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*Residents of Vinton, Iowa, evacuate their homes following a 2008 flood.*

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## On the cover

*Vinton, Iowa, damage from a 2008 flood.*  
Source: BPUion, Star Press

## 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](mailto:editor@NRHArural.org) or *Rural Roads* editor, NRHA, 521 E. 63<sup>rd</sup> St., Kansas City, Mo., 64110.



## Every bit helps

Nice work on a well-written article about Conrad 30 (winter 2009).

Thank you for bringing attention to important rural access issues and resources from which our communities can benefit. Every bit helps.

Congratulations on a job well done.

*Laura Rowen*  
Idaho State Office of Rural Health and Primary Care

## Certified professional midwives deserve coverage

The winter 2009 article is lovely, and I am looking forward to sending it to family and friends.

I was a bit disappointed that the information in the sidebar only covered certified nurse midwives. While certified nurse midwives are an invaluable asset for the many women who choose hospital birth, only a small portion of the total number of home births in the United States are attended by certified nurse midwives. The majority of home births are attended by certified professional midwives, many of whom, like myself, are licensed by the state they live in to do home deliveries. Currently licensure for out-of-hospital midwives is available in 24 states, with legislation pending in 12 other states. It would have been nice to see information about certified professional midwives included in the sidebar.

Other than that the article is great. Thanks so much for doing it. I really liked the variety of midwives that you interviewed.

*Gretchen Spicer*  
certified professional midwife/ licensed midwife

# Share your story.

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

Contact Lindsey Corey at [editor@NRHArural.org](mailto:editor@NRHArural.org) or 816-756-3140 to share your ideas and experiences.

Editorial suggestions must not be advertisements.



## Coverage isn't access



This issue's timely feature on health workforce underscores another factor to include in our nation's health reform discussion.

Coverage does not equal access. Without appropriately trained, culturally competent health care providers in our rural facilities, we cannot ensure access to quality care.

Where data are available, the numbers are staggering. A December 2008 report from the American Association of Medical Colleges documented 22 state and five national studies showing current or projected physician shortages. Doctors are tracked most vigorously, but the shortages permeate nursing, allied health and behavioral health with equal fervor. The problem is complex, as are the solutions, but NRHA understands where to start. Titles VII and VIII of the Public Health Service Act contain the bulk of our nation's health workforce development programs – and those programs have never been adequately funded.

Applying a gentle crowbar to the Graduate Medical Education funding formulas and residency training slots would do wonders as well. NRHA is not alone in voicing support for these solutions and others.

If you would like to get involved, contact me and join our group on NRHA Connect.

*Beth Landon*

Beth Landon  
NRHA president

pit stop

## 5 things I picked up in this issue:

1. One Iowa nurse needed a boat to get to work. *page 6*
2. More than 500 Arkansas physicians volunteer to help train future doctors. *page 11*
3. Technology can help treat hepatitis C. *page 24*
4. Hays, Kan., kindergartners and hospital staff knitted 300 pink scarves for female patients. *page 28*
5. New London Hospital celebrates Earth Day every day. *page 45*



*Residents of Vinton, Iowa, put out sandbags to stop floodwaters in June 2008.*

## Weathering the storm

### Small hospitals resilient to natural disaster

By Angela Lutz

**As the sun rose the morning after Hurricane Ike devastated Galveston Bay, Texas, in September 2008, Robert Pascasio was shocked to learn how close Bayside Community Hospital had come to flooding.**

“The worst part of the ordeal was when the sun came up, and I saw how close the storm came to the hospital,” says Pascasio, CEO of the 14-bed critical access hospital (CAH) in Anahuac, Texas, at the northeastern edge of the bay. “We had water within a couple feet of the back door. We sit on the shoreline, but we’re about 20 feet above sea level.”

In June 2008, parts of the Midwest were also hit

with extreme flooding. In Marengo, Iowa, Genny Maroc, CEO of Marengo Memorial Hospital, a 25-bed CAH, saw floodwaters rise right up to people’s doors.

“We had a staff member who was brought out of her home by boat,” she says. “She’s one of our dialysis nurses, and despite her own difficulty, she came in to care for patients.”

Last summer’s floods hit eastern Iowa along the Iowa River and central Indiana along the Ohio River the hardest, as well as portions of Michigan, Minnesota, Missouri and Wisconsin.

Hurricane Ike, one of the most destructive hurricanes in U.S. history, caused significant damage to the Gulf Coast, particularly in and around Galveston.

Many of the communities affected by the natural disasters are still trying to recover.

“Nobody really comprehended how massively destructive this storm surge was going to be,” Pascasio says of the 2008 hurricane. “Nobody, not even the Weather Service, knew what to expect. At the end of the day, we wound up being the only hospital in our area that stayed open before, during and after the storm. Some larger facilities closed or flooded. We were it.”

## Staring down the surge

When facing the chaos caused by the floods, Bev Riege, clinic director of Virginia Gay Hospital Clinics and Home Health, a 25-bed CAH in Vinton, Iowa, discovered both the importance and difficulty of successful communication during a disaster, particularly when phone and electrical lines are down.

“We had three blocks that were flooded,” says Riege. “Our electrical plant was right on the river, so it was flooded and destroyed. Most places were without power for five days.”

Riege worked at the emergency operation center to keep hospital staff updated on road closings and different bacteria found in the floodwaters.

“The changes came so quickly about when the water was cresting and what highways were closed that trying to get the word out to everyone was difficult,” Riege remembers. “Without electricity it’s harder to communicate and keep everyone updated on all of the changes.”

Thanks to a backup generator, Virginia Gay was able to remain open and provide tetanus shots and emergency care to the community during the cleanup. They also treated patients from Mercy Hospital in Cedar Rapids, Iowa, one of the areas hit hardest by floods.

At Bayside, Pascasio and staff usually begin preparing for hurricane season in late April or early May, when they fuel the generators and double up on supplies, including drugs and medical and dietary supplies.

“We are capable of going for five days without any support from the outside world,” says Pascasio.

They also organize for a disaster crew of staff who volunteer to do whatever it takes to keep the hospital open and operational.

“I’ve been here for eight years, and staffing the disaster crews was never an issue,” says Pascasio. “They’re the most important resource of all. They’re reimbursed, but when you’re staring down the face of a 25-foot storm surge, I don’t know if there’s any amount of money in the world that’s enough.”

Bayside acquired a new generator following Hurricane Rita in 2005 with a grant from the Texas Office of Rural Community Affairs. They also installed travel trailer connections, which are used to set up disaster-time sleeping quarters for staff. Following Ike, the continued presence of hospital staff was especially important.

“The closest hospitals to us that were open were in Beaumont, 50 miles away,” Pascasio says. “We put the staff on a rotating schedule. They never have to worry about where they will sleep.”

At Marengo Memorial, Maroc and her staff follow the federal disaster response guidelines outlined in the Hospital Incident Command System, which defines everyone’s role when reacting to a disaster. Roles are practiced in drills and defined by colored vests. Luckily, Marengo didn’t need to put the drills to a real-life test.

“Marengo has a levee on the Iowa River, and that protected us,” Maroc says. “If there were a breach in the levee, Marengo would flood. We are very flat. If that were to happen, water would be at least at light-switch level in our rooms.”

“We had a staff member who was brought out of her home by boat. Despite her own difficulty, she came in to care for patients.”

Genny Maroc, Marengo Memorial Hospital CEO

Because of this threat, Marengo staff is prepared to evacuate the hospital with three days’ medical supplies. They are also equipped to respond to take in patients from nearby hospitals.

Despite their preparedness, Maroc realized communication was still problematic, and she learned ways to update staff more effectively in the future.

“One thing I thought we did pretty well but not well enough was indicating on maps which were good alternate routes to take to work,” she explains. “But just sending the maps to the managers wasn’t the best way to communicate. Now we have a communication board where we post disaster-related information in a centralized location. The cooks and housekeepers also need to know.”

After the hurricane, Pascasio is also considering making changes.

“The bad news is we have a 60-year-old institution that’s in need of replacement,” he says. “The good news is it’s built like a bunker. It raised the issue for me that we need to be doing something about relocating this facility. We might be just a little too close to the water.”

*continues*

## No time when need is greater

Responding to the disasters, hospital staffs quickly learned to expect the unexpected.

“We have drills, but during a real-life situation, you recognize things that on a table-top drill, you might never realize,” says Maroc. “Our staff was great. Many of them stayed (at the hospital) if they thought by going home they wouldn’t be able to get back.”

Pascasio was also impressed by the response of his community and staff.

“At the end of the day, it’s the truth of any community hospital: it’s all about the staff,” he

says. “I’m fortunate to have people who man the organization who are committed to the thought process that there’s no time when need is greater than during a disaster such as this.”

Many people lost everything in the hurricane, and in some communities, “literally hundreds of homes were wiped off the face of the earth,” says Pascasio.

**“We are capable of going for five days without any support from the outside world.”** Robert Pascasio, Bayside Community Hospital CEO

“The people who evacuated returned to find they didn’t have a home anymore,” he adds. “It was a staggering site.”

Since transportation to the hospital was largely unavailable immediately following the hurricane, the staff at Bayside visited the remote sites where they usually set up community clinics several times a year to provide services such as flu shots and back-to-school checkups.

“They normally conducted the clinics in volunteer fire departments, but they were all wiped out by the storm,” says Pascasio. “They ended up setting up on the concrete slab that was a church or a fire department. The patients either couldn’t get to us or they couldn’t afford to leave because they were working during the daylight hours to recover what they could. So instead we went to them.”

During the initial rescue efforts, Pascasio recalls the shock he experienced at learning the University of Texas Medical Branch (UTMB) in Galveston had flooded and been forced to close. Bayside took in several patients from Galveston County who normally would have gone to UTMB.

“We wound up getting patients who were washed off the island and were literally fished out of the bay by emergency helicopters,” he explains. “Some of them had what appeared to be burns from being washed through the chemicals out there in the bay.”

Still reeling from the effects of the hurricane, Martha Hargraves, PhD, tenured associate professor at UTMB, is watching the community slowly rebuild. Living and working in Galveston, she describes the damage as “totally devastating.”

### Flooding can cause groundwater contamination.

Many rural residents rely on private wells, and when floodwaters rise above the well’s casing, contaminants from the ground can get in the water, including oil, pesticides, herbicides and bacteria like e-coli.

According to Cliff Treyens, National Groundwater Association public awareness director, a few simple guidelines can help prevent groundwater contamination.

