

rural roads

Fall 2010 National Rural Health Association



Amish outreach

Cancer project brings awareness

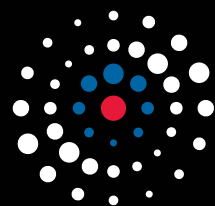
Mobile clinics deliver care to rural communities

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Write us

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

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



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Rural boom



Baby boomers are about to hit rural America – 71 to 78 million of them.

A USDA study noted this will likely be the biggest migration in America since 1900. Rural America's retirement-age population will increase this decade by two-thirds, from 8.6 to 14.2 million, according to the study. Those numbers will continue to rise because many boomers will seek rural residