launch a helicopter to a patient with a poor EKG reading in hopes of getting the patient help in less than two hours.

Care like this is not available in our region without the collaboration of both our large system and rural hospitals in conjunction with our medical staffs and their concern for the underserved in rural Texas.

Brian Petter is vice president of rural services at Methodist Healthcare System in San Antonio, Texas. He joined NRHA in 2010 and is a 2011 Rural Health Fellow.

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

Innovative rookies and seasoned professionals share their experiences.

The "turf" of rural health is truly nonpartisan.

Keith Mueller

Seeking creative solutions to rural challenges

By Keith Mueller

I look back on more than 20 years of rural health policy analysis and research and think, "Wow, what a special treat."

I have been blessed to help strengthen the hand of rural health advocates in national and state policy development and to have worked with dedicated colleagues on behalf of people who enjoy the rural lifestyle and opportunities it provides. What a dreamland for a political scientist whose aspiration is to help people reach their full potential, especially those who need a policy intervention to overcome disadvantages not of their own making.

Ironically, I started my academic career in urban politics, influenced by working for Henry Meier, the longest-serving big-city mayor of his generation, in Milwaukee, Wis. My interest was in helping the economically disadvantaged populations of the nation's inner cities.

After moving to Nebraska and marrying into a ranching family, I gained a deep appreciation for the attraction of rural life and the challenges in providing health care services in remote locations. (An asthma attack on a ranch in the middle of winter influenced my thinking.)

I've participated in the policy process by providing the best research available to answer specific policy questions as a researcher, a research interpreter or a policy advocate. The "turf" of rural health is truly nonpartisan, an arena wherein analysis makes a difference. I've experienced the excitement of helping advance policy discussions during debates about the 1993 reform proposals, the 1997 and subsequent balanced budget bills, the Medicare Modernization Act of 2003 and the Accountable Care Act of 2010.

Creative solutions are required to address the constant challenge of sustaining high-quality local health care services despite the disadvantages of sparsely populated, often low-income rural places. We are entering an era of dramatic change in the way we organize, finance and deliver health care services.

What a time of opportunity for those of us who believe we can do better and secure a better future for people living, working and playing in rural places.

Keith Mueller, PhD, is professor and chair at the University of Nebraska Medical Center Department of Health Services Research and Administration. He has been a member of NRHA since 1996 and was NRHA's 2010 Volunteer of the Year.

Support those who support you.

NRHA partners were chosen for their commitment to improving rural health care.

PLATINUM PARTNERS

The Joint Commission
HELPING HEALTH CARE ORGANIZATIONS HELP PATIENTS

PHILIPS

"Our Corporate Partners are a valuable source of knowledge that our members can use to add to our knowledge center."
– Dennis Berens, 2010 NRHA president

"Rural health care will improve through a strong partnership between our members and our Corporate Partners."
– Alan Morgan, NRHA CEO

"Corporate Partners understand that one size does not fit all, and one product does not fit all sizes. Their products are designed and customized to meet the needs of NRHA members."
– Beth Landon, 2009 NRHA president

NRHA Corporate Partners

Our Corporate Partners are building relationships with National Rural Health Association members. They have a proven track record in quality and reliability of products and services meeting the needs of rural health care providers.

To ensure successful relationships, the NRHA Services Corporation Advisory Panel reviews and recommends candidates for the Corporate Partners program and ensures all of our Corporate Partners understand the unique challenges facing rural hospitals, clinics and health care providers.