- **Be sure the well is properly located and constructed.** “The ground should not be low-laying and should slope away from the well casing to prevent pooling,” Treyens explains. “Also, most states have codes that specify how far the pipe needs to be out of the ground. It’s usually a foot to 18 inches.”
- **Be sure the well is grouted correctly.** “If your well is improperly grouted, even if the casing is 18 inches high and the flood only five inches high, this can still cause contamination,” says Treyens. “Any water that pools around the base can potentially get into the well.”
- **Maintain the well.** “People shouldn’t disinfect their own wells,” Treyens warns. “They should have a professional do it. Also get the water tested regularly to see if bacteria have turned up, especially if you’ve been in a flood situation.”

To find a qualified water well contractor, visit the National Groundwater Association’s web site at [www.wellowner.org](http://www.wellowner.org).



Three blocks of Vinton, Iowa, flooded in 2008, including the electrical plant.





2008 floods left homes and businesses on the main streets of Vinton, Iowa, partially submerged in water.

## “At the end of the day, it’s the truth of any community hospital: it’s all about the staff.”

Robert Pascasio, Bayside Community Hospital CEO

“To date, there are approximately 8,000 individuals without housing of any kind,” she says. “The city has lost 30 percent of its population of 58,000. All public housing has been deemed unfit to live in.”

Hargraves is concerned about the impact the loss of jobs will have on Galveston’s ability to re-build. According to Hargraves, some institutions are choosing not to re-open, such as the Shriners Children’s Burn Hospital and at least four schools.

“I think the joblessness is going to greatly impact the city’s ability to come back, because jobs are what bring people back,” she says. “Housing will also be a challenge. I’m predicting that a significant number of people can’t come back unless the economic base is re-established.”

As a result of the damage, UTMB was also forced to lay off 3,800 of its 10,000 employees. According to Hargraves, they were the only indigent care provider for nearly 14 counties.

“If you look at Katrina, it’s been three years, and they’re still coming back,” she adds. “I would guess three to five years before the university will really come back to its former capacity.”

### Returning to normal

In Iowa, the community of Vinton is also struggling to return to normal.

“There are still some people who are unable to get back into their homes due to the amount of damage,” Riege says. “They haven’t heard from insurance, FEMA (Federal Emergency Management Agency), all the places they need to hear back from to find out if their house is savable or not.”

In the meantime, Virginia Gay and several area businesses have “partnered to form a coalition to help those still in need of resources,” and they have found them living quarters, Riege says.


The assistance didn’t stop with local groups, either.

“There was a group that came from Vinton, Florida, to help,” Riege recalls. “They were from an area where there was a lot of hurricane damage, and a group from Vinton, Iowa, had helped with their cleanup.”

Many hurricane victims in Anahuac and Galveston, are also still waiting on federal assistance.

“We still have people living in cars and tents,” says Pascasio. “We don’t expect anything for standing up and doing our jobs and supporting the community, but outside support has been slow in coming.”

In spite of this, the willingness of those who live and work in the rural area to support each other continues to be invaluable.

“I’m proud of the way everyone performed,” Pascasio says. “It is one of the true advantages to being in the country like we are.” 

### Helping you plan for a disaster

The Agency for Healthcare Research and Quality (AHRQ) offers several emergency preparedness tools to help hospital staff be ready in the event of a natural or man-made disaster.

The models approximate facility evacuation times based on the number of patients, available transportation and surge capacities of nearby facilities; efforts to locate and track hospital evacuees using electronic records; and how to set up an incident command center and conduct disaster drills.

For more information about AHRQ’s suite of emergency preparedness tools, visit [www.ahrq.gov/prep](http://www.ahrq.gov/prep).



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*Michael Myers*

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# PROJECT+ Pipeline

part one in a three-part series

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*University of New Mexico's BA/MD program recruits state residents primarily from rural areas. These students began the fully funded undergraduate program in 2006 and 2007.*

## From pipeline to practice: College students put down rural roots

By Lindsey V. Corey

Hospital human resources departments and university career centers alone aren't attracting enough graduating health professionals to small towns.

Rural community members need to take responsibility for recruiting students, says Richard Perry, Oklahoma Area Health Education Centers (AHEC) program director.

"These towns have a role and are already providing a lot of community-based health professional training during rotations; they just don't know it," he says. "It's the perfect time to identify students they want to encourage to come back."

*continues*





University of New Mexico's BA/MD program class beginning in 2008.

## Community as campus

He's working with Oklahoma's universities and four rural towns to implement a community campus model to train and recruit students across the state. Students, from optometry to mental health, will spend less time on campus – maybe only two years for a medical student – and then live in the towns where they will complete a variety of clinical experiences while taking classes online.

“If they're in a community for two or three years, they may put down roots and stay and go into practice there,” Perry says. “That's our dream, to keep them in Oklahoma, not just in Tulsa or Oklahoma City.”

But a good clinical experience alone won't woo prospective family medicine doctors and nurse practitioners. The students must have a positive community experience too, he says.

AHECs across the state are spearheading these workforce pipeline efforts. In Enid, where Andy Fosmire leads the Northwest Oklahoma AHEC, the YMCA has offered free passes to students throughout their local rotations. Access for further practice is provided in a shared simulation lab, residents have offered free housing, and businesses are coordinating student gatherings.

Enid, which already has a family residency program, hosts about 400 health care students throughout a year, Perry says.

“So probably 1,000 students per year were going into rural Oklahoma for training, but nobody looked at them as a whole until now,” he says. “Now we can work together to make their learning and recruitment better.”

While some of the academic programs require minimal rural training, Perry says it has been difficult to get higher education institutions on board.

“The honest-to-goodness challenge is to get universities willing to give up a little control to these communities. It's not just one direction. They have to listen,” he says. “Community members are stepping up and saying what they need from the universities, and they've been promised a lot from ivory towers that don't always save them. It's a whole lot of trust on both sides, but it's so important for everyone to really commit to these rural rotations in this model. These communities need people.”

## Caring for all people

Oklahoma isn't alone. While 20 percent of the U.S. population is rural, less than 10 percent of doctors practice in remote areas.

Medical schools in the 1970s through early 1990s held enrollments steady because of an anticipated surplus of physicians. And aging baby boomers, 70 percent living in rural areas, have increased the demand for health care, while those employed in health care are retiring without enough new doctors to replace them.

**“We look beyond their GPA because students from smaller towns may not be as academically educated. It's about their bigger love of medicine and real interest in working in a rural area.”**

*Kathy Kersting, University of New Mexico BA/MD program manager*

“If the United States wants a health care workforce that cares for all people of the U.S., including the 65 percent of the population who live in zip codes with less than 75 physicians, then changes are required,” says physician workforce researcher Robert C. Bowman, MD, A.T. Still School of Osteopathic Medicine professor and founding chair of NRHA's Rural Medical Educators. “If we really want health access and a diverse and distributed health care workforce, AHEC activities can help.”

Mark Mengel, MD, Arkansas AHEC program executive director and the University of Arkansas



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*Reducing healthcare costs. Improving healthcare quality.*

Medical Sciences regional programs vice chancellor, says the state's eight regional AHECs are answering the call.

"We're managing the pipeline from interest to support in training and after," he says. "It's a long process, so we have to be diligent about being everywhere in the pipeline because if we miss one step in the pipeline, we lose people. It's that important."

Arkansas AHECs offer local training for a variety of programs including respiratory therapy, medical technology and dental hygiene.

"We try to plug gaps where we see them in the health professions pipeline," Mengel says.

In 2008, 6,000 health professionals – pharmacists, doctors, nurses, lab technicians and social workers, among others – participated in AHEC-sponsored continuing education opportunities across Arkansas.

And the AHEC network operates six family medicine training programs graduating 42 residents a year. More than half of the family doctors in Arkansas were trained through these programs since 1973, and 54 percent of those physicians practice in rural areas, Mengel says.

"We have a professional recruiter who works with students, residents and AHECs to try to match them with practice opportunities," he says. "We spend a lot of time on the road identifying opportunities in hospitals and practices to try to match them with student interests. We're like a statewide career center."

Graduates of the programs often become clinical faculty, Mengel says. More than 500 physicians volunteer across the state.

"Doctors want to stay involved in the latest technology, and teaching the med students keeps them sharp, which they enjoy," he says. "It also relieves isolation in small towns, and they understand there's a huge need for primary care providers that's worrisome to everyone."

## Partnering to provide

The need is also prevalent in the Southwest. The University of Arizona developed Visionary Interprofessional Health Service Training in Arizona (VIHSTA) near the Mexico border in 1994 and will expand the program to a northern Navajo community this summer.

Undergraduate and graduate students in medicine, pharmacy, nursing and public health can apply to spend five weeks of their summer breaks on the

## Factors associated with high rates of acceptance to medical school:

- Mostly urban and highest income origins
- Asian, European or South American birth or parents
- Born in counties or cities with medical schools
- Major medical center connections in parents or location
- Higher standardized test scores
- Professional parents, private schools or college prep schools
- Younger at medical school admission

## Qualities of students who choose rural and underserved practices:

- Most likely to choose public schools, osteopathic schools, family medicine specialty
- Origins in zip code with fewer than 75 physicians
- Lower levels of social organization in parents and community
- Lower standardized test scores
- Most service-oriented and people-oriented
- Older at medical school admission

## Advice for improvement:

### 1. Increase competitiveness of rural students.

Students must be made aware of all their options for colleges and medical schools, and AHECs need to expand mentoring to rural students who may lack resources and awareness.

### 2. Increase rural training.

Medical students who train in the state where they were raised, those from lower family income levels and those who choose family medicine careers have greater levels of in-state retention. AHECs must work with medical schools and with rural communities to pool resources to increase rural training opportunities at all stages of the health professions pipeline.

### 3. Increase awareness in future leaders.

Students with many advantages are likely to become future health care leaders and must understand the needs of underserved people beyond the confines of major medical center locations.

### 4. Change admission policies.

The substantial shortage of medical professionals requires admission policies expand to consider the 65 percent of students currently left behind. There must be a systematic process of targeting the areas of need.

*Source: Improving the rural and underserved health care workforce in America: the importance of birth origins by Robert Bowman, MD, and Kelly Withy, MD, PhD*



University of Arizona health professions students work in Nogales each summer.

students to learn about the other disciplines prior to working together in the real world for the rest of their careers,” says Marylyn Morris McEwen, PhD, College of Nursing associate professor and VIHSTA’s co-principal investigator. “Many of our students come from urban environments and wouldn’t have a clue about the opportunities or issues in rural environments, particularly rural, border communities, without this partnership.”

