

rural roads

Spring 2011 National Rural Health Association



Montana bucks trend Campaign reduces meth use

Lights, camera, rural Alabama

Remembering Rosemary

Teen donates children's books to hospitals

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

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On the cover



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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.



Cover to cover compliments

I just received my winter issue of *Rural Roads*. As a former magazine editor, I wanted to write and tell you how terrific your publication is – well written with great design. Kudos.

As you might expect, I place advertising for many different clients and receive sample publications of all sorts. Honestly, this is the first time in a long time I have sat down and really read a publication. Your content was so interesting.

Regards,
Michael S. McGraw, PhD
The McGraw Group

Share your story.

Should you or a colleague be featured in the next issue of *Rural Roads*?

Contact Lindsey Corey at editor@NRHArural.org to share your ideas, innovations and experiences.

Editorial suggestions must not be advertisements.

Big tasks for rural health



I want to thank the National Rural Health Association for a great Rural Health Policy Institute. I was struck by the different and often contradictory conclusions when looking at the same law. The goal is access to health care for rural America. We need to work together to reach that goal.

I hope that you are all planning to join me in Austin, Texas, for NRHA's 34th Annual Rural Health Conference. Annual Conference is the time for us to come together and share what is working. It is okay to steal those great ideas and use them in your communities – imitation is the sincerest form of flattery.

See you soon, and thanks for all your hard work for rural health.



Kris Sparks
2011 NRHA president

pit stop

5 things I picked up in this issue:

1. Sumpter Blackmon, a family physician from Camden, Ala., plans never to retire because only two other docs serve his whole county. *page 12*
2. One hundred percent of NRHA staff members donated to the association last year. *page 30*
3. Before the Montana Meth Project, half of the state's prison population had committed a meth-related crime. *page 6*
4. A Mississippi teen has collected nearly 10 times more books for hospitals than there are residents in her town. *page 10*
5. Frontier populations were referenced 22 times in the health reform bill. *page 18*

Teens in the largely rural state of Montana participate in the Paint the State project. In 2006 and 2010, hundreds of teens participated in the Montana Meth Project-organized event, creating monument-sized pieces of anti-meth artwork across the state.



Pictures don't lie

Graphic ad campaign helps reduce meth use By Angela Lutz

In a strip of candid, black-and-white photo booth shots, two teenage girls smile and mug, laughing as they take turns wearing a pair of sunglasses. The pictures have been casually tossed atop a cluttered dresser alongside a pair of pink headphones and a gold necklace engraved with the words “best friends.”

This photographed scene would look right at home in the bedroom of any female high school student, except for the words printed across the front in white block letters: “Before meth, I had a best friend. Now I have a junkie.”

In another shot, a young woman's chapped, dirty lips frame a mouthful of gnarled, rotten, black and yellow teeth. “You'll never worry about lipstick on your teeth again,” it says.

These two images may sound extreme or grotesque, but they encapsulate the message of the Montana Meth Project, a large-scale public awareness campaign aimed at reducing methamphetamine use, especially first-time use among teens. The campaign includes print and online ads, television commercials, radio spots and community events.

“The ads have to be hard-hitting and edgy, because that's what resonates with teens,” says Amy Rue, Montana Meth



Montana Meth Project ads were designed using input from teens.

Project executive director. “Changing the way they think about the drug is the first step toward changing their behavior.”

Not even once

Since the project’s inception in 2005, first-time meth use among teens in the largely rural state is down 63 percent, and meth-related crime is down 62 percent.

Before 2005, according to Rue, Montana spent more than \$300 million on drug abuse treatment, child endangerment, lost productivity and imprisonment due to meth use. In fact, nearly half of the state’s prison population had committed a meth-related crime.

“It truly costs society, whether it’s your family member that’s a meth user or not,” Rue says. “We need to stay ever-vigilant.”

She attributes the project’s success in reducing meth use and related crime to its realistic and graphic depiction of the devastating consequences of meth, the physical ravages of which have been well documented through successive mug shots of meth users.

“The rapid physical deterioration of the individual is readily apparent,” says David Hartley, University of Southern Maine Muskie School of Public Service Rural Health Research Center research professor. “It starts with young women in their 20s, and within a year or two they look middle-aged; they have lesions on their faces; their teeth are falling out.”

The strength of the Montana Meth Project seems to lie both with the accuracy and the shock factor of its message, largely shaped by teens through focus groups and feedback.

“The kids respond very well to the campaign and recognize the authenticity of it,” Rue says. “They recognize their peers played a role in shaping it. They feel they own it, and they certainly internalize the message.”

Volunteer Marcy Brakefield has been involved with various aspects of

the project since 2005, including fundraising and counseling for teens and families. A recovering meth addict who started using as a teenager, Brakefield has seen the positive influence of the project’s message on teens. She says if people had been talking honestly about meth when she was younger, it would have helped her make a more informed, healthy decision.

“The ads have to be hard-hitting and edgy, because that’s what resonates with teens.”

Amy Rue, Montana Meth Project executive director

“I think the mission and purpose of the project is a good one,” she says. “It’s important that we have discussions about it and be realistic and talk about the negative impacts of that lifestyle.”

In 2006 and 2010, Brakefield and hundreds of teens participated in the Paint the State project, during which they created monument-sized pieces of art depicting the project’s anti-meth message. The paintings and sculptures often included the slogan “not even once” to communicate the drug’s addictive nature.

“They spent a lot of time and energy on it,” Rue says. “It’s become part of the Montana landscape.”

A culture of tolerance

In an ongoing national study, Hartley has noticed meth use declining while alcohol use is on the rise. According to Hartley, less than 1 percent of rural 12- to 17-year-olds have tried meth, while 35 percent have tried alcohol. Additionally, 12 percent of rural teens engage in binge drinking, compared to 10 percent of urban teens.

More on the Montana Meth Project

Prevention campaigns modeled after the Montana Meth Project now exist in seven additional states: Arizona, Colorado, Georgia, Hawaii, Idaho, Illinois and Wyoming. To learn more, visit montanameth.org.

continues



Montana Meth Project ads graphically depict the realities of meth use.

This is especially concerning, Hartley says, because “the notion of alcohol as a gateway drug has shown to be true.”

“Kids who start drinking young are more likely to start experimenting with other substances,” he explains. “They’re also more likely to commit a crime, which is what they saw in Montana.”

“Whether you agree with the message or not, it’s getting people talking.”

Marcy Brakefield, Montana Meth Project volunteer

One of the factors Hartley believes is responsible for higher rates of alcohol abuse in rural areas is what he calls a “culture of tolerance.”

“Kids in rural areas are less likely to have had a serious talk with their parents about drinking and drugs, and they’re less likely to think their parents disapprove of drinking,” he says. “A higher percentage of urban kids believe their parents disapprove.”