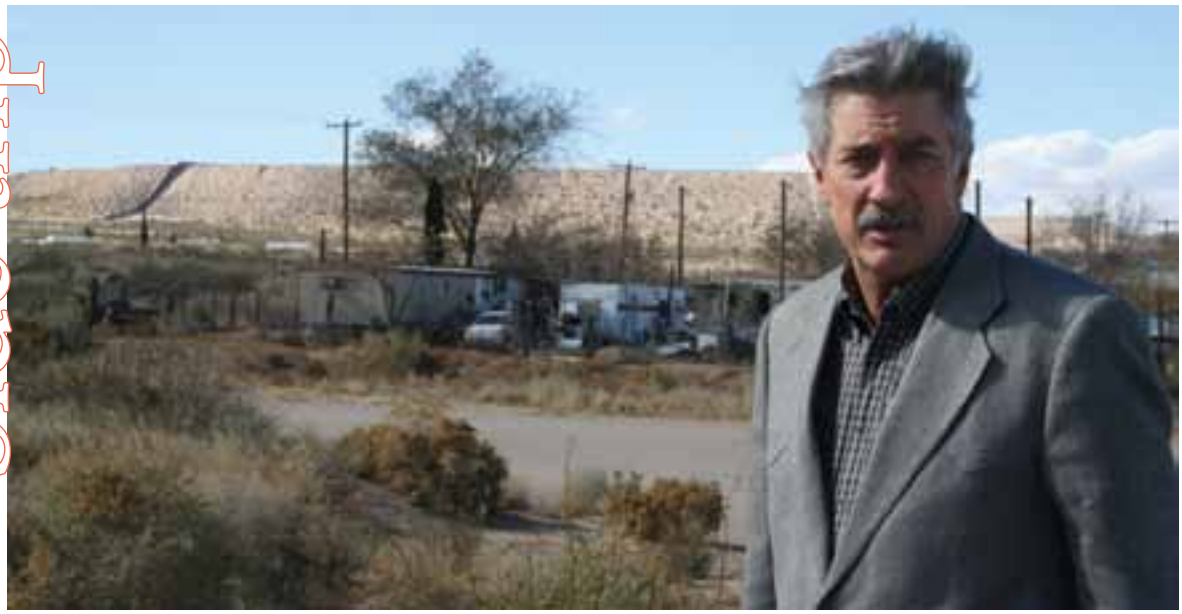
GOLD PARTNERS

ACI BOLAND
Alere
AHIPS
Amerinet
aris
CERNER All Together
Colonial Life Making benefits count.
THE COMPLIANCE TEAM, INC
CPSI
EideBailly
Healthland
HMS
HTSG HealthTech Solutions Group
KINGS HEALTHCARE FINANCE
NEXTGEN HEALTHCARE
Prairie Dog | TCG
QSR Quick Study Radiology
QHR | QUORUM HEALTH RESOURCES
RSM McGladrey Accounting | Tax | Business Consulting
SIEMENS
SIGHTPATH MEDICAL
Swank HealthCare
TimeLine
Together Rx Access
VIRTUAL RADIOLOGIC
WGA

SILVER PARTNERS

501(c) AGENCIES TRUST
AmCare GROUP, LLC
Diamond HEALTHCARE CORPORATION
FirstChoice COOPERATIVE
HFP HealthFacility Partners
impact! communications, inc. www.doitwithimpact.com
netorange
PHOENIX HEALTH SYSTEMS
SOLVERAS PAYMENT SOLUTIONS
SOMA TECHNOLOGY, INC.
Wellness Environments

Side trip



Paul Dulin visits colonia communities near Sunland Park, N.M. In the background, the wall dividing the U.S.-Mexico border can be seen snaking up the hill.

5 questions: Get to know Paul Dulin, New Mexico Department of Health Office of Border Health director

1. **What inspired you to choose a rural career?**

   What really drew me into working professionally in rural areas was my service as a Peace Corps volunteer in Honduras from 1977 to '79. I worked with landless hillside farmers promoting soil and water conservation strategies, tree planting and forest protection, and improved nutrition among the poorest segments of the Honduran population, with Honduras being the poorest of the Central American countries at the time.

2. **What is one of the greatest challenges to providing health care to border populations?**

   In New Mexico, approximately 20 percent of the U.S. border region population is exclusively Spanish-speaking or has minimal proficiency in English. We still have not figured out the best way to transmit health literacy through mass media. Only a small percentage of health care professionals in New Mexico are bilingual, and a similarly low percentage of professionals have the cultural competence to communicate with clients of Mexican heritage.

3. **Where have you made the greatest progress in expanding care to border populations?**

   In the last four years, the Office of Border Health has been able to establish a collegial working relationship with Chihuahua State Health Services in both the Juarez and Nuevo Casas Grandes health jurisdictions and have shared bi-national strategic plans to develop programming.

   Beginning in 2007, the New Mexico Department of Health and Chihuahua State Health Services partnered with the Texas Department of State Health Services to develop the Border Influenza Surveillance Network, with 17 sentinel surveillance sites that report influenza-like illness on a weekly basis. This network was in place during the H1N1 outbreak and facilitated a timely and effective response in dealing with the emerging pandemic.