Last year, 14 students were selected to live and work in Nogales, where the Southeast Arizona Area Health Education Center identified a needed project (this time on aging), offered a cultural immersion experience and coordinated housing and travel in the rural, frontier county that is 98 percent Hispanic. The AHEC program also provides funding for the participants’ stipends and housing.

And it’s money well spent, according to Gail Emrick, the AHEC’s executive director. Two 2008 participants returned to work at the county’s only hospital, Carondolet Holy Cross Hospital, after graduation.

“This type of integrated approach to learning and workforce development should be encouraged and scaled up. It demonstrates the impact that academic institutions can make when combined with local community partnership,” Emrick says.

Monica Weinheimer lives just a five-minute bike ride from a hospital in Tucson but says the VIHSTA experience reinforced her goal to serve the underserved. She doesn’t mind the hour commute to work as a nurse at Holy Cross in Nogales.

“It gave me an understanding on the ground instead of just reading about it,” she says. “You don’t really understand the need until you spend time here.”

### A new approach

There’s no textbook to capture living in and caring for rural America, but those with rural backgrounds are more prepared to serve small towns and more likely to become service-oriented professionals, Bowman’s

U.S.-Mexico border in Nogales or on a reservation collaborating on a community health project and gaining clinical experience.

“It’s a tremendous amount of work, but a unique opportunity for health professions

research shows.

“Common sense and uncommon dedication have always succeeded,” Bowman says. “Rural-born family physicians are four times more likely to practice in rural areas than the general U.S.-born physician workforce. And graduates practicing family medicine are three times more likely to be in rural locations.”

But medical schools primarily admit students from urban areas.

“Children born, raised and trained in ultimate concentrations of people, physicians, specialists, medical schools and health resources for the first 30 years of life dominate medical school admission and are least likely to be found in practice in rural areas,” Bowman says. “Progressive changes in admission, training and policy have shaped workforce away from those in most need of health care. Until politicians, rural or underserved advocates or experts in workforce and health policy realize these basic facts, there will not be improvement.”

Bowman, who studied 300,000 medical school students who graduated between 1987 and 2000, calls today’s physician distribution frustrating.

**“Medical schools must select students who will ultimately choose to practice in the areas and specialties of greatest need.”**

Robert Bowman, MD, A.T. Still School of Osteopathic Medicine professor and family physician

“The only way to fail to increase rural workforce is to admit ever more exclusive – highest income, most urban origin, highest scoring – students that train in the most exclusive locations and follow exclusive health policy to exclusive careers and locations. This is the current American approach,” he says. “The driving question becomes why aren’t we modifying our medical school recruitment and acceptance practices mindful of this reality? Medical schools must select students who will ultimately choose to practice in the areas and specialties (family medicine and primary care) of greatest need, but this is not currently the case.”

But Bowman says he’s proud to work for a medical school that admits “some of the most normal and least exclusive” students and trains them for three years in community health centers.

The University of New Mexico School of Medicine’s



combined BA/MD program is also working to recruit “normal students.” The program will increase the school’s medicine class by one-third next year when its first class of 25 students who entered the program as freshmen begins med school.

The program, fully funded by the state legislature, sends two full-time recruiters throughout New Mexico to find students who will pay no undergraduate tuition or fees.

“They spend a good part of their time in the rural and smaller towns to try to help prepare students,” says Kathy Kersting, program manager. “We look beyond their GPA because students from smaller towns may not be as academically educated. It’s about their bigger love of medicine and real interest in working in a rural area.”

The program only admits New Mexico residents, two-thirds of them from rural regions. Students shadow rural doctors and work on community health projects between their sophomore and junior years. They also sign a non-binding commitment letter noting their intention to practice in the state after their residency.

## An old success story

For nearly four decades, WWAMI has been at work in the Northwest. The partnership between the University of Washington School of Medicine and the state governments of Wyoming, Alaska, Montana and Idaho does not require students return to practice medicine but has retained many of its graduates.

“This is the only regional medical school in the country, and it was billed as an experiment in the early 1970s,” says Frank Newman, PhD, Montana State University professor emeritus and former WWAMI director. “But it’s been a huge success.”

In 30 years, 61 percent of graduating students have stayed within the five-state area. And over the course of the past 20 years, almost half of WWAMI’s students have pursued primary care careers, which are especially valuable since 35 percent of the WWAMI region’s residents in lives in rural, underserved areas, according to the University of Washington.

Each of the participating states designates a specific number of medical school seats supported through a combination of appropriated state funds and tuition. Wyoming, Alaska, Montana and Idaho students pay the same tuition as Washington residents.


“This has brought equal access to medical school in states that are truly not large enough to have a freestanding medical school on their own,” Newman says.

The WWAMI program emphasizes a decentralized form of medical education. First-year students take basic science courses with university faculty in their home states, and each is assigned a local physician to shadow. The full class is on campus in Seattle for the second year, and students go to any of the participating states for two years of clinical training with full-time and volunteer teachers.

Montana began the Targeted Rural Underserved Track (TRUST) in 2008 to encourage its WWAMI students to complete all their rotations in the state “so they have maximum exposure to health care delivery systems in Montana and to increase the probability they will decide to practice primary care in rural areas of Montana,” explains Newman, who manages TRUST.

Five of Montana’s 20 students annually selected for WWAMI will be admitted through the TRUST program, which will target students from rural and/or disadvantaged backgrounds with a strong commitment to service.

From the beginning, they will be assigned rural physician mentors or physicians serving a federally funded community health clinic, complete online journals and participate in monthly rural seminars. During their entire fourth year, TRUST students will be assigned to a rural or underserved internship. And they are expected to enroll in a primary care residency or one that complements rural health care. Doctors who then choose a health professional shortage area will have access to loan repayments through the Montana Rural Physician Incentive Program.

“We’re waiting on four years of medical school and three years of residency, but we have a tracking program set up to determine if TRUST works and should be duplicated in other states,” Newman says. “We’re optimistic it will improve upon WWAMI’s success and further increase the number of students returning to their home state to practice. It’s about what’s best for the state and its students.” 

## Asked and answered

We asked for post-secondary projects, and universities and AHECs across the country answered.

Several rural workforce pipeline programs are highlighted here, but there simply isn’t enough space to share all the success. Please visit NRHA Connect at [connect.NRHA Rural.org](http://connect.NRHA Rural.org) to continue the discussion online.

Look for high school health professions programs to be featured in the summer *Rural Roads*. And send information on innovative projects aimed at rural elementary and middle school students to [editor@NRHARural.org](mailto:editor@NRHARural.org) by June 1.

## Quorum Health Resources helps hospitals achieve financial success

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Following QHR's advice, the hospital team built an ambulatory surgery center in collaboration with Gritman's surgeons.

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"QHR is a good foundation for us. We're a small rural hospital and don't have the resources to go it alone. When we get an idea, someone will say, 'Let's run it by QHR. They've been there and done that,'" says B.J. Swanson, board chair.

"The resources QHR offers are not available in any other model that I've seen, from strategic and facility planning to consulting projects like billing, coding, compliance, mock JCAHO surveys. Even isolated out here, I can always get the help I need," says Martin.

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## Technology brings classroom to rural nurses

By Lindsey V. Corey



*Angela Norman, University of Arkansas for Medical Sciences Faculty Clinic director of nursing education, teaches master's-level student Stephanie Salvitti.*

As soon as dinner is off the kitchen table at the Williams' home in Norlina, N.C., laptops replace it.

The kids are doing homework, and mom is attending class.

Rita Williams is one of thousands of rural health professionals across the country working full-time while advancing her nursing career through distance education.

"And I'm doing it in my pajamas," she laughs. "We live out in the boondocks, so otherwise I'd have to drive an hour and a half, sit in a classroom for three hours and never see my kids. For me, online is the only way."

Williams, a long-time registered nurse at Maria Parham Medical Center in Henderson, N.C., was awarded a full scholarship to complete American Sentinel University's bachelor's of science in nursing (BSN) program.

"I want to be a great role model for my children, but it seems so hard to accomplish the things I am preaching at them... stay in school, set goals and reach them," she says. "I couldn't take what little extra money I have for my education because I need to put it toward theirs."

The online university's Project Working Mom scholarship will enable Williams to pay it forward at the 102-bed hospital.

She says she'll never forget the Maria Parham nurse who helped wash glass out of her hair after an accident 18 years ago. She's the reason Williams is a nurse today.

"I've done some nursing supervision at the hospital, but with this degree I'll be able to do more so I can influence younger nurses coming in and teach them to be caring too," she says. "There's a real need for more people who put compassion into their care."

### An educational foundation

To help meet that need in other rural areas, the Health Resources and Services Administration (HRSA) recently awarded a three-year \$1.75 million grant to the University of Missouri-Kansas City's (UMKC) School of Nursing to implement its RN-BSN Rural Nursing Initiative (RNI).

The program targets rural associate-degree and diploma nurses in rural communities in Arkansas, Idaho, Kansas, Louisiana, Missouri, Montana, Nebraska, Oklahoma, South Dakota, Texas and Wyoming.

Of the estimated 413,000 practicing nurses in these areas, 63 percent lack bachelor's level preparation, according to HRSA research.

RNI's curriculum is tailored to rural health needs and includes instruction on implementing community-based projects.

"Offering these nurses a baccalaureate degree will allow them to deliver the comprehensive spectrum of nursing services urgently needed in rural communities," says Anita Skarbek, UMKC clinical instructor. "It also provides them an educational foundation for eventual participation in nursing instruction, research or advanced practice."

Funding for the program includes a recruitment campaign designed to enroll rural nurses with the hope that they will continue to practice in their communities. RNI students will receive a laptop equipped with the required software and 24-hour technical support so nurses in remote locations can work with others around the country in a live, online classroom.

Thirteen nursing students in southern Arkansas are working toward their BSN and master's of nursing science degrees through an interactive video program, primarily recorded at the University of Arkansas for Medical Sciences (UAMS) main campus in Little Rock and broadcast at the South Arkansas Area Health Education Center (AHEC) in El Dorado.

Since she began a year ago, Angela Norman, UAMS Faculty Clinic director of nursing education, has increased enrollment by 11 students. The acute care nurse practitioner was a student in the same distance learning programs she now recruits for and teaches.

"We're all about growing our own, and here I am able to give back like the people who educated me," she says.

Norman, who was born in El Dorado and has worked in health care there for 19 years, initially reached out to area nurses she knew could take on a leadership role.



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“I serve as a cheerleader,” she says. “I can relate to them because I was a working mom when I did it, which proves it’s possible. I feel their pain and struggles with schedules, but I strongly believe the more higher prepared nurses we have, the more our community will benefit. It’s easy for me to sell because I really believe these programs will enhance the quality of care they deliver.”