Alcohol is also different than meth in terms of perception because many children have parents who drink.

“One of the tricky things about alcohol is that it’s legal for parents to drink,” Hartley says. “So we don’t necessarily want to model abstinence. It’s not absolute like meth – it’s a different kind of drug that way.”

But he says tactics similar to what the Montana Meth Project has used could also help address growing rates of alcohol abuse among rural teens, and that one of the keys is making communities aware of the problem and getting adults involved by helping them start the conversation.

“The prevention programs that have been more successful have convinced parents that they need to be less tolerant and to target the folks who sell it to ensure they’re not selling to minors,” he adds. “In the case of meth, part of that was taking pseudoephedrine off the shelves. The old ‘just say no’ approach has been largely ineffective, so we need to intervene on the environment.”

Brakefield agrees, noting that honestly and realistically communicating the effects of meth use have given the Montana Meth Project its far-reaching influence.

“Whether you agree with the message or not, it’s getting people talking,” she says. “People don’t want to see meth destroying their friends, families and communities. People are rallying together, and it’s reaching every corner of the state. Whether you like it or not, something must be working.” 

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 4-6
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. 7-8
Daytona Beach, Fla.

RuralHealthWeb.org



Pages of Love founder Hannah Roberts and volunteer Dollie Welch sort books to donate to a Tennessee hospital.

Reading is contagious

Teen donates children's lit to hospitals, clinics

By Lindsey V. Corey

Abbe Garcia looks up to Hannah Roberts. Hannah was just 12 — the same age Abbe is now — when she started collecting and donating children's books to hospitals and clinics. That was six years and 13,000 books ago.

In one of too-many-to-count waiting rooms she and her family frequented, Abbe found a book about Esther. Her mom, Deanna Garcia, found a “Pages of Love” sticker inside.

“The nurse told Abbe she could keep the book, and when I was reading it to her little sister, I saw the sticker with an e-mail address, so I just had to thank them,” Deanna says. “There’s a lot of anxiety when you’re waiting to see a doctor and waiting on tests. You’re trying not to worry and fret because kids pick up on that, and you’re trying to be strong for your child who is actually going through it. Reading that book with her made the time pass a little faster.”

“If you have to be a kid in a hospital, it’s nice to know someone cares.”

Abbe Garcia, 12

Deanna was surprised to learn a sixth-grader was behind the donated book and that it had come from the rural elementary school Deanna had attended.

“I just flipped out,” she says. “I think it’s the neatest thing that a child came up with this way to give books a good home.”

Book drive

Hannah’s home was full of books. Her parents, James and Danna Roberts, are both teachers, and “I was kind of a nerd child,” admits the now senior at Sumrall High School in Sumrall, Miss., population 1,425.

When it came time to clean out her closet, Hannah had outgrown and boxed up 200 books.

“I’d been sick a lot when I was little with bad asthma and bronchitis, and my mom would complain that there wasn’t enough for me to do in waiting rooms, so I figured if I had 200 books, we could probably get a lot more if the whole school got involved,” Hannah remembers.

She talked to her principal and convinced a local restaurant to sponsor a pizza party to award the class that collected the most books.

“Before you knew it, we had thousands of books in my house, in the trunk of the car, books at my grandparents’ house, everywhere,” she says. “I never thought it would be an annual thing, but it just caught on and expanded.”

Paying Pages forward

Soon after Abbe’s hole in her heart was repaired, Deanna encouraged her daughters to share their books through Pages of Love.

“I sat them down and told them, ‘We can’t read all these books all the time, and Hannah is a little girl a little older than you who had this great idea. So let’s take books you’ve already enjoyed and give them to Hannah to put in hospitals to give others kids a book,’” Deanna remembers.


Deanna, Abbe and Isabelle took three boxes, more than 100 children’s books, when they travelled a half hour to Sumrall to meet and thank Hannah. Abbe even donated the book she’d received with the “Pages of Love” sticker already inside the front cover.

“Hannah is awesome,” Abbe says. “I like that she thought about kids in hospitals and started this to help kids like me. If you have to be a kid in a hospital, it’s nice to know someone cares.”

Hannah says delivering books for Pages of Love is a reminder of how fortunate she is to be healthy.

“I’ve learned how much something small like a book can brighten someone’s day and make hospitals a little more bearable,” she says. “Literature can provide an outlet for a sick child to escape the hospital room. And a simple book can distract a child from a shot or entertain that child to give their parents a well-deserved rest.”

Hannah will graduate this year. She hopes to become an oncologist, and she hopes her family will help her continue Pages of Love when she’s away at college.

“My dad has about 2,000 books in his classroom now for me to sort and sticker,” Hannah says. “Bless his heart.” 

Got books?

Pages of Love books are donated to hospitals and physician offices in Mississippi and Tennessee.

Send new or gently used children’s and young adult books to

Hannah Roberts
561 Cooley Springs Road
Mt. Olive, Miss. 39119

Lights, camera, rural Alabama

Student film shines light on dedicated doctors

By Lindsey V. Corey



Carly Palmour and Caitlin Looney introduce their rural health documentary at its premiere in Tuscaloosa, Alabama.

It takes a certain kind of doctor to accept pickled okra or today's catch as payment.

It takes a certain kind of physician to make house calls in 2011.

And it takes a certain kind of person to work 14 hours a day, be on call the rest of them and plan to never retire.

Doctors Sumpter Blackmon, Roseanne Cook and Willie White are that kind. They're featured in "A Certain Kind," a short film by University of Alabama-Tuscaloosa students Carly Palmour and Caitlin Looney that's captured the attention of rural health activists and policymakers across the state and the country.

These three primary care physicians serve rural Wilcox County, the second poorest in Alabama, with a population of 12,384. That's one physician for every

4,128 people.

"I'm just an eternal optimist," Blackmon, MD, says in the documentary. "I'm saying this is the best place in the world for a doctor. Just give me somebody that likes to do a little fishing and hunting and likes the outdoors. And I would like for he or she to have more than a modicum of intelligence and durability, and we can make it go. We're going to keep that hospital open no matter what it takes."

But it's not easy. Blackmon works 12- to 13-hour days and pledges to never retire, and White, MD, says he literally lives at John Paul Jones Hospital, working 96 hours each week.

"We see everybody that comes to the emergency room whether they have the ability to pay or not, and that's what's hurt us over the last years," White, whose student loans were covered for serving the underserved area, tells the camera. "I started here in 1985, and the next physician they recruited was 19 years later. Recruiting is hard in this area because nobody wants to come here... I'm from the area, so I didn't mind coming back here."

Enter the county's – and the film's – ray of hope: 23-year-old Brooke Perryman, a University of Alabama-Huntsville Rural Medical Program student who plans to return to Wilcox County to care for her neighbors – and her cows – in seven-or-so years. She's been working toward medical school since she was 16 but worries about being on call 24-7 because of the physician shortage.

Straight to the horse's mouth

When Palmour and Looney asked John Wheat, MD, Rural Scholars Programs director and community and rural medicine professor, about rural issues, he sent the rookie filmmakers three hours south to the heart of Alabama's Black Belt region.

“I told them to go straight to the horse’s mouth,” he says. “Wilcox County epitomizes the conditions of physicians in much of rural America, particularly economically depressed areas. And what you see is what you get.”

Wheat, who has been trying to attract a doctor to the area for more than 20 years, says the only thing that surprised him about the film was that two undergrads “captured it so well.”

“It’s an accurate depiction of the impression Wilcox County makes on urban people,” he says. “It’s bleak. There’s nothing about the positive aspects of rural life, but it’s going to take urban people’s support to get what we need in Wilcox County.”

The human side

At first, it was just a class project to the 19-year-old from Birmingham. Palmour says the physicians were willing to share their experiences, but interviews often had to be cut short or cancelled because of patient need.

to 10 minutes,” she says. “We wanted to address a bunch of issues, so we ended up making it a character piece. These doctors aren’t in it for the money; they sometimes get paid in fruit or vegetables. They’ll do anything to save their community. We figured the best way to tell it was through the people trying to address the issues.”

Wheat says they hit the mark.

“There’s plenty of material written about the needs of the Black Belt of Alabama, 12 counties of high minority, low socioeconomic people with a lot of health disparities,” he says. “We’ve seen data for decades on how bad it is, and people have kind of gotten numb to the statistics. But you can’t deny this film. It’s riveting and really points to the human side of all these bleak statistics.”


After 20 years of developing pipeline programs to get rural students into med school, Wheat says “it’s become old hat.”

“We’ve got programs; everybody accepts it,” he says. “But there needs to be much more done. I’d sort of reached the limit of what I could do in the current policy system and medical schools. This film helps a lot of people see we’re not doing enough. It documents the need better than anything written in black and white could.”

He asked Palmour to create a second documentary following rural students like Perryman in medical school programs designed to prepare them to return home and those who have graduated and are now treating patients in their communities.

“We need to show what the remedy looks like,” Wheat says. “Yes, it can be done, and we need to do more of it.”

Palmour will go back to the Black Belt to start the sequel this summer.

“With ‘A Certain Kind,’ a movement has picked up, and people are regaining enthusiasm around goals in the rural health community,” she says. “I think this one could be even more powerful.” 

“These doctors aren’t in it for the money; they sometimes get paid in fruit or vegetables.

They’ll do anything to save their community.”

Carly Palmour, student filmmaker

“As soon as we started meeting these people, our goal changed drastically from passing the course to creating something to be used for the greater good,” says Palmour, now a junior studying documentary film production. “It was difficult to go there and gain trust because we’re two pretty well-off university students. And it was emotionally draining, but we became invested when we realized this could possibly benefit the community.”

For one semester, Palmour and Looney drove six hours roundtrip about twice a week. They were practically regulars at Ms. Kitty’s, one of a handful of restaurants in Camden, population 2,144. They frequented the doctors’ waiting rooms and rode along with Cook for house calls.

“It was very difficult to cut 12 hours of footage down

Watch and learn

Watch “A Certain Kind,” by Carly Palmour and Caitlin Looney, at vimeo.com/15727128.

And learn about the University of Alabama Rural Scholars Programs at cchs.ua.edu/edu/crm/rural-health-programs.



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Rural training track conclave builds partnerships, momentum

By Dustin Summers, NRHA policy and program services manager



Randy Longenecker welcomes participants to the Rural Training Track Conclave in Columbus, Ohio.

On the first night, they are easy to spot. The Cajun is wearing his cowboy boots. The thin man from Idaho is telling stories about mule-back trips into the wilderness. Attendees from central Maine and Wisconsin are discussing the mild weather here in Columbus, Ohio.

They look the part – rural doctors who have chosen to live, practice and impart their knowledge to future physicians in some of the most underserved areas of the country.

“The perception that many... students have of a rural training track is a cabin in the middle of the woods, and we are striving to eliminate that misconception.”

Jim Demos, MD

They have gathered here, for the first time, to learn from one another and share successes and obstacles. Although their stories and appearances are different, they're cut from a common cloth.

It's February, and 15 program directors from the nation's 24 1-2 rural training tracks (RTT) have

gathered for a three-day meeting. The “1-2” designation refers to the structure of these residency programs, in which a new resident completes his or her first year of medical training in an urban setting and then completes the second and third years in a rural area. The combination of settings allows residents to not only develop their skills in a resource-rich urban environment but to also train in an underserved rural area where unique challenges often arise.

In addition to the RTT directors, several state office of rural health representatives are also in attendance to allow for coalition-building between the RTTs and their state office of rural health counterparts. These partnerships are crucial to strengthening RTTs and the continued growth of programs.

Challenges and opportunities

The meeting is introduced by Randall Longenecker, MD, a rural family physician in West Liberty, Ohio, and project director for the RTT Technical Assistance Program. Longenecker's soft-spoken demeanor hides the daily struggle of serving as a rural residency director.

“We hope you will find value in what we do here over the course of the next couple of days and that we emerge with some goals and some ideas as to how we can improve our lot,” he says in his opening comments.

If anyone knows the importance of this challenge, it's Longenecker. Less than a month before the meeting, Longenecker received news that his own RTT would be closing due to budget cuts and financial shortfalls.

“We are disappointed,” he says, “but this gathering gives me more encouragement than I had a week ago. There is still a need for rural family doctors, and we can work to fill that void.”

After introductions and brief presentations from representatives from the Office of Rural Health Policy and the National Rural Health Association, the morning session continues with an impassioned presentation from Program Consultant Ted Epperly, a physician from rural Idaho.

“We know the challenges,” he says, “but we cannot afford to allow this opportunity to pass, to squander the momentum and the expertise that we

have gathered here in Columbus.”

Inside an RTT

The Mad River Family Practice Clinic in Logan County, Ohio, sits in front of a massive field filled with frozen puddles and muddy ruts left by tractors. A frozen waterfall spills from the overhead gutters, and the parking lot is empty except for a few sedans stained with salt and pickup trucks caked with mud.

“This gathering gives me more encouragement than I had a week ago.”

Randall Longenecker, MD

Inside, phones ring and nurses pull patient files from overstuffed cabinets. This is what a functioning rural clinic looks like. For some of us, it’s the first time we have seen what goes into maintaining a dedicated rural training track.

The Mad River clinic has two family medicine residents. Inside the small office they share, the two young doctors tell stories of their training, sleepless nights, commutes and balancing a home life with the continued rigors of their medical training. When asked if they regret choosing to train in a small, rural community, they both immediately say no.

“We see so much here,” they say, “and we are able to see how our work impacts these underserved families.”

Why choose an RTT?