4. **What's your favorite dish to prepare when it's cold outside?**

   Every December, just before the new year, I prepare about 20 liters of the seasonal Mexican dish posole, based on my recipe of browned pork loin, onions, garlic, green peppers, red chili puree, Mexican oregano and cumin, and three gallons of posole (giant white hominy). Then we invite about 20 people over to feast.

5. **What should everyone know about border health?**

   The U.S.-Mexico border region is unique. While recent violence and the economic downturn have reversed trends in increasing migration and constant trans-border movement (800,000 to 1 million people each day), the border region has long been and still is the locus of the highest concentration of Hispanics in the States. As migration has swelled the numbers and distribution of immigrants nationwide, present and future lessons learned in the border region are now becoming applicable in immigrant enclave communities throughout the country.

Paul Dulin has been a member of NRHA since 2010. He serves on NRHA's Border Health Initiative.

We're in this TOGETHER!

Our card helps people save on the prescription medicines they need to stay healthy.

Our website helps people access information about healthcare resources and more.

NATIONAL RURAL HEALTH ASSOCIATION
NRHA
GOLD LEVEL CORPORATE PARTNER

With Together Rx Access, eligible uninsured Americans gain access to immediate savings on prescription products right at their neighborhood pharmacies AND resources that help people take care of what's most important...their health.

Together Rx Access®
Prescription Savings Program
00000 0000
MEMBER NAME

Nearly 90% of uninsured Americans are eligible for the Together Rx Access Card.

Visit *TogetherRxAccess.com to learn more and to order your supply of brochures and quick start savings cards.*

Brought to you by:

Abbott
A Promise for Life

Bristol-Myers Squibb Company

gsk GlaxoSmithKline

Janssen
Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc.

King Pharmaceuticals

LIFESCAN
a Johnson & Johnson company

McNEIL PEDIATRICS™
DIVISION OF ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC.

ORTHO DERMATOLOGICS™

ORTHO-McNEIL
Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc.

ORTHO-McNEIL NEUROLOGICS
Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc.

ORTHO WOMEN'S HEALTH & UROLOGY™
DIVISION OF ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC.

Pfizer

PriCara
Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc.

Stiefel
a GSK company

Takeda

tibotec
THERAPEUTICS

VISTAKON PHARMACEUTICALS, LLC

ViiV Healthcare

Each cardholder's savings depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased.

Participating companies independently set the level of savings offered and the products included in the Program. Those decisions are subject to change.

Members on the move

Introducing NRHA's new leadership

NRHA is a member-driven organization, so our volunteer leadership is critical to the success of the association. We are proud to announce the following individuals were elected by their peers to serve in leadership roles in 2011.

President-elect

Lance Keilers

Treasurer

Sandra Durick

Constituency group chairs

Clinical
Ray Christensen, Minnesota Rural Health Association

Community-operated Practices
Scot Graff, Community Healthcare Association of the Dakotas

Diverse Underserved Populations
Alice Kirk, Texas A&M University

Frontier
Charlie Alfero, Hidalgo Medical Services

Rural Health Clinics
Gail Nickerson, Adventist Health

Congress constituency group representatives

Hospital and Community Health Systems
John Everett
Tom Henton
David Pearson
Tim Putnam
Ryan White
John Worden

Rural Health Clinics
Richard Garza
Deborah Holzmark

Research and Education
Kevin Bennett
Kathleen Spencer

Statewide Health Resources
Jerry Coopey
Brad Gibbens
Janice Wilkins

Student
Michael Small

NRHA announces new class of Rural Health Fellows

2011 NRHA Rural Health Fellows meet during NRHA's Rural Health Policy Institute in Washington, D.C.

After the completion of a competitive review process, 12 fellows were selected to participate in NRHA's year-long, intensive program aimed at developing leaders who can articulate a clear and compelling vision for rural America.

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

The 2011 Rural Health Fellows are:

Sally Buck, associate director, National Rural Health Resource Center, Duluth, Minn.

Elizabeth Burrows, CEO, Vermillion-Parke Community Health Center, Clinton, Ind.

Danielle Hamann, public policy associate, Avera Health, Sioux Falls, S.D.

Deborah Herzberg, CEO, Davis County Hospital, Bloomfield, Iowa

Bren Lowe, CEO, Pioneer Medical Center, Big Timber, Mont.

Brian Petter, vice president for rural services, Methodist Healthcare System, San Antonio, Texas

Mary Ellen Pratt, CEO, St. James Parish Hospital, Lutcher, La.

Tim Putnam, CEO, Margaret Mary Community Hospital, Batesville, Ind.