The students also shadow Norman locally for clinical practice and all work at hospitals that provide full tuition reimbursement in exchange for them continuing their employment for at least one year after program completion.

## Reaching out to rural

Most students in Washington’s new Rural Outreach Nursing Education (RONE) project receive loan repayment tuition reimbursement for committing to their workplaces.

Ron O’Halloran, administrator at Ferry County Memorial Hospital in Republic, Wash., says it’s well worth the \$40,000 investment over a two-year period to have his certified nurse assistants become registered nurses. When Ferry County staff sign up, they’re committing to a minimum of five years at the 25-bed facility: one while they study to become an LPN, another during RN classes and three years after graduation to “repay” the loan.

“I’ve been involved in rural health for a number of years, and no region had any fewer problems with nursing recruitment than any other,” he says. “When I came to Republic, we put together a group of people to ask how we could reach rural people who wish to become nurses but can’t leave their communities to attend urban-based campuses. I saw RN-BSN programs online but no associate’s degrees and wondered why we couldn’t train our nurses earlier this way too.”

Republic is 130 miles from the nearest university with nursing programs at every level, and there’s a long waiting list.

“We needed a way to help individuals advance their careers from home where their families are intact and give us a larger pool of candidates,” he says. “We’ve been more fortunate than a lot of rural hospitals because we haven’t had to use too many traveling nurses, but it’s an ever-looming possibility because we’re right at the edge all time.”

O’Halloran took his wish list to the Western Washington AHEC, where assistant director Jodi Palmer secured funding from the state’s office of rural health that helped form a statewide steering committee about two years ago.

“There aren’t enough nurses or advanced nurses and not enough people to educate them, so we have to adapt,” Palmer says. “It’s so difficult to get into the limited nursing programs, and this expands the education without

building new bricks and mortar.”

Lower Columbia College, a community college in Longview, Wash., already offering online nursing education in its a small region, wanted to help, but the team had to get around a state mandate that required community colleges limit program offerings to their assigned districts.

“Luckily, the community college presidents were supportive of e-learning, and we got their buy-in,” Palmer says.


Approval was also needed from the Washington Nursing Commission, which unanimously endorsed the program. And RONE kicked off in January with 12 students based out of four rural hospitals. Each of the participating hospitals must provide a clinical preceptor for 10 hours a week to train the local students.

**“It’s so difficult to get into the limited nursing programs, and this expands the education without building new bricks and mortar.”**

Jodi Palmer, Western Washington Area Health Education Center assistant director

“Those clinical faculty, who have a bachelor’s in nursing and RONE program orientation, teach them the hands-on skills and use traveling simulators to practice on, so they get no fewer clinical hours than the students on campus, and their eyes are a little more open because they’re already working in a facility,” Palmer says. “In a traditional program, usually a faculty member at the college is assigned 10 students, so in this case the clinical experience is richer because there are fewer students.”

Palmer is already recruiting students and additional facilities to begin the program in 2010.

“We hope to expand to high school students and other small-town residents interested, and we’re working with community and migrant health centers, which have medical assistants – rather than nursing assistants – with a unique set of skills that we don’t want to exclude,” Palmer says. “We’re trying to bridge the learning gap and open it up to a broader group. There’s a lot of need out there, and luckily a lot of interest.” 



*Potential students meet with Dartmouth Medical School's admissions director as part of the school's Medical Student for a Day program.*

## A day in the life at Dartmouth Medical school hosts potential students

By Lindsey V. Corey

Growing up in New Hampshire, Jean Troiano always knew about Dartmouth University.

But the ivory towers were a little intimidating for the small-town girl.

That changed when she participated in Dartmouth's Medical Student for a Day program last semester.

"It was awesome, very eye-opening," Troiano, 19, says.

The Keene State University sophomore was one of 16 undergraduate students who attended hematology class, toured the hospital and medical school and met with medical students as part of Dartmouth Rural Health Programs' twice-annual effort to reach out to colleges across the state.

"We want to give students an inside look at the

realities of med school and demystify Dartmouth as a prestigious place," says Cathy Morrow, MD, pre-doctoral director in Dartmouth's department of community and family medicine. "It's about putting a human face on this place so they realize they can come here too if they work hard."

Prior to spending the day on the Hanover campus, Troiano was considering transferring colleges because Keene State doesn't offer a pre-med major. She originally went for its athletic training program before deciding she wanted to become a doctor.

"I was scared that not having the right degree on my application would keep me from getting into med school, but then I sat next to a Dartmouth med student who told me she had her undergrad degree in French," Troiano says. "It was such a relief because I know I'm getting a good education and am happy where I am."

Chris Chabot, PhD, Plymouth State University professor of neurobiology,

physiology and behavior, also sends interested students to participate in Dartmouth's free Medical Student for a Day program. He advises Plymouth's pre-med majors.

"This is a reality check for them. Even though we talk about what they need to do, somehow this day-long experience hits home a little better," he says. "Some have been scared off and realize they really need to get their ducks in a row, which isn't a bad thing. Usually, they come back with a renewed excitement and sense of confidence."

That makes Chabot's job a little easier.

"I see a lot of really bright students who don't think they have a chance in hell of getting into med school," he says. "They're afraid to shoot too high, and no one's ever told them they could. We try here. This program helps."

Morrow says participant surveys show the informal lunch with Dartmouth's Rural Health Scholars was most appreciated.

"Getting to know our students keeps their interest alive and promotes the belief that they can do this because we open the doors and show them our students aren't so different from them," she says.

Throughout the day, prospective medical school students from across New Hampshire also meet with Dartmouth Medical School's admissions director, financial aid director and medical education dean. They learn about loan repayment programs and the National Health Service Corps.

The Ivy League university houses the state's only medical school, and while Dartmouth is private, it has a long-standing partnership with the New Hampshire State Office of Rural Health, which helped develop and has



Jean Troiano



Potential students attend class with current Dartmouth Medical School students.

funded the Rural Health Scholars enrichment program for 12 years. Since 2004, the Medical Student for a Day event has been hosted by the rural scholars, who applied and were selected to participate in the program for four years.

"We're in a different situation with no direct responsibility of the medical school to the state, so this is a relationship forged over time that we think is important in both directions," Morrow says. "The med school should be linked to the state's rural health interests, and even as a private institution, we still have to be responsible for the state we reside in."

**"Med school is not for everybody, but we like to think we encourage those destined to be doctors."**

Cathy Morrow, MD, Dartmouth Medical School department of community and family medicine pre-doctoral director


Morrow, a family practitioner, is especially concerned with the decline of student interest in primary care.

"We have to counterbalance the specialty school thinking and help people appreciate that primary care is a rewarding way to practice and desperately needed all over the country in rural and underserved areas," she says. "We know that if you come from a rural area, like many of the kids who joined us for the Medical School for a Day program, you're more likely to return to that kind of area to practice."

Troiano hails from Campton, N.H., population 2,900.

"I'm scared of big cities, so I see myself helping people in a rural place, definitely," she says.

Morrow says the day at Dartmouth has led to important connections for the school, students and state.

"Med school is not for everybody, but we like to think we encourage those destined to be doctors," she says. 

## Statewide telemedicine network educates doctors

By Angela Lutz



*Experts at the University of New Mexico Health Sciences Center use Project ECHO technology to reach rural doctors across the state.*

Every Wednesday afternoon at the University of New Mexico in Albuquerque, rural doctors from across the state meet to discuss the progress of their hepatitis C patients. One by one, they present their cases, most of which include barriers to care — poverty, isolation, lack of insurance or transportation, addiction, obesity.

Though many of the doctors live and work hundreds of miles apart, with telemedicine technology, they can attend the meetings without leaving their offices.

Presiding over the meetings is Sanjeev Arora, MD, professor of medicine at the University of New Mexico Health Sciences Center and director of Project Extension for Community Healthcare Outcomes (ECHO). Along with his team of experts, Arora has revolutionized the treatment of complex, chronic diseases such as hepatitis C by connecting doctors in remote locations to the knowledge of specialists through

weekly conference calls.

“When the rural doctors present their patients to the experts at the university, it creates a case-based learning loop; they learn from the experts and from each other,” explains Arora. “They slowly become experts. It allows tasks that could previously only be done by a few people to be done by many.”

### Leveraging resources

It made sense to begin Project ECHO’s first program to treat hepatitis C in New Mexico. Of the four million Americans with hepatitis C, 30,000 live in New Mexico, including 2,000 prisoners. Arora ran the state’s only



dedicated hepatitis C clinic, and the number of patients who needed to see him exceeded capacity. There was an eight-month wait to get in, and patients were driving there from five hours away.

“For many (patients), having to drive to Santa Fe or Albuquerque once a month was too much,” says Leslie Hayes, MD, family practice physician at the Health Centers of Northern New Mexico in Espanola. “Up until Project ECHO came along, all I could offer most of them was some general health advice and vaccinations against hepatitis A and B.”

In Albuquerque, Arora would begin the treatment, and then patients would need to return monthly for 12 to 15 months. For patients lacking reliable transportation or insurance, this was often difficult.

“Hepatitis C can kill through cirrhosis or liver cancer, and many people were dying unnecessarily,” Arora says. “We had to figure out a way to multiply the resources available through the university so patients in rural areas and prisons could get care in their home locations.”

It was out of this need that Project ECHO was born in 2004. By using telemedicine technology to leverage the health care resources available through the university, rural doctors have been able to “provide care for underserved populations that would normally not have access to treatment,” says Arora.

“We’ve been able to show that with this model of technology and best practice protocol, we can provide the same level of care in rural areas and prisons as at the university hepatitis C clinic,” he adds.

Between 40 to 80 percent of hepatitis C cases are curable, but patients must adhere to strict treatment regimens. Since many hepatitis C patients are also facing additional health problems such as depression, obesity and substance abuse, improved access to care is even more vital, as treatment often includes facilitating a lifestyle change, Arora explains.

During a weekly conference call, many doctors present patients who are struggling to quit drinking.

One patient has been hospitalized several times with pneumonia, cirrhosis and severe gastrointestinal bleeds. He has recently decreased his alcohol consumption from 30 beers per day to three, and he’s also working to get his diabetes and smoking under control. He lives in a rural, hard-to-access area, but thanks to Project ECHO, he is able to check in to an area facility for treatment every seven to 10 days.

In this particular case, Arora insists the patient must quit drinking immediately.

“Would he consider going to rehab?” Arora asks. “Even with serious consequences, he continues to drink. This means his behavior is very deeply ingrained, and he cannot stop on his own. His only chance of survival is going to an inpatient clinic.”

“Often physicians have a high need for learning, and in a rural area they don’t have too many peers or teachers. They can get frustrated and isolated.”

Sanjeev Arora, MD, Project Extension for Community Healthcare Outcomes director

Another patient has a similar history, including depression and more than 30 years of heavy drinking and smoking. Arora is as concerned with his psychiatric symptoms as his physical ones.

“He has to treat his depression,” Arora says. “He has to open that door himself. He needs a will to live to help us solve this problem.”

Another doctor discusses a patient struggling with obesity, and yet another who has recently relapsed into

*continues*

### Project ECHO has clinics to treat the following:

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- Chronic pain
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- High risk pregnancy
- HIV/AIDS
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- Psychotherapy
- Pulmonary
- Rheumatology

For more information, visit [echo.unm.edu](http://echo.unm.edu).

*continued*

heroin addiction.

Because so many hepatitis C cases are compounded by other health problems, regular appointments with physicians are vital, and patients are more likely to keep their appointments when they can receive care close to home.

**“If you partner effectively, you can make a major impact at solving the problem.”**

Sanjeev Arora, MD, Project Extension for Community Healthcare Outcomes director

“Being able to offer treatment locally has been wonderful,” says Hayes. “Currently we have 10 patients on treatment with an eleventh who just completed treatment, having successfully cleared the virus. The project gives patients two strong incentives to give up their alcohol or drug use: it gives them hope, and it gives them someone, a health care provider, who cares for them.”

“Patients are very grateful because they are getting care without having to travel and irrespective of their ability to pay,” Arora adds. “Everyone can see an expert in their own area within a couple of weeks, be evaluated and begin treatment. Many have been cured, and many lives have been changed in that way.”

### Expansion of the extension

In New Mexico, 21 clinics are now using Project ECHO to treat hepatitis C, as well as 11 other complex chronic diseases and conditions. The total number of

programs exceeds 130.

The project model has caught on not only because of the innovative way it uses resources to treat patients, but because of its educational benefits to physicians and the constant learning that takes place during the weekly calls.

“Many providers have told us that leaders at federally qualified health centers, our primary customers, are having improved retention,” says Arora. “Often physicians have a high need for learning, and in a rural area they don’t have too many peers or teachers. They can get frustrated and isolated. This relieves that.”


In Espanola, Hayes has learned a “huge amount” about hepatitis C, a disease she sees every day, through Project ECHO.

“I feel a sense of pride that I am actually at the forefront of knowledge about hepatitis C,” she says.

And the technology is inexpensive to implement. A videoconferencing camera can be installed for approximately \$4,000 and can be shared by multiple doctors utilizing the program to treat different diseases. If an individual provider wants to join and has more limited funds, a typical webcam costs \$150.

In the future, Arora hopes to expand the project so “every area in New Mexico has access to the model.”

He also plans to implement the model in other states, starting with Washington, and to eventually use it to improve health care in developing countries.

“The most important thing I’ve learned is the value of partnerships and collaborations,” Arora says. “Even if you have an extraordinarily complex problem like improving access to specialty care for rural areas and prisons, if you partner effectively, you can make a major impact at solving the problem.” 

Discover how the Project ECHO model can work in your community.

Don’t miss Sanjeev Arora’s keynote address at NRHA’s 32<sup>nd</sup> Annual Rural Health Conference May 6 in Miami Beach, Fla.

For more information, visit [www.RuralHealthWeb.org/annual](http://www.RuralHealthWeb.org/annual).

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# Employee, patient satisfaction off the charts at Kansas hospital

By Angela Lutz

When it comes to employee and patient satisfaction, the staff at Hays Medical Center (HMC) in Hays, Kan., knows a thing or two. The proof is in the numbers.

“Probably the greatest measure of the impact we’ve seen during our focus on improving employee satisfaction and culture is in satisfaction numbers,” says Jodi Schmidt, vice president and chief development officer at HMC. “As of our last employee survey, 97 percent of people said this is a great place to work.”

HMC’s high satisfaction rating is more than a decade in the making. A similar survey conducted 13 years ago found approximately 25 percent of employees rated HMC as a great place to work. That’s when Schmidt and other leaders decided to make some changes.

“We set an overriding, organization-wide goal to be the best tertiary care facility in rural America,” Schmidt says. “It has to do with width and breadth of services.”

To increase services at the 192-bed facility, HMC staff worked closely with the late Michael DeBakey,

considered the “father of open heart surgery,” to create the DeBakey Heart Institute, which provides the most extensive cardiovascular care available in western Kansas. HMC also provides women’s health, surgical, orthopedic and cancer services and coordinates care with 22 critical access hospitals as a supporting hospital.

**“Rural facilities have all the issues of larger health care systems; they just have fewer people to deal with them.”**

Jodi Schmidt, Hays Medical Center vice president and chief development officer

To boost the morale of HMC’s 1,200 employees, staff leaders worked toward establishing what Schmidt calls a family atmosphere.

“One of the key pieces has been open communication,” she says. “We try to be open and accessible in terms of our management team. We’re forced to make tough administrative decisions, but we try to think of the impact on our people, and we share with them the reasons for the decisions. It engenders trust and openness.”

Teamwork is also a large part of the culture at HMC, and staff is encouraged to work together to improve issues in their specific departments. They also conduct weekly motivational “huddles” on each unit, and all staff members attend yearly culture training sessions.

“We see amazing things come out of letting people be a part of outlining ways to improve,” Schmidt says. “People take a lot of pride in their work.”

According to Schmidt, the nature of smaller, rural communities engenders a special sense of pride and purpose in hospital employees, as their patients are also their friends, neighbors and relatives.

“A few years ago when we wanted to invigorate our focus, we asked for a slogan to help all of us remember that it could be someone near and dear to us that we care for,” she explains. “We came up with ‘We do important work for important people.’”

Because of the staff’s personal ties to their patients, initiating special events connecting the hospital to the community seemed natural. One such event was the “pink scarf project,” which worked to provide a pink scarf to each of the hospital’s female cancer patients. Many employees knitted and crocheted scarves, as did community members and even local elementary school students.

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Lehigh Valley Hospital and Health Network  
Allentown, Pa.





*Hays Medical Center in Hays, Kan., is in the 90<sup>th</sup> percentile of its peer group for patient satisfaction scores.*

“I broke out my knitting needles; I hadn’t used them since I was 18, and that was a really long time ago,” Schmidt laughs. “We needed 170 scarves, and we ended up with 300. It makes people feel good about the work they do.”

And, as Schmidt has found, employee contentment translates into patient satisfaction. HMC’s patient satisfaction numbers are in the 90<sup>th</sup> percentile of their peer group, and they have received several quality awards, including making the inaugural list of the 100 best places to work in health care in *Modern Healthcare* magazine in 2008.


Though HMC staff has certainly taken some big steps forward over the last decade, Schmidt says it’s a constant work in progress.

“We want to continue down the same path in terms of making employee satisfaction a priority, and we set goals each year around those opportunities for improvement,” she says. “We continue to challenge ourselves to do better.”

Despite the workforce shortages facing rural hospitals, Schmidt is convinced HMC can stay on the leading edge, especially since “we have a successful retention rate once we get (physicians) here,” she says.

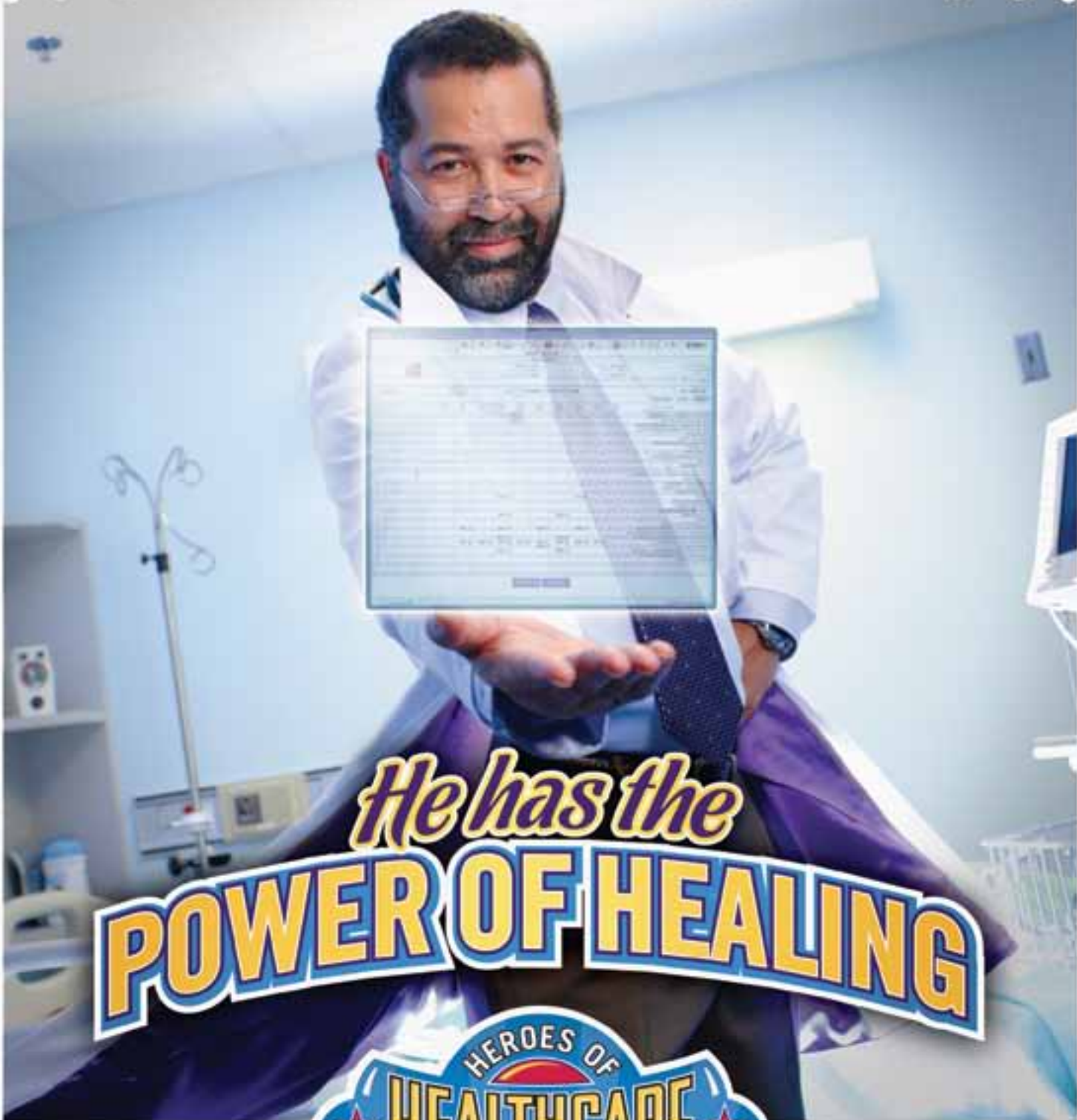
“Rural facilities have all the issues of larger health care systems; they just have fewer people to deal with them,” she adds.