In the afternoon, we retire to a conference room where small-group interaction explores pertinent topics: funding, marketing, recruiting and sustainability. It’s in these small groups that the program directors begin to share what makes these residencies so unique and essential.

“We have students that come out here, and they absolutely love it. They get to do things that their counterparts don’t get to do,” says John Haynes, MD, from Shreveport, La.


“Students talk. They compare stories and notes,” adds Jim Demos, MD, from Baraboo, Wis. “A resident will say, ‘I got to deliver 80 babies during my time at Baraboo,’ and another will say, ‘Wow, I only got to deliver eight during my time at a much bigger place.’ These are the things that prospective residents need to hear. The perception that many of these fourth-year med students have of a rural training track is a cabin in the middle of the woods, and we are striving to eliminate that misconception.”

Representatives from several state offices of rural health join the RTT directors in these conversations. Their input and collaboration is valuable to this project and the continuance of the RTT program across the country.

“One of the primary goals of this conclave is to build partnerships between RTTs and the offices of rural health in their respective states,” says Teryl Eisinger, director of the National Organization of State Offices of Rural Health. “We want to build partnerships where resources and support can be shared.”

“It’s great to have the opportunity to be together in the same place, the same room,” adds Dave Schmitz, a rural physician in Idaho serving as RTT Technical Assistance Program assistant project director. “Just having the opportunity to hear from all of these other directors that are facing the same challenges year in and year out is a source of strength for the rest of us.”

Urgency and hope

On the last day, participants are all spent. They’ve toured clinics and hospitals, shared stories and made plans for the future. As they file into the conference room for the last session, attendees drag rolling suitcases behind them as everyone prepares to leave. The sense of urgency has given way to a feeling of hope. Inroads have been made, and as Longenecker reiterated, the sense of encouragement has grown. 

The 2011 Rural Training Track-State Office of Rural Health Conclave was made possible as a portion of the RTT Technical Assistance Program Grant, a cooperative agreement between the National Rural Health Association and the U.S. Department of Health and Human Services’ Office of Rural Health Policy.

RTT results

For more on rural training tracks, join program directors at NRHA’s 34th Annual Rural Health Conference at 3:15 p.m. May 5 in Austin, Texas.

For the full agenda, including a rural education track, visit RuralHealthWeb.org/annual.

NRHA celebrates 25 years of frontier health leadership

By Lindsey V. Corey

There's rural, and then there's frontier.

"There is a huge variation between places considered rural or non-urban," says Charlie Alfero, Hidalgo Medical Services CEO and the National Rural Health Association's Frontier Constituency Group (CG) chair. "Certainly, access to health services in a community of 3,000 is different than a community of 30,000, yet they are both considered rural depending on who you ask."

But NRHA gets it and has for 25 years, says Carol Miller, who served as the association's original Frontier CG chair and later co-founded the National Center for Frontier Communities.

"In 1986, a group of very committed people got together to make the case that the most isolated in travel time and very sparsely populated areas were different from the rest of rural," she remembers. "We date the beginning of the frontier movement as being that NRHA meeting."

About 20 people like Miller – "I'd lived and worked in rural all my life" – gathered in Kansas City, Mo., and have been frontier health activists ever since.

"It's exciting to be a part of a movement that

started absolutely grassroots," says the former clinic director and volunteer paramedic. "At first it was about drawing attention, but now frontier is just part of the conversation. The awareness of the differences of frontier has trickled down from the very first meetings NRHA had 25 years ago to even way outside of health care. That's something all of us should be proud of."

"When it comes to making sure benefits extend all the way out to the smallest and most isolated communities, we can't become out of sight, out of mind."

Carol Miller, frontier health advocate

Miller now lives near Ojo Sarco, N.M., between two ambulance bays, both at least an hour away. And the closer EMTs can't travel to her community because it's in a different county. She's currently working to get her first responder certification again so the local fire department can upgrade to fire and rescue.

"Out here, we understand frontier intuitively," she says. "It's hard for us to fit in. Smaller places don't fit in a box, and it's often hard to get funding where it's needed most."

But Miller and other Frontier Constituency Group members have always been optimistic.

"We had a no whining rule from the beginning, knowing we'd never

Highlights of the contemporary frontier movement

1893

After the 1890 census, Frederick Jackson Turner publishes "The Significance of the Frontier in American History," declares frontier gone, settled.

1980

After the 1980 census, Deborah and Frank Popper begin writing about the enduring frontier, refuting Turner's work.

1985

Nebraska clinic administrator Larry Jeter distributes Popper article to Health and Human Services Region VII. Regions VII and VIII hold first meeting to discuss frontier issues.

1986

February 1986, NRHA convenes the first Frontier Medicine Task Force meeting. Gar Elison is elected chair.

May 1986, first frontier session at an NRHA Annual Rural Health Conference.

Health Resources and Services Administration Bureau of Health Care Delivery and Assistance Frontier Policy 86-10 is enacted.

1987

First "frontier" provision in law. Public Health Service Act calls for special consideration for frontier health centers.

succeed if we just focused on how bad things were,” she says. “We had to seek out successful communities around specific issues, to find places to put out as models for others. That approach has led to our success from EMS reimbursements to behavioral health innovations. We know we’re meeting a need.”

And frontier health advocates are being heard.


“NRHA has made huge strides in public policy that ensures a differential consideration of payments based on the inequities of the market model in rural places,” Alfero says. “Most recently, in health care reform [legislation], there were over 20 references to ‘frontier’ as a special population. The Frontier CG reminds us that even within rural populations, greater consideration is needed for the most vulnerable health systems and communities in general. We would like to thank NRHA, the Office of Rural Health Policy and others for recognizing the unique nature of the American frontier by helping ensure access to services and working towards better health through policy and program implementation.”

“It’s exciting to be a part of a movement that started absolutely grassroots.”

Carol Miller, frontier health advocate

Advocacy continues to be priority for members of the Frontier CG, who range from researchers to community health providers.

“Recognition of the frontier HPSA [health professional shortage area] in the Affordable Care Act [health reform] is extremely important, and it’s so gratifying the way the future of frontier is looking now,” Miller says. “But

it’s an ongoing struggle to keep the best parts funded. I caution people just because something is there now, you still have to stand up for it all the time. Because we have so few people and frontier people don’t tend to travel to Washington or have to travel hours to their congressional rep’s office in their own state, I tell them if you want to be considered, you have to be really active and make sure everyone is aware of how difficult it is to sustain a program. When it comes to making sure benefits extend all the way out to the smallest and most isolated communities, we can’t become out of sight, out of mind.” 

Focus on frontier

Learn more about and join the frontier health movement at NRHA’s 34th Annual Rural Health Conference in Austin, Texas.

The plenary session, “Celebrating 25 years of leadership in frontier health systems,” will highlight NRHA’s past and present work on behalf of frontier communities at 8:30 a.m. May 5.