Michelle Reisinger, nurse practitioner, Community Healthcare Systems, Onaga, Kan.

Nicole Rouhana, clinical assistant professor, Stony Brook University, Stony Brook, N.Y.

David Schmitz, associate director, Family Medicine Residency of Idaho Inc., Boise, Idaho

Ryung Suh, president and CEO, Atlas Research, Washington, D.C.

News briefs

ONC listens to NRHA member concerns

Key members of the Department of Health and Human Services Office of the National Coordinator (ONC) for Health Information Technology (HIT) joined NRHA's Rural HIT Task Force's second annual meeting in the fall in Arlington, Va.

"They were specifically interested in hearing from our members serving on the frontlines of rural health," says NRHA CEO Alan Morgan. "It was a wonderful opportunity for rural HIT stakeholders to speak with ONC senior leadership about what they need to be successful."

NRHA also presented the results of its nationwide critical access hospital survey on meaningful use readiness, which demonstrated to ONC staff that only about 30 percent of rural hospitals would presently qualify for meaningful use incentives.

ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use advanced HIT and the electronic exchange of health information.

"It was important for them to hear innovative rural telemedicine success stories as well as our concerns and the daily challenges rural health providers face," Morgan says. "They spent quite awhile discussing the issues and really valued our members' perspectives. We're grateful for ONC's time and efforts and look forward to continuing this partnership."

Other highlights of the meeting included the participation of Office of Rural Health Policy-sponsored telehealth resource centers. Representatives from resource centers located in Georgia, California, Idaho and Arkansas provided updates about their achievements and obstacles.

NRHA's Rural HIT Task Force meets once a year and participates in quarterly conference calls. The task force is supported by a grant from the Helmsley Charitable Trust.

Policy meeting focuses on HIT for rural hospitals

NRHA hosted a two-day emerging health policy issue meeting in October with the support of the Helmsley Charitable Trust. Attendees focused on the integration of health information technology (HIT) as a means of support for America's rural critical access hospitals (CAH).

Representatives hailed from the Office of Rural Health Policy, the Office of the National Coordinator for HIT, Avera Health Systems and other telehealth resource centers and stakeholders.

"The infusion of HIT innovations is of critical importance as hospital administrators and practitioners strive to further improve the quality and availability of services in rural health care facilities," NRHA CEO Alan Morgan says.

Given the integral role CAHs play in rural communities, the meeting's discussion centered upon ways to ensure the highest level of patient safety and quality care are available in these facilities through the utilization of HIT.

Throughout the Arlington, Va., meeting, participants provided NRHA with direction as the association continues to advocate on the behalf of CAH sustainability.

Send your career updates to editor@NRHArural.org.

accelerating advocacy

Contact Congress to save rural health programs

In what amounted to the largest political shift in the U.S. House of Representatives since 1948, Republicans gained 63 seats and control of the House agenda. Democrats maintained control of the Senate but did lose their 60-vote, filibuster-breaking super majority. So with Congress no longer under a single party's control, both sides will have to play nice.

In their new role, House Republicans will focus heavily on reducing the federal deficit, an overall noble cause, but this means certain programs receiving federal funding could be fighting to survive. Fortunately, a number of current federally funded rural health programs enjoy bipartisan support, but without hearing from people in their home states, your congressional representatives will not know how truly important these programs are.

It is important that you contact your members of Congress often and urge them to support rural health programs. Visit the appropriations section of the NRHA web site, RuralHealthweb.org, for more information on current federally funded programs that may be at risk.

To find contact information for your members of Congress, go to house.gov/ and enter your zip code.

Can all our departments
convert to the same EHR
without a trip to the ER?

"Of course."

— Tom Stephenson, CEO

At HMS, we work closely with you to make sure your transition process causes as little discomfort as possible, both for you and your patients. From role-based implementation to on-site training, we'll keep your entire hospital happy and healthy throughout the conversion — no matter how many people are involved.

HMS has 26 years of experience and serves more than 680 hospitals. To learn more about how we deliver a smooth EHR transition, and to see how we took the fear out of going live for one hospital, visit **hmstn.com** or call **(800) 383-3317.**

HMS®
Integrated Clinical & Financial Hospital IT Solutions

2011 NRHA Buyers' Guide

Welcome to the National Rural Health Association's 2011 Buyers' Guide.

We hope you'll keep this listing of trusted suppliers and vendors handy throughout the year, as the organizations included are dedicated to making the noble work of rural health professionals like you easier and better.

Corporate Partners, who support NRHA throughout the year, are indicated with the partner seal depicting their level of support. Some offer NRHA member discounts, so please consider their products and services as you make purchasing decisions throughout 2011.

For more information on NRHA's Corporate Partner program, visit NRHAsc.com or contact Larry Bedell at bedell@NRHAsc.com or 913-269-1199.

Platinum Level Corporate Partners

The Joint Commission

Joint Commission Resources offers a full spectrum of resources to help health care professionals provide safe and efficient care through consulting, education, publications and multimedia products.
jcrinc.com

PHILIPS

A global leader in medical devices and diagnostic imaging, including X-ray, ultrasound, MR, CT, nuclear medicine, PET, radiation oncology, patient monitoring, information management, resuscitation and consumables.
philips.com

ADVERTISEMENT

Because we care

ACI/Boland plans and designs hospitals for the same reason you deliver health care: because we care. We welcome helping you with your next hospital renovation or replacement.
aciboland.com

Diagnostic testing solutions

Alere focuses on financial solutions for CAHs by maximizing hospital revenue through rapid diagnostic testing solutions and appropriate patient disposition.
alere.com

The American Board of Physician Specialties

(ABPS) is a multi-specialty physician board certification organization. Our physicians place patients first, focusing on the needs of local communities.
abpsus.org

Health care group purchasing

Strategically partnering with health care providers to reduce costs and improve quality. Amerinet offers a comprehensive and competitive portfolio of product and service contracts.
amerinet-gpo.net

Aris Teleradiology delivers

high quality radiology services to underserved communities, while creating an envi-ronment for radiologists to experience professional excellence.
aristeleradiology.com

Health information technology

Cerner is a global leader in health information technology. Our industry-leading technology allows rural health organizations to improve quality of care while increasing revenue capture.
cerner.com

Employee benefit programs

Colonial Life and Accident is a highly rated national company that specializes in voluntary employee benefit programs designed to enhance every company's employee benefit portfolio.
coloniallife.com

THE COMPLIANCE TEAM, INC

EXEMPLARY PROVIDER™ ACCREDITATION

Accreditation simplified

Exemplary provider accreditation simplified for critical access hospitals and rural health clinics modeled after the Compliance Team's industry-leading, CMS-approved DMEPOS accreditation program.
exemplaryprovider.com

Information system/EMR

CPSI provides a complete and fully integrated health care information system/EMR that includes software, hardware, conversion/implementation services and continuing support.
cpsinet.com

ADVERTISEMENT

RSM McGladrey
Accounting | Tax | Business Consulting

Professional services firm McGladrey is a professional services firm that provides accounting, tax and business consulting services to nearly 3,000 health care organizations throughout the country.
mcgladrey.com

SIEMENS

Siemens Healthcare, bringing innovative medical technologies, health care information systems, management consulting and support services to help customers achieve tangible, sustainable clinical and financial outcomes.
usa.siemens.com

SIGHTPATH MEDICAL

As the leading mobile ophthalmic services provider, Sightpath Medical provides facilities with state-of-the-art technology for cataract and refractive surgery and YAG and SLT procedures.
sightpathmedical.com

Swank HealthCare
Tim Swank, Chairman

Swank HealthCare is a leading distributor of online health care education for hospitals, clinics and medical treatment facilities worldwide.
swankhealth.com

TimeLine RECRUITING

Physician recruiting TimeLine specializes in physician recruiting. As a member of NRHA your facility receives significant savings, extensive recruitment services and an unprecedented guarantee on your investment.
tlrec.com

Together Rx Access
Prescription Savings Program

Free prescription savings Together Rx Access, a free prescription savings program, helps uninsured Americans save on prescription medicines right at their neighborhood pharmacies. Call 1-800-250-2864.
togetherrxaccess.com

VIRTUAL RADIOLOGIC

vRad is a national radiology practice working in partnership to optimize radiology's pivotal role in the delivery of patient care, enabled by vRad's next-generation technology.
virtualrad.com

WGA WILLIAM GALLAGHER ASSOCIATES

William Gallagher Associates is a leading provider of insurance brokerage and risk management services to organizations with complex risks and dynamic needs, specializing in health care-related risks.
wgains.com

501(c) AGENCIES TRUST
Maximizing Savings. Minimizing Risk.