HMC is currently working to add spinal, plastic and reconstructive surgeries to their services. As they continue to grow, Schmidt stays focused on “the key core elements.”

“We start with our employee satisfaction, which leads to patient satisfaction, which leads to financial success, which will allow us to improve and bring new services to our community,” she says. 



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# Beginnings & Passages



Drew Varland

I was struck with a strong sense of community and purpose.

## The change I needed By Drew Varland

I needed a change when I left the busy, 52-bed emergency department of a major medical center in Denver, which I'd managed for several years. I wanted a stronger sense of purpose in a small-town environment, so I accepted the position of chief nursing officer at Pioneers Medical Center in Meeker, Colo., population 2,500.

Meeker is a historic rural community with a picturesque mountain setting. It is a mecca for people who enjoy the outdoors. The friendliness of the community was evident during my first visit. Whether you are walking or driving, everyone waves a greeting. If you have a question or need assistance, people are more than happy to oblige. The pride and sense of community is strong.

Pioneers Medical Center has everything under one roof: outpatient health clinic; 15-bed critical-access hospital; ER; and 33-bed long-term care facility.

We provide the community's health care needs. Our patients are our families, friends and neighbors. The skill level of our clinical staff and providers belies the stereotype of a small-town setting. These people are knowledgeable and caring, with top-notch skills and expertise.

The biggest challenge I've encountered is limited resources. However, that challenge also leads to the biggest rewards that manifest themselves through teamwork, ingenuity and "must-do" attitudes.

Staff and physicians wear many hats to get the job done. I have seen the CEO shoveling snow during a blizzard, observed maintenance and housekeeping staff interacting with patients and families during a crisis and even physicians helping move equipment and furniture to make the facility more efficient. I like that!

During my first winter in Meeker, a gentleman presented to our ER with chest pain. He was diagnosed with a heart attack and needed a hospital with a cardiologist and catheterization lab. We could not get a helicopter or airplane in for transport due to a winter storm and decided the patient would be transported by ground ambulance.

I was on call that night and came in to accompany the patient and two EMS volunteers. The usual 90-minute drive took almost three hours because of the storm. The patient did fine, and as we headed back to Meeker, I was struck with a strong sense of community and purpose. I had found the change I needed.

*Drew Varland, RN, has been the chief nursing officer for Pioneers Medical Center in Meeker, Colo., since 2005.*

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



Innovative rookies and seasoned professionals share their experiences.

Rural health care is founded on being part of a bigger whole that surrounds you everywhere you go.



Mari Hunter

## Hooked on rural health By Mari Hunter

Have you ever tried to describe why you love your favorite food or a particular book or movie? You can feel it, taste it, smell it, remember the strength of the emotion, yet how to send those feelings clearly to another person eludes you. Rural health care is often similar to this: a complicated, strong emotion hard to succinctly describe.

Life and work in a rural area means you will learn not only your patients' names and problems, but their whole families. You see each and every one of them in all phases of their lives. You transition through these multifaceted steps with them, individually and often as a group. A mosaic of the community character, history and dynamic unfolds rapidly. It is often fascinating and adds a depth to family practice that is not frequently reached in more urban and anonymous settings.

You live with your patients: you use the same electric company, shop at the same grocery and attend the same school sports. This is humbling, making you more centered on the needs of your patients and your community.

You understand their dilemmas on a personal level. It is different out here; there are fewer options, fewer resources, more difficult decisions about which cares are truly needed

and which make us as health care professionals feel better while not truly improving the patients' health or quality of life.

Rural work also makes you more self-reliant: you will deal with pregnancy, hyperlipidemia, Alzheimer's, childhood vaccinations, broken bones and cancer all in one morning, without a local consultation or quick referral options.

But there will be the team: the nurse who works nights and moonlights in hospice to help you decide what to do for the terminal, demented patient scaring his family. Or the ward clerk who worked for 20 years at the Medicaid office and knows who to call at 2 a.m. for help with a family involved in an accident who have lost all their possessions and money. The list is endless and will always make you proud of what a little facility can accomplish.

Rural health care is founded on being part of a bigger whole that surrounds you everywhere you go. Its presence in your life, no matter how respectful, may not be for everyone. Though once you are hooked you may never be able to leave.

*Mari Hunter, DNP, has served as a family practice physician and emergency room provider for the Ferry County Public Hospital District in Republic, Wash., for a year. She has worked in rural health for 18 years.*

## Advice from our experts

### What are some changes facing Medicare, and where can I find resources to help navigate the changes?

The U.S. health care system is changing, and the Centers for Medicare & Medicaid Services (CMS) and its beneficiaries and providers – including those of you in rural areas – will likely be right in the middle. In past years, Congress mandated more than a few changes affecting rural areas. Here's a sampling:

- The Medicare Improvements to Patients and Providers Act, enacted last year, enhanced telehealth services that support rural health. It also extended transitional outpatient payments to rural hospitals with 100 beds or fewer and sole community hospitals. Last year's outpatient payment rule included a related change, a 3.9 percent increase in total payments to rural hospitals. CMS will also maintain 2008's 7.1 percent payment increase to sole community hospitals.
- The Tax Relief and Health Care Act brought us the Recovery Audit Contractor (RAC) program in 2006. The program was first tested with six states. The demonstration returned \$38 million to providers who were underpaid and restored \$900 million to the trust fund when Medicare paid too much. RAC will be implemented nationwide by the end of 2009.
- The Medicare Modernization Act from 2003 required CMS to move from fiscal intermediaries (Part A) and carriers (Part B) to a single point of payment by 2011, the Medicare Administrative Contractors (MACs). CMS is ahead of schedule. All 15 MACs have been announced, and six are processing claims.

Meanwhile, CMS is changing the payment system so we are paying for quality health care, not just services. The goal – better care at lower cost – depends on measuring quality objectively and rewarding providers for high-quality care. It depends on transparency, such as publicly reporting provider performance through Medicare's Compare web sites, so patients have information to make decisions about their own health. It also depends on 21<sup>st</sup> century communication, such as demonstration projects that encourage electronic health records, personal health records, incentives for electronic prescribing, and using the my.medicare.gov personalized web site.

CMS wants to provide you with resources that will keep you up to date, and we want your feedback.

- Participate in our regularly scheduled Open Door Forum calls for rural providers;
- get to know your regional offices' rural health coordinator, who can be contacted through our web site;
- consult our *Innovator's Guide to Navigating CMS* ([www.cms.hhs.gov/CouncilonTechInnov](http://www.cms.hhs.gov/CouncilonTechInnov)); and
- check out our sites [www.cms.hhs.gov](http://www.cms.hhs.gov) and [www.medicare.gov](http://www.medicare.gov).

*John T. Hammarlund is a CMS regional administrator in Chicago and Seattle.*

### During this recession, how can our facility save money without sacrificing service?

Like other small community health systems, Fort HealthCare has felt the impacts of the rocky economy.

Our approaches to find cost savings opportunities have centered around communication with our employees. We continue to work with them to flex our organization to the volumes we are experiencing.

In addition, a mid-level management team reviews all vacated positions seeking opportunities to do things differently.

Our staff members also help us review our supply costs by doing introverted looks into the supplies that each department utilizes and searching for either reduction in utilization or more cost-effective alternatives. They also do a review with our materials management department to make sure we are getting the best prices on the products we must purchase.

Our simple suggestion is to engage your employee base, as they often have the best grasp around where opportunities exist.

*James J. Nelson is senior vice president for finance and strategic development at Fort HealthCare Inc. in Fort Atkinson, Wis.*

## How can our staff help reduce patient stress and expenses to ensure they can continue to afford visits and medications?

Providers need to educate and empower their patients by creating an open line of communication. You need to know if a patient is about to lose their job, and establishing an open line of communication will help them be honest and upfront.

In return, you and your staff need to be upfront with them. Provide an itemized bill at the hospital or clinic appointment and ask them to look it over before they leave. This takes a little time upfront, but it prevents wasting time and paper backtracking later. It also may help prevent costly lawsuits.

I encourage all hospitals to have patient advocates. They can make all the difference in a stressful situation, like the one who helped guide me with my husband's

recent cardiac arrest. The last thing you want is a patient to walk out that door feeling like they need to fight your hospital over the bill.

If you can't afford to have a patient advocate on staff, be sure your doctors and staff are proactive advocates for your clients.

Give out-of-work patients free prescription samples when you can, or advise them to check online for discounted drugs from reputable sites. Suggest health care savings accounts if area layoffs appear eminent. Discuss payment plan options before they leave. When pharmaceutical reps come in pushing their drugs, ask them about patient assistance programs, and help with forms to make sure your patients qualify.

It all comes back to communication.



*Michelle Katz has written two books on saving money in health care and has appeared on NBC's Today Show, CBS Evening News and Oprah and Friends Radio. The health care consultant will speak on May 7 at NRHA's 32<sup>nd</sup> Annual Rural Health Conference in Miami Beach, Fla.*

## Need advice?

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

# journneys

My biggest challenge...

## Recruiting dental professionals where there aren't any



The biggest challenge the Southeast Health on Wheels (SHOW) Mobile Program faces today is the inability to find and recruit dental care providers.

Our program is designed to provide primary health and dental care, health literacy and educational programs to the residents of the Missouri boot heel, a rural, economically depressed region of southeast Missouri with critical health and dental care needs. The SHOW Mobile's target service area is the 10th poorest congressional district in the nation. No one is denied service regardless of their ability to pay.

Our 38-foot mobile "whole health" facility with specially designed medical and dental operatories was purchased with federally designated funds in 2006.

Cape Girardeau's Southeast Missouri Hospital partners with Southeast Missouri State University (SMSU) to provide the health care providers who staff the SHOW Mobile. The program offers medical care to four communities a week. Ideally, we would be able to provide dental care in each of those rural towns during those weekly visits.

The SHOW Mobile is also designed to offer university students experiential learning opportunities with rural underserved populations. But Missouri's only dental school is on the opposite side of the state, which means we can't use dental students for rotations, and our area has a severe shortage of practicing dentists.