For the full conference agenda and to register, visit RuralHealthWeb.org/annual.

Source: NRHA member Carol Miller

New York Times interviews Gar Elison and Frank Popper for the Dec. 12 article “Some say frontier is still there, and still different.”

1988

NRHA’s board votes to elevate the Frontier Task Force and establishes the Frontier Constituency Group with board and policy representation.

1990

National Center for Frontier Communities is incorporated as Frontier Education Center. The center is the only national organization dedicated to the issues and concerns of frontier communities.

1997

Medicare Modernization Act passes and establishes the Frontier Extended Stay Clinic demonstration.
Western governors adopt frontier policy.

2003

Affordable Care Act becomes law featuring frontier provisions including the frontier health professional shortage area.

2009

National Center for Frontier Communities moves to Silver City, N.M.
25th Anniversary Frontier session during NRHA Annual Rural Health Conference.

2011

Is health reform the right prescription for rural America?

By Maggie Elehwany, NRHA government affairs and policy vice president



Maggie Elehwany

Rural America faces a looming health care crisis – a crisis in accessing care. For health reform to be effective in rural America, the access to care crisis must first be resolved. Access to insurance doesn't matter if you don't have

access to a provider.

The National Rural Health Association has long lobbied Capitol Hill and the Administration to resolve rural America's access to care crisis, and health reform legislation provided an opportunity to make important advances. Though NRHA did not take a position in support or opposition of the controversial bill, we used the legislative vehicle to advance significant agenda items aimed at improving access.

Our message to Capitol Hill was simple: If health reform is to work for rural patients and providers, the law must first resolve the workforce shortage crisis in rural areas and eliminate long-standing payment inequities for rural providers.

Insuring the uninsured

This is not to say the primary goal of health reform – to reduce the number of uninsured by expanding access to insurance coverage – is not important in rural America. Quite the opposite is true. More rural residents are uninsured or covered through public sources (23 percent compared to 19 percent of urban residents). And fewer rural Americans receive insurance through their employer than their urban counterparts (64 percent vs. 71 percent), meaning many more are likely to be underinsured.

Though rural patients and providers face many of the same challenges as their urban counterparts – exploding health care costs, escalating charity care and aging infrastructure – there are many unique challenges to the delivery of health care in rural America that only exacerbate the crisis in accessing care. Rural Americans are, per capita, older, sicker (with higher percentages of chronic disease) and poorer. Distances, topography, weather, culture, language and lifestyle each can create great challenges in accessing care in rural areas.

Addressing the workforce shortage

Most rural states face crippling primary care vacancy rates, and many positions remain unfilled for years. The crisis will only worsen as the baby boom generation gets older and health professionals retire. Experts predict that by 2030, when over a fifth of our country's population is over 65 years old and needs increasing levels of care, the nation will have shortages of at least 100,000 physicians and perhaps as many as 200,000.

A third of the nation's active physicians are older than 55 and likely to begin retiring in the next few years. In fact, by 2020, physicians are expected to hang up their stethoscopes at a rate nearly two and a half times the current retirement rate. And the Bureau of Labor Statistics projects that in order to accommodate growth in demand for registered nurses and to replace RNs leaving the workforce, 120,000 new nurses will be needed annually from 2004 through 2014.

The Affordable Care Act (or health reform) takes positive steps in helping improve access in rural America. Though certain program expansions may be dependent upon the federal appropriations process, NRHA strongly supported the critical investment made in the bill to develop and improve the rural health care workforce, a problem that has plagued rural America for a century.

A few specifics include:

- Vastly improved funding for the National Health Service Corps (NHSC). Through scholarship and loan repayment programs, NHSC helps health professional shortage areas in the nation get the medical, dental and mental health providers required to meet their tremendous need. Since 1972, more than 30,000 clinicians have served in the Corps, expanding access to primary health care services and improving the health of people living in urban and rural areas where


health care is scarce.

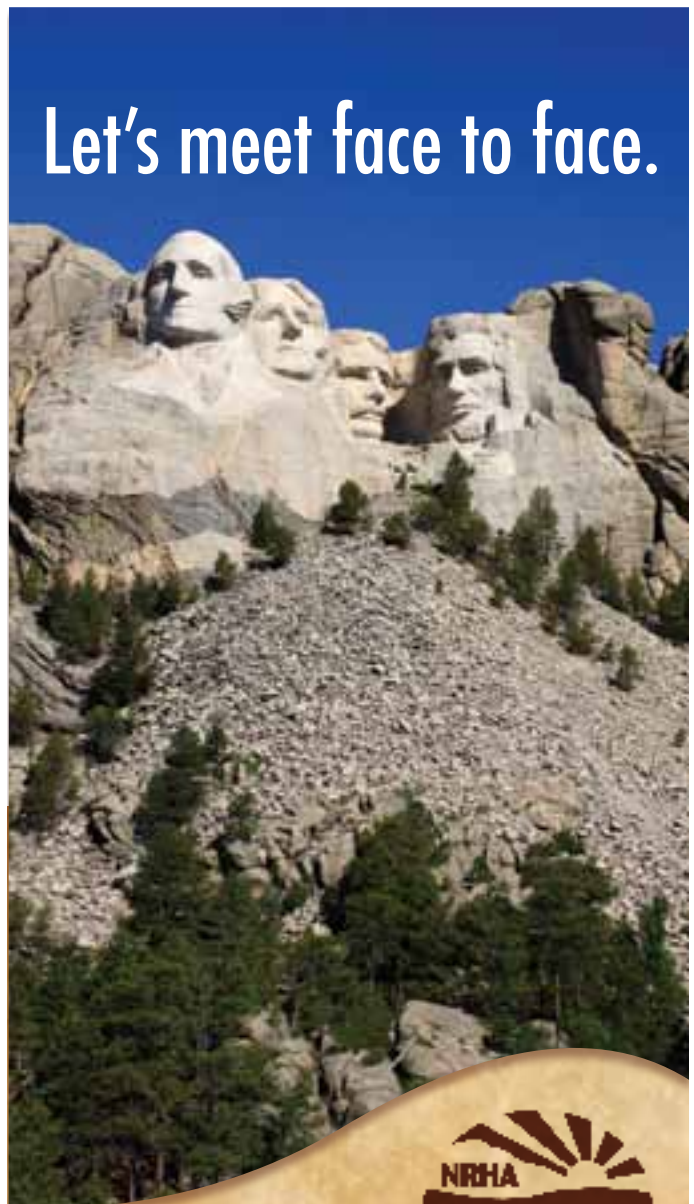
- Dramatic increases in funding for other health profession training programs including area health education centers (AHECs) and nursing programs. AHECs and other programs are essential to providing rural students the skills they need to matriculate into health professions.
- Increased medical residency slots in rural areas. Studies have long shown that students from rural areas and/or those who were exposed to rural practice while in school are more likely to seek employment in these communities.