Join over 100 nonprofit health care organizations that reduced unemployment costs and save thousands annually. NRHA contact: Ellen Johnson, ejohnson@501c.com.
501c.com

ADVERTISEMENT

SOLVERAS PAYMENT SOLUTIONS™

Solveras payment solutions is a sales and marketing organization providing complete electronic payment solutions to over 15,000 small businesses, medical practices, wholesalers, distributors and software providers throughout the country. solveras.com

SOMA TECHNOLOGY, INC.™ Worldwide Medical Equipment Sales and Service

Refurbished medical equipment Soma Technology is a leader in the refurbished medical equipment industry capable of outfitting entire health care facilities with quality products at the most affordable prices. somatechnology.com

Wellness Environments

Wellness Environments builds new and renovated clinical spaces for rural health care facilities. wellnessenvironments.net

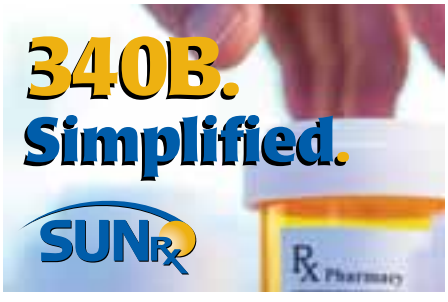
Avreo complete radiology workflow solutions Avreo's web-based solutions encompass robust RIS, PACS, and report production features within a single application/database system. Our innovative approach provides true remote diagnostic reading and transcription so health care professionals can work from any location.
800.844.9926 avreo.com

BKD LLP
CPAs & Advisors

BKD National Health Care Group BKD National Health Care Group provides audit, tax, Medicare, operations and other consulting services to thousands of rural health care providers, including hospitals, long-term care and senior living facilities, FQHCs, RHCs, HHAs, physicians and more.
800.581.4290 bkd.com

patientkeeper

Enabling meaningful use at CAHs Only PatientKeeper offers critical access hospitals clinical and financial applications to streamline physicians' workflow, built with the physician user in mind. And PatientKeeper integrates seamlessly with existing HIS's – no "rip and replace" required.
781.373.6100 patientkeeper.com



Revenue from 340B contract pharmacies Let SUNRx build a compliance-driven 340B contract pharmacy program that captures thousands of dollars in revenue monthly from third party payors. Launch your program today without startup fees, hardware, software or inventory costs.866.958.340B sunrx.com

Tri-Tec Monitors
Catering to the needs of critical access and rural hospitals for over 30 years. We offer reasonable rental and service plans on a complete line of cardiac monitors. Special financing for critical access hospitals.
901.752.8740 tritecmonitors.com

Lights, camera, Austin

Check out this list of some of the hits filmed in star-studded Austin, Texas:

Courage Under Fire
Dazed and Confused
Fast Food Nation
Hope Floats
Lonesome Dove
Miss Congeniality
Office Space
The Rookie
Spy Kids
Varsity Blues
What's Eating Gilbert Grape

Sixth Street music venues/ACVB Photo

And plan now to join rural health in the spotlight during the Rural Medical Educators Conference May 3 and the 34th Annual Rural Health Conference May 3-6. Visit RuralHealthWeb.org/annual.

Off the beaten path

Headless chicken's legacy

In 1945, a rooster from Fruita, Colo., population 12,274, became legend after a botched beheading.

The axe missed his brainstem, leaving the bird very much alive – albeit headless. Christened Mike the Headless Chicken, the tenacious bird survived for 18 months, traveling the country gathering fame with his manager, who fed him with an eyedropper.

Today a statue of Mike can be found in downtown Fruita, and each year during the third weekend of May residents and visitors are invited to a festival in Mike's honor. Get ready to party your head off May 20-21.

Visit miketheheadlesschicken.org.

shifting gears

Don't wait 'til spring for green

- **Avoid de-icers** made from sodium chloride, which contains cyanide. Instead opt for sand or calcium chloride, which do less damage to concrete, cars and plants.
- **Save wood-burning fireplace ashes.** They can be mixed in a compost heap to provide nutrients to your garden.
- **Set the thermostat at 68 degrees**, and turn it down even lower while you're gone for the day. Lowering the heat by 10 degrees for eight hours a day can reduce your heating bill up to 15 percent.

Tell us what puts your town on the map. E-mail editor@NRHArural.org.

National Rural Health Association

521 E. 63rd St.
Kansas City, Mo. 64110