The few dental providers in the region are too busy to give up even a day a month to care for SHOW Mobile patients, and they wouldn't be reimbursed for their time because Missouri Medicaid does not cover adult dental care.

To meet the objectives of the program, as well as to meet the critical oral health needs of our neighbors, it is essential for us to provide dental services. Unfortunately, this has been impossible so far despite our

exhaustive efforts.

It is well documented that the lack of dental health services is a significant contributor to the health disparities in southeast Missouri. The entire region is a designated dental health care provider shortage area, so many of our residents have little or no access to dental care services.

This is the biggest challenge I have today. It's something that I can't just leave at the office. Wherever I go, it's always there. I'm always hoping I'll run into someone with an innovative solution to our problem, someone who can help us help these patients.

*Sandy Ortiz is program director of SHOW Mobile in Cape Girardeau, Mo.*

## Overcoming insurance, transportation and recruitment barriers

Under or uninsured populations see a doctor less and much later than those with insurance due to their financial restraints. And by the time they do see a doctor, their illness is much worse than someone who can afford to see a doctor earlier for the same condition.

They are often unaware of resources or options available to them, and cultural barriers create a gap in communication between health professionals, agencies and the clients they serve.

Transportation is also a barrier. Many of the smaller minority-serving agencies are not aware of nonprofit discounts for transportation bus passes. Also, there are sometimes stipulations as to who can receive them or a required number of clients for the agencies. This puts the smaller minority-serving agencies at a disadvantage when they are already dealing with limited budgets. So clients become out of care due to the task of arranging transportation.

Recruitment and retention of not only clients but staff remains a problem. Many nonprofits, specifically in the Austin-Travis County area, do not have a reflection of the clients they serve or any required training or workshops for the staff to better educate themselves on the clients they serve.

*Margaret Haule is founder and director of Minority Health Outreach in Austin, Texas.*





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Todd and Ryma Biederman on vacation with their children Meg and Jake

## 5 things you should know about NRHA member Todd Biederman

- **He is president of Blackhawk Healthcare.**

Since 2003, Blackhawk Healthcare, based in Austin, Texas, has been an owner and operator of small community and critical access hospitals. They own two critical access hospitals, Richards Memorial Hospital in Rockdale, Texas, and Mangum Community Hospital in Mangum, Okla.

When hospitals need assistance, they contact the team at Blackhawk, who will then lease the hospital buildings and purchase the operations. They also provide resources to purchase equipment and recruit providers.

“If a community were to lose its hospital, it would reduce access to patient care and could be devastating to the local economy,” Biederman says.

- **The most challenging part of his job is getting help to everyone who needs it.**

“Right now, there are so many struggling rural hospitals that need our assistance,” says Biederman. “It’s our mission to serve rural communities, and appropriately deploying our resources to serve as many rural hospitals as we can is a challenge.”

- **The most rewarding part of his job is saving hospitals and saving lives.**

When Blackhawk goes into a community that needs assistance operating a hospital, Biederman looks at “opportunities that will be a blessing for everyone involved,” including the patients, providers, community and Blackhawk. As a result, they allow hospitals to continue providing care and saving lives.

“We have incredible team members, and their goal is to deliver the highest quality patient care possible,” Biederman says. “Our intention is that everyone in the organization will make decisions from their heart in all that they do. It’s exciting to watch everything unfold as we grow. The dedication and determination from our team members never cease to amaze me.”

- **He loves sports.**

To relax, Biederman jogs, plays golf and helps coach youth basketball and baseball. He also enjoys spending time with his wife, Ryma, and their kids, Meg, 11, and Jake, 9, and attending their sporting events and activities.

- **He is an NRHA Rural Health Fellow.**

Through his participation in the Fellows program, Biederman hopes to learn more about NRHA and the positive impact he can make as a leader in rural health care.

“I thought it would be a nice way to support rural health care initiatives,” he says. “We are attracting the types of people to our organization who really have a place in their hearts for rural America. That’s what drives them, and we’re looking for kind, compassionate leaders.”

If you’re a new NRHA member and would like to be featured in *Rural Roads*, e-mail [editor@NRHArural.org](mailto:editor@NRHArural.org).



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## Members on the move

**Patricia Dobbins** has been appointed by the Florida Department of Health as administrator of the Hendry and Glades County Health Departments.

Dobbins has practiced professional nursing for 35 years in a variety of settings, including at the Veteran's Administration, in urban and rural hospitals, as a nurse educator for 15 years, as an entrepreneur and business owner, and currently as the executive community health nursing director of the Hendry and Glades County Health Departments.

Dobbins was a graduate of the inaugural 2007 class of NRHA Rural Health Fellows.

**Kathy Duncan**, RN, faculty expert from the Institute for Healthcare Improvement, has been selected to serve on the steering committee for the National Quality Forum's project "Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination," which seeks to endorse a set of measures applicable across all settings of care. NRHA nominated Duncan for the position.

Duncan has been an NRHA member since 2008.

## News briefs

### NRHA congratulates member Mary Wakefield on HRSA appointment

President Obama appointed Mary Wakefield, PhD, as administrator of the Health Resources and Services Administration (HRSA).

Wakefield, a long-time NRHA member who has served on NRHA's Rural Health Congress and Government Affairs Committee, is one of the nation's top experts on rural health and workforce issues and most recently served as the associate dean for Rural Health at the University of North Dakota School of Medicine and Health Sciences.

"We are obviously delighted with the selection of Dr. Wakefield to this vitally important position for rural America," says Alan Morgan, NRHA CEO. "Her experience as a nurse, a PhD and a leading rural health care advocate make her uniquely qualified to lead HRSA as President Obama endeavors to expand access to the uninsured and underserved."

### \$74 million awarded to tribal programs for mental health, substance abuse treatment

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded grants in fiscal year 2008 that are projected to provide more than \$74 million to federally recognized tribes or tribal organizations serving the mental health and substance abuse prevention and treatment needs of American Indian and Alaska Native populations.

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

## New NRHA members

Michael Albrecht  
Samantha Algrim  
Lisa R. Allen  
Christopher Baalman  
Dave Baldrige  
Patricia Barker  
Amanda Baxa  
Paige Behm  
Erin Bird  
Sherri Braksick  
Katherine M. Brewer  
Paul R. Brosor

B. Darlene Byrd  
Jeri Byrne  
Sam Cordes  
Sarah Devlin  
Stacey Dimitt  
Travis Dixon  
Michelle Drucker  
Holly Dudzik  
Bethany Duff  
Kathy Duncan  
Daniel R. Eisemann  
Gregory Empey  
Ginger Fewell

Flora Fisher-Porter  
Melissa Garber  
Carta C. Gilbert  
Hannah Haack  
Bridgette Hager  
Katherine Hall  
Micah Hall  
Richard Hartman  
Trent Howard  
Courtney Huhn  
Jessilyn Humble  
Terri Hurst  
Christina Johnson

Alisa Jost  
Matt Kaiser  
Michael Karr  
Adam Keesling  
Julia Kenny  
Rachael Krob  
James O. Lawrence  
QuyChi Le  
Jessica Leiker  
April Alexandria  
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Molly Lindquist  
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Christine Labourdette Manalla  
JoAnn Manty  
Gabrielle McCully  
Helen Miner  
John Muir  
Susan Murty  
Travis Nelson  
Alyssa Newth  
Theresa Fogarty  
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Karen T. Pechie  
Laura Platt  
Irma Potter  
Mistee Richardson  
Cheryl L. Riester  
Tessa Rohrberg  
Nicole Rouhana  
Alicia Schoen  
Chris Shaffer  
Kellen Sherlock  
Ray L. Shoemaker  
Kara Sloan  
Kipman Smith



These grants are in addition to more than \$65 million SAMHSA made available to tribal service providers for grants awarded during fiscal year 2007. Two years ago, SAMHSA initiated a new policy geared toward expanding tribal eligibility for more grant programs.

“This highlights our belief that funding should go directly to those on the frontlines – those in the tribal communities,” says SAMHSA Acting Administrator Eric Broderick. “Through our Tribal Initiative, SAMHSA has succeeded in increasing resources available to American Indian and Alaska Native communities to address critical needs.”

Information on programs that will be funded is available at [www.samhsa.gov/tribal/08grantees.aspx](http://www.samhsa.gov/tribal/08grantees.aspx).

## Association offers campaign toolkit, completes health center economic impact studies

Through grant funds provided by the U.S. Department of Agriculture Rural Community Development Initiative, the California State Rural Health Association (CSRHA) and its partners John Snow, Inc., and the Rural Health Design Network have developed a two-year capital campaign training program, Transforming the Future Health of Rural Communities through Economic Development. The program is designed to build the capital fundraising capacity of rural health organizations through leadership development and strategic planning.

This capital campaign toolkit, a collection of resources and rural-focused advice, shares knowledge and resources that will promote the financial

viability and success of rural health care organizations throughout California.

In addition to developing the toolkit, CSRHA partnered with California State University-Chico to implement economic impact studies to determine the overall impact and influence of four distinct rural health organizations. The studies aimed to reveal the possible consequences of losing the health centers and how losing each might impact the community’s population, income and business revenues.

For more information on the studies or to order a toolkit, visit [www.csrha.org](http://www.csrha.org).

## NRHA Fellows examine quality reporting at critical access hospitals



*The 2008 class of Rural Health Fellows graduated in January.*

A project completed by Linda Bergsma, Jill Cochran, William Nelson, David Pearson, James Tyler and Karla Weng from the 2008 class of

NRHA Rural Health Fellows identified data elements used to review quality, patient satisfaction and cost for critical access hospitals (CAH). The project addressed the following elements:

- cost and financial stability to identify meaningful financial outcomes that reflected the overall financial health and stability of the CAH;
- customer satisfaction to identify a subset of customer satisfaction items from Hospital Consumer Assessment of Healthcare Providers and Systems that are also related to safety and quality, including communication, education and cleanliness;
- patient safety and quality, including pneumonia, heart failure and outpatient measures;
- and organizational culture and environment, including employee satisfaction and ethical standards.

*continues*

Tyrel Somers  
 Jeff Speaks  
 April L. Stamper  
 James M. Standford  
 Amanda Steventon  
 Anthony J. Strickland  
 Jarod Snyder  
 Ashley J. Thomas  
 Derek D. Totten  
 Zachary P. Triplett  
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 Robert Valentine

Paul Villas  
 Helen Volger  
 Renee Walburn  
 Teresa Wall  
 Peter T. Walsh  
 Dallas C. Walz  
 Stephen C. Ward  
 Terry Willett  
 John Yost

*continued*

Rural Health Fellows Patricia Moulton, Todd Biederman, Darrold Bertsch, Barbara Meusing and Jeffery Perotti also completed a project detailing the vital roles of critical access hospitals as caregivers, members of the community, employers and drivers of the local economy.

For more information on the projects or the Rural Health Fellows program, visit the NRHA web site at [www.RuralHealthWeb.org](http://www.RuralHealthWeb.org).

## INHS receives distance learning, telemedicine grant

Inland Northwest Health Services (INHS) was awarded a \$367,000 distance learning and telemedicine grant from USDA Rural Development. The grant will be used by Northwest TeleHealth, a service of INHS that brings health and educational services over a telemedicine network directly to health care providers and patients in rural areas.

“This grant will help enable us to improve services and expand the capability of the existing TeleHealth network in rural areas to reach greater patient populations,” says INHS Chief Operating Officer Nancy Vorhees. “This will allow rural communities to have more higher-quality continuing education, community education and health care consults between rural patients and urban physicians.”

Through the grant, Northwest TeleHealth will upgrade or establish services in 13 counties. Northwest TeleHealth network locations include health care facilities such as regional medical centers, rural hospitals and clinics, mental health facilities, corrections facilities and Native American health centers.

## NRHA celebrates 2009 Congressional Award recipients

NRHA honored these Capitol Hill champions of rural health at the NRHA and Partners Rural Health Policy Institute at the U.S. Botanic Garden reception in January.

### Senate recipients

Blanche Lincoln (D-Arkansas)

Pat Roberts (R-Kansas)

### House recipients

Pete Stark (D-California)

Jerry Moran (R-Kansas)

### Congressional staff recipients

Jenelle Krishnamoorthy, Office of

Sen. Tom Harkin (D-Iowa)

Michael Park, Senate Finance Committee,

Minority Office

## NRHA calls for presentations for 2010 Annual Conference

NRHA is currently soliciting presentations for the 33<sup>rd</sup> Annual Rural Health Conference to be May 18 to 21, 2010, in Savannah, Ga.

Each year, more than 200 rural health professionals present 50 concurrent educational sessions, 20 research papers and up to 100 research and educational posters. Any person with an interest in rural health care or rural health research is invited to submit session proposals or original research for presentation during the 2010 conference.

The deadline for concurrent session submission is July 31, and the deadline for research paper submission is Jan. 8. For more information, visit [www.RuralHealthWeb.org](http://www.RuralHealthWeb.org) or contact Meaghan McCamman at [mccamman@NRHArural.org](mailto:mccamman@NRHArural.org).



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National Rural Health Association

## Relational Technology Solutions: A reliable source of capital

Relational Technology Solutions (RTS) understands the challenges in keeping up-to-date with the ever-changing technology landscape in the health care market, particularly at the critical access level.

A leading independent technology and financial solutions provider ranked fifth on the 2008 Monitor Top Private Independents, RTS provides financing, supply and disposition services for a broad range of IT and medical equipment assets essential to hospitals.

Through its Healthcare Solutions practice, RTS serves as a reliable source of capital for health care organizations seeking to deploy the latest advances in diagnostic imaging and medical/surgical equipment, reduce the total cost of IT ownership and accelerate technology adoption to maintain competitive advantage. With expertise in supporting the acquisition of both new and certified refurbished equipment, RTS helps



hospitals address a variety of clinical needs that are unbudgeted or under-budgeted and ensures that these organizations realize the lowest TCO in deploying health care assets.

As investors and experts in health care technology, RTS ensures that you acquire assets at the best possible price, use them at the most cost-effective rate and dispose of them in a way that recovers a portion of your investment.

For more information, visit [www.rts.com/services\\_healthcare.asp](http://www.rts.com/services_healthcare.asp).



## Wellness Environments helps critical access hospitals build or renovate facilities

Yes, even in today's economic climate, if you are a critical access hospital and need any or all of the following: CON help, financing, project management, feasibility studies, land development, designing/building, construction management, leasing/purchasing, etc., Wellness Environments can help.

Wellness Environments specializes in supplying complete, pre-engineered modular hospital products for critical access hospitals. Wellness Environments can help with projects from the ground

up or from the shell inward.

Best of all, because of the unique, pre-engineered modular products, the total cost of Wellness Environments clinical spaces can be reimbursed up to 101 percent by Medicare. The interiors are done quickly and cleanly, generally 40 to 50 percent faster than traditional methods.

At Wellness Environments, our name is our mission statement.

Wellness Environments is a one-source provider, installing walls and wall coverings, all finishes, med gases, furniture, case goods, etc., into interior hospital clinical spaces. Patented products are proven and tested using 12 years of research data.

Simply call Wellness Environments at 615-321-5052 to find out how.





# 4 ways to attend the NRHA Annual Conference and save



short cuts

You can't afford to miss NRHA's 32<sup>nd</sup> Annual Rural Health Conference May 5 through 8 at the historic Fontainebleau Resort in Miami Beach. Here are four ways to save before, during and after the event.

Visit [www.RuralHealthWeb.org/annual](http://www.RuralHealthWeb.org/annual) for more information on the Rural Medical Educators and Annual conferences and to register.

- 1 Maximize your travel budget. Plan to also attend the Rural Medical Educators Conference May 4 and pre-conference workshops, including one on getting stimulus dollars, at the Fontainebleau Resort.
- 2 Fly into Ft. Lauderdale and share a shuttle from the airport directly to the resort for less than \$25 per person. Visit [connect.nhrarural.org](http://connect.nhrarural.org), and use NRHA Connect to coordinate your travel plans.
- 3 Attend sessions on cost-saving topics including affordable technology options, proven grant writing tips, recruitment and retention values and value-based purchasing strategies.
- 4 Network, learn from the best and return home with practical ways to apply new knowledge and skills that will pay off all year.

## 2009 Rural Health Policy Institute by the numbers



**11** wall plaques were presented to graduating Rural Health Fellows.

**4** national experts presented and answered questions on the health workforce policy panel.

**14** attendees stretched out during free yoga.

**425** eggs were consumed over 3 days.

**11** attendees spotted President Obama's car.

**5** U.S. senators spoke with attendees.

**800** rural health advocacy packets were created and distributed on Capitol Hill.



## shifting gears

In recognition of Earth Day on April 22,

*Rural Roads* takes a look at ways hospitals can be eco-friendly during facility reconstruction or renovation.

- **Install pervious concrete.**  
New London Hospital in New London, N.H., installed pervious concrete in 2007, and they expect a positive return on their investment. Pervious concrete can last more than 30 years, twice as long as other parking lots. The concrete also allows storm water to seep into the ground, which recharges groundwater, reduces runoff and prevents pollution.
- **Paint the roof white.**  
This has been shown to deflect heat and reduce energy use, which will cut down on costs.
- **Check out the Green Guide for Health Care** featuring tips on healthy and sustainable building design, construction and operations for the health care industry. Free downloads are available at [www.gghc.org](http://www.gghc.org).

FirstChoice  
Cooperative  
DELIVERS



It **PAYS** to make the right **CHOICE** with FirstChoice Cooperative because our Process is centered on **YOU!**

# FirstChoice

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## COOPERATIVE

FirstChoice Cooperative is the most innovative and cost effective Group Purchasing Coop in the United States.

We Deliver real Cost Savings and generate real CASH dividends for all members on an equal basis regardless of size.

FirstChoice Cooperative has a complete contract portfolio with over 450 contracts in place to deliver the results that you deserve from your Group Purchasing Cooperative!

Remember! Everyone in the Cooperative is a healthcare provider, municipality or an educational institution and we benefit from each other and our cumulative committed volumes.



### FirstChoice Cooperative

believes that all of our members should be the primary beneficiaries of the benefits received from our combined efforts. Therefore, we know that our proven process **DELIVERS** the best overall cost and **CASH** dividends in the industry!

### Our Mission

To provide a process for all providers, regardless of size, to reduce supply cost in our communities where we live and work while maintaining the highest level of quality!

### Member Benefits

- No access fees - no enrollment nor monthly fees!
- Cooperative is owned by its members.
- No tiered pricing, therefore all members enjoy the same price which is based on the total Coop commitment, therefore reducing each member's cost.
- Generates a new revenue source on every contract utilized through CASH PATRONAGE DIVIDENDS paid to your hospital.
- We have the best monitoring process in the industry on Patronage Dividends, and we can tell you at any time how much has been received on your account.
- Allows each member to participate and vote on which proposals to pursue and ratify-one vote per member regardless of size.
- Regular scheduled meetings that allow you, the member, to voice your opinion as well as network with your peers.

Please contact FirstChoice Cooperative for more information at  
1-800-250-3457 or [www.fccoop.org](http://www.fccoop.org).



# Map out your 2009

Make NRHA conferences your destination for education, advocacy and networking.

**Rural Medical Educators Conference**

May 4  
Miami Beach, Fla.  
*Early registration discount deadline: April 3*

**Annual Rural Health Conference**

May 5-8  
Miami Beach, Fla.  
*Early registration discount deadline: April 3*

**Quality and Clinical Conference**

July 21-24  
Park City, Utah  
*Early registration discount deadline: June 19*

**Rural Pharmacy Conference**

Sept. 9-11  
Kansas City, Mo.  
*Early registration discount deadline: Aug. 11*

**Rural Health Clinic Conference**

Oct. 6-7  
Portland, Ore.  
*Early registration discount deadline: Sept. 14*

**Critical Access Hospital Conference**

Oct. 7-9  
Portland, Ore.  
*Early registration discount deadline: Sept. 14*

**Minority and Multicultural Health Conference**

Dec. 9-11  
Memphis, Tenn.  
*Early registration discount deadline: Nov. 8*

**Rural Health Policy Institute**

Jan. 25-27, 2010  
Washington, D.C.  
*Early registration discount deadline: Dec. 23*

Portland,  
Oregon



Park City,  
Utah



Kansas City,  
Missouri



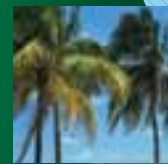
Washington,  
D.C.



Memphis,  
Tennessee



Miami Beach,  
Florida



[www.RuralHealthWeb.org](http://www.RuralHealthWeb.org)



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American Sentinel University is a proud NRHA corporate partner and offers members an unmatched opportunity to earn a degree that can advance their career.

American Sentinel University is accredited by the Distance Education and Training Council (DETC). The Accrediting Commission of the Distance Education and Training Council is listed by the U.S. Department of Education as a nationally recognized accrediting agency and is a recognized member of the Council for Higher Education Accreditation.