Fighting for access

Health care reform, at least temporarily, makes many improvements to correct systemic Medicare and Medicaid payment inequities that afflict rural providers. Medicare bonus payments for primary care practitioners and the additional Medicaid dollars to states and providers included in the bill will not resolve the primary care shortage but are critically important and long overdue.

Many health reform provisions remain controversial. Even though the 112th Congress does not have the votes to repeal the Affordable Care Act, there is an effort to curtail funding for health reform and its programs. NRHA remains resolute in its fight for rural patients and providers and will fight against cuts in programs and/or funding that will harm rural patients' access to care.

NRHA is the voice of rural health, closely monitoring the budget and appropriations and proactively advocating on behalf of health care for rural America. There is much work to be done. Stay tuned to RuralHealthWeb.org, and stay involved. 



Let's meet face to face.



NRHA's Quality and Clinical Conference

July 20-22

Rapid City, S.D.

Don't miss this interactive event for quality and performance improvement coordinators, researchers, hospital administrators, and doctors and nurses practicing on the front lines of rural health.

RuralHealthWeb.org/quality



Remembering Rosemary



A passionate advocate

“Rosemary was a passionate advocate for eliminating rural health disparities. She was a champion for multicultural and multiracial people. She was a great friend to everyone on staff, and she made everyone smile. The NRHA family misses her dearly.”

- Alan Morgan, NRHA CEO

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

Rosemary served as the National Rural Health Association’s minority liaison and program services manager in the Kansas City, Mo., office for 27 years. She died on March 16 due to complications from pancreatic cancer.

“The world has lost a very cool woman,” says NRHA member Marilyn Kasmar. “But she has certainly left a legacy behind in all of us. We will work hard to carry on the work she believed so strongly in.”

Rosemary is survived by her husband, Ricky; her daughter, Monica; and her grandsons, Monté, Danté, Deyvion and DéMoreay.

Most definitely proud



“She loved helping others and loved to feel like she was making a difference. We’re most definitely proud of the work she did.” - *Monica McKenzie, Rosemary McKenzie’s daughter*

A lasting legacy

To carry on Rosemary McKenzie’s legacy and honor her memory, the National Rural Health Association has established the Rosemary McKenzie Legacy Award to be presented annually during the Rural Multiracial and Multicultural Health Conference.

Donations are also being accepted for a scholarship to help individuals attend this educational event.

A memorial slideshow will be presented during the 2011 NRHA Annual Rural Health Conference (May 4-6) and the Rural Multiracial and Multicultural Health Conference (Dec. 7-8).

Tax-deductible contributions may be sent to
NRHA honoring Rosemary
521 E. 63rd St.
Kansas City, Mo. 64110

She was the real deal.

“Rosemary’s caring nature extended far beyond her family. She took care of me, and she took care of our Rural Multiracial and Multicultural Health Council. When I reflect upon our friendship and the work she did for our council, I think of the old R&B hit, ‘Tell it Like it Is.’ There was no pretense with Rosemary. If she liked it, she said so. If she didn’t, she said so. It wouldn’t affect her work or stop her from assisting me in any way, but she let me know what she thought.

“She was the real deal. Can’t you see her there, such a familiar face at NRHA events? Full of energy, bouncing from one place to the next. And there was always a smile on her face.

“Rosemary was a very positive and upbeat person, an attribute she demonstrated up until the very end of her life. What an inspiration she was. What a blessing it was to know her as both colleague and friend.” - *Sandra Pope, NRHA Multiracial and Multicultural Council chair*



She could always find a way.

“I am feeling great. Will be taking chemo in a couple of weeks and can’t wait. Plans are in place and they sound good.’ This e-mail I received from Rosemary reflects the person I knew and loved for over 20 years. She was always cheerful and positive that no matter what happened we could work it out, and we did.

“I had the privilege of working with her on NRHA Annual Rural Health Conferences, NRHA Rural Multiracial and Multicultural Health Conferences, the NRHA Rural Task Force, the advisory board of the South Carolina Rural Health Research Center and several HRSA-funded research and service projects. Rosemary always demonstrated a practical and creative approach. She could always find a way. She was the most dependable of colleagues. She always went the extra mile to accommodate other people’s wants and needs. She was just plain fun to be around. To me Rosemary McKenzie was the true spirit of NRHA and our desire to further the cause of health for rural people. She is gone but ever present in my heart and mind.” - *Michael Samuels, NRHA member*

Beginnings & Passages



Aniesa Slack

Until I left the farm, I didn't realize that rural life was so different from the rest of the world.

City life calls student back to country roots

By Aniesa Slack

It took me months to stop waving at every car I met on the road when I moved to the big city. And that was just the beginning of the culture shock that I was about to experience. As a first-generation college student I couldn't wait to get out of Oxford, Kan., population 1,067, and live the life I thought my parents never could.

I never imagined how much I would miss my country roots, mostly because until I left the farm, I didn't realize that rural life was so different from the rest of the world.

My experience has convinced me that rural Americans have a distinct culture, one that crosses socioeconomic strata, encompasses all ethnicities and knows no geographic boundary. Rural doesn't describe a place; it describes a people, my people. But I didn't always see it that way. I spent my undergrad years trying to find myself and my calling.

The further I got from home, the more people I met who were shockingly out of touch with any lifestyle not found in metropolitan areas. It was as if urban tunnel vision had created a society blind to the world of rural America.

Baffled and discouraged, I called Mom and Dad for advice. There I was, explaining to them how unfortunate it was that my rural culture was misrepresented, taken for granted and misunderstood by the urban majority. But not by me. I identify with rural folks. They represent me, my family and my neighbors. I understand these people, can relate to their problems and empathize with their situations.

They deserve a doctor who recognizes the challenges they face and can appreciate the sacrifices they make. And just like that, I realized I had finally found my calling.

Aniesa Slack is a second-year medical student at the University of Kansas School of Medicine and was recently accepted into the Rural Track Program, where she will continue her clerkship rotations in a rural setting. She joined the National Rural Health Association in 2010.

*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.

I enjoy seeing families grow and evolve over time.



Nicole Rouhana

Rural midwives empower women

By Nicole Rouhana

Over the last 25 years, I have had the privilege of caring for rural women and their families and feel honored to be part of their childbirth process and witness the empowerment that birth can provide.

Initially beginning my career as a pediatric registered nurse in rural Saudi Arabia, I found my passion for nurse-midwifery. Graduating from the University of Medicine and Dentistry in New Jersey in 1989, I went on to provide women's health care in rural counties of New York and Pennsylvania, attending the births of over 2,000 infants. For 10 years I was the only prenatal care provider in Tioga County, located in upstate New York.

One of the most rewarding aspects of my role is having a strong presence in the community that I serve and being able to advocate for women. This allows me to be a voice for rural women who otherwise might not be heard. I often have women share things with me not because I am their care provider but because they feel comfortable sharing intimate details and know I will take the time to listen. Gaining entrance as an "insider" of the community facilitates this interpersonal relationship.

I also enjoy seeing families grow and evolve over time. Mothers frequently bring their teenagers to the practice, so I can see how much they have grown and hear of their accomplishments.

Often I care for the daughters of the women in my practice. It is such a special feeling to know that the woman giving birth was a baby I delivered over 20 years ago, and her mother is right there with us. Midwifery care can indeed be multi-generational.

In 2000, I completed a family nurse practitioner program at Stony Brook University, allowing me to broaden my scope of practice and care for all members of the family. I am currently in the final phases of doctoral studies at Binghamton University's O'Conner Program for Rural Nursing.

I firmly believe that advanced practice nurses have the capability to improve health outcomes for underserved rural populations.

Nicole Rouhana is clinical assistant professor and midwifery and perinatal women's health programs director at Stony Brook University. She joined the National Rural Health Association in 2009 and is a Rural Health Fellow.

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10 things to do in downtown Austin

while attending the National Rural Health Association's 34th Annual Rural Health Conference May 4-6

By Becky Conditt

Side trip



Becky Conditt in downtown Austin, Texas

10. The **Texas Capitol** is an extraordinary example of late 19th century public architecture and is widely recognized as one of the nation's most distinguished state capitols. The main campus of the University of Texas at Austin is four blocks to the north. Wonderful views of the capitol's dome from many vantage points throughout the Austin area are protected from obscuration by state law.



ACVB Photo, Frederica Georgia

9. **Congress Avenue** south of the Congress Avenue Bridge is lined with boutiques, funky "junque" stores, restaurants, neighborhood bars and coffee shops. One of the most famous SoCo Austin landmarks on the avenue is the Continental Club, a smoky bat cave of a place where many top musical acts have launched their careers. (Speaking of bats, they hang out under the Congress Avenue Bridge.) One of my favorites on South Congress is the Big Top Candy Shop.



8. There are several **Segway tours** offered in the downtown area. You can even take a haunted Segway tour that explores Austin's ghostly past, moonlit towers and the world's largest urban bat colony of more than 1.5 million Mexican free-tailed bats living downtown.



Photo, austinthespot.com

7. Likely Texas' best known street, **Sixth Street** is certainly Austin's entertainment center, known as the heart of Austin's live entertainment scene and the capital of third-coast music. Make sure to stop in Wild About Music for some cool souvenirs.



ACVB Photo, Frederica Georgia

6. **The Warehouse District**, just west of the central business district, is a bit trendier and pricier than Sixth Street. True to its name, the businesses in this district have been renovated from former warehouses into restaurants, top-notch concert halls and distinctive bars. Live music is everywhere in the Warehouse District, and great restaurants are easy to find.

5. **Antone's Nightclub**, the first club on Sixth Street, opened its doors in the summer of 1975. The venue was founded by legendary promoter Clifford Antone and has hosted such blues greats as Muddy Waters, B.B. King, Buddy Guy, John Lee Hooker, Pinetop Perkins, James Cotton and countless others. Antone's helped launch the careers of Stevie Ray Vaughn, Jimmie Vaughn, the Fabulous Thunderbirds, Los Lonely Boys, Ian Moore, Bob Schneider and many more.

4. **Lady Bird Lake Hike and Bike Trail** is the most-used trail in Austin, so if you're looking for a place of quiet and solitude, look elsewhere. If you're looking for a pleasant, mostly flat walk with excellent views of downtown Austin and Lady Bird Lake, then this trail fits the bill. The Texas Tech University Health Sciences Center F. Marie Hall Institute for Rural and Community Health will be sponsoring a free fitness walk on the trail during NRHA's conference.



ACVB Photo, Zilker Kite Festival



ACVB Photo, "Oil Field Girls" (Jerry Bywaters) at the Blanton Museum of Art

3. Austin has an **eclectic array of museums**

located in the downtown area. The Bob Bullock Texas State History Museum tells the story of Texas with three floors of interactive exhibits. The Blanton Museum of Art at the University of Texas is one of the foremost university art museums in the country and has the largest and most comprehensive collection of art in central Texas. Austin Museum of Art has two locations:

the downtown museum reflects the unconventional spirit of Austin and appeals to a broad general audience. The Laguna Gloria site is located in a recently restored 1916 Italianate-style villa that was the home of Texas legend Clara Driscoll. The grounds include a lush, 12-acre area overlooking Lake Austin with sculptures and revitalized historic gardens. This beloved site has been declared a national treasure and is on city, state and national registries of historic places.

2. In **Zilker Park**, Barton Springs Pool is one of Austin's famous landmarks and easily the most popular swimming hole in the city. The Artesian spring-fed swimming hole is over 900 feet long. The pool was formed when Barton Creek was dammed up, so it has a natural rock and gravel bottom.

1. NRHA's **Annual Rural Health Conference** is the nation's largest rural health conference, created for all of those with an interest in rural health care, including rural health practitioners, hospital administrators, clinic directors and lay health workers, social workers, state and federal health employees, academics, community members and more. Visit RuralHealthWeb.org/annual, and we'll see y'all soon.

Becky Conditt is director of Capital Area Health Education Center in Austin, Texas. She joined NRHA in 2004 and is a board member.

Members on the move

Zink edits compilation of country doc stories

National Rural Health Association member Therese Zink, MD, recently edited “The Country Doctor Revisited: A Twenty-first Century Reader,” a collection of stories, poems and essays by rural health professionals across the country.

Zink and more than 30 others contributed to the 191-page anthology, published last year by Kent State University Press.

“The contributors to this collection marvel, grumble, grapple, poke fun and meditate on the beauty and challenges they have encountered in the valleys, on the reservations and in the small towns of rural America,” says Zink, who practices in rural Minnesota and teaches in the University of Minnesota rural physician associate program. “Today rural health care is much more than Norman Rockwell’s physician taking care of farmers. Providers and patients look different, and technology is part of the mix. I wanted to create an up-to-date portrait of rural health care so students could understand modern practice.”

The university’s Family Medicine Interest Group, which includes University of Minnesota-Twin Cities first- and second-year medical students, are reading the book and using discussion questions available at thecountrydoctorrevisited.com. And the Society of Teachers of Family Medicine will fund 10 more book discussion groups for medical students around the country. The grant will cover the cost of books, lunch and parking for rural residency faculty to facilitate four discussion groups beginning in the fall.

“It offers students exposure to rural residency faculty and a chance to network with other students around rural health issues,” Zink says.

For more information, contact Zink at zink0003@umn.edu.



News briefs

100 percent of staff supports NRHA through donations

Every National Rural Health Association employee donated to the association’s annual giving campaign in 2010.

“Working at NRHA is more than just simply a job for us,” says CEO Alan Morgan. “NRHA staff truly does believe in the mission of our organization. I hope that our members recognize our strong commitment to improving rural health care and that they will join us in contributing in 2011.”

Morgan also says 68 percent of NRHA’s board of directors donated last year. As a nonprofit association, NRHA’s overhead represents only 14 percent of expenses, with 53 percent going directly to educational programming.

Tax-deductible contributions may be sent to NRHA’s Annual Giving Campaign, 521 E. 63rd St., Kansas City, Mo., 64110, or donated online at RuralHealthWeb.org.

Quality and clinical care come together in South Dakota event

The National Rural Health Association’s Quality and Clinical Conference will be July 20 through 22 in Rapid City, S.D.

This sixth annual event offers attendees the opportunity to engage in discussions and presentations on the latest developments in quality improvement, including innovations in health information technology.

This year’s agenda will feature two dedicated tracks: a rural hospital and clinical quality track and a telehealth track, focusing on emerging capabilities in the field of quality assurance. Participants will also tour a mobile health unit that serves rural populations in western South Dakota. And NRHA will provide a legislative update and advocacy advice.

Prior to the Quality and Clinical Conference, NRHA will also host its annual Skill Building Workshop July 19 and 20 in Rapid City. This meeting gives attendees the tools needed to grow their individual state associations and local organizations.

Visit RuralHealthWeb.org/quality for more information.

Send your career updates to editor@NRHArural.org.

NRHA congratulates rural health fellows



The National Rural Health Association congratulates the following 2010 Rural Health

Fellows for completing the intensive program aimed at developing leaders who can articulate a clear and compelling vision for rural America.

Janelle Ali-Dinar, PhD, Physician Recruiting for Catholic Health Initiatives of Nebraska director

Evonne Bennett-Barnes, MD, Office of Minority Health Resource Center capacity building specialist

Patrick Cross, DPT, University of South Dakota assistant professor of physical therapy and the Omaha Tribe of Nebraska's Carl T. Curtis Health Education Center/ Four Hills of Life Wellness Center rehabilitation director and physical therapist

Kathleen Quinn, PhD, University of Missouri School of Medicine Area Health Education Center program director

Kathleen Spencer, Rural Assistance Center information specialist

Janice Wilkins, Landmark Group health care services vice president

“NRHA’s Rural Health Fellows program has improved my ‘toolbox of skills’ in the realms of leadership and political advocacy,” says Cross. “More importantly, it has helped me build new relationships with federal legislators, legislative assistants and leaders involved in rural health care management, practice, research and policy making.”

As part of the year-long program, the fellows developed three projects examining how the Patient Protection and American Affordable Care Act will affect rural health care from workforce issues to Medicare and Medicaid payment inequities.

For more information, visit RuralHealthWeb.org.

NRHA to represent rural hospitals on health reform workgroup

The National Quality Forum’s board of directors selected the National Rural Health Association to serve as a voting organizational member of its hospital workgroup of the measure applications partnership.

The group, under U.S. Department of Health and Human Services contract, will help develop quality measures hospitals will have to follow as part of the Affordable Care Act. Key stakeholders were chosen to provide input.

“This gives NRHA a seat at the table to determine how quality measures should be applied at rural hospitals,” says Brock Slabach, NRHA senior vice president of membership services and a former critical access hospital administrator. “We’re pleased to have this opportunity to help ensure rural has a voice in health reform.”

accelerating advocacy

Caught in the rural health safety net

Funding for rural health safety net programs is crucial to maintaining access to quality care, reducing workforce shortages, creating networks between providers to streamline care and developing health care infrastructure in rural communities. Without this funding, many providers would be either forced to close their doors or operate with outdated technology and depleted resources.

Rural health safety net programs play a vital role in ensuring rural Americans have sufficient access to health care services. With budget cuts looming, it’s more important than ever to make sure Congress is aware of the dramatic impact a reduction in funding would have on these programs.

Rural providers often operate on razor-thin margins, and federal funds can have a noticeable impact. For instance, the Flex Grant program supports activities related to improving quality and enhancing health outcomes for patients. The grants also help rural hospitals address operational challenges

to enhance economic viability and ensure access to basic hospital services.

The Small Hospital Improvement Grant helps hospitals with 50 or fewer beds upgrade their networks to improve operational efficiency and increase training to improve patient outcomes.

Cuts to these programs would have a disproportionately negative impact on rural communities. Facilities closing due to a lack of funding would be devastating, not only because of reduced access but also impacts on economy and employment.

As the budget debate continues, it’s vitally important that rural Americans remind lawmakers how crucial these programs are to their communities. For more information on the fiscal year 2012 appropriations process, visit RuralHealthWeb.org, or contact the National Rural Health Association’s government affairs staff at 202-639-0550.



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Jeff Tindle, CFO
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Carrollton, Mo.



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Kick up your heels

Known as the live music capital of the world, Austin, Texas, is home to a lively and diverse music scene in which the careers of countless artists have been launched.

While in town for the National Rural Health Association's Rural Medical Educators and Annual Rural Health conferences May 3-6, make time to take in some tunes.

- The Arcade Fire, 2011 Grammy Award winners for album of the year, will be in town at the Backyard at Bee Cave on May 3.
- There are more than 200 live music venues in Austin, and more than 1,900 musicians call the city home. Take a walk down Sixth Street and through the Warehouse District to stumble upon quintessential venues such as the Continental Club or Antone's, as well as newer clubs with live bands every night. Check out austinlivemusic.com to find out who's playing where.
- If you prefer to be the star of the show, the Highball features seven themed karaoke rooms, as well as bowling and live acts. See thehighball.com.



ACVB Photo, Andy Schrader

Off the beaten path



Photo: artofthepictures.blogspot.com

shifting gears

Natural flavor in a pinch

An indoor herb garden is not only a healthy, natural way to flavor your favorite dishes, it also brightens up a room and cleans the air.

Windowsill gardens are especially beneficial if you're crunched for time and space.

Check out these sites to get started:

- indoorherbgarden.org
- easytogrowherbs.com
- herbkits.com

Royal flush: Toilet Seat Art Museum

Located just outside San Antonio, Texas, in the town of Alamo Heights, population **7,353**, is the most unlikely of art museums: the Toilet Seat Art Museum, to be exact. The creative outlet of retired master plumber Barney Smith, the works of art originated in the **1960s** out of convenience – as a plumber, Smith had ready access to damaged toilet seats. Over the last **40** years, the eclectic collection has expanded to comprise more than **700** unique creations, including paintings, collages and mounted deer antlers.

Tell us what puts your town on the map.

E-mail editor@NRHArural.org.



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Arrive May 3 for the Rural Medical Educators Conference and a health information technology workshop.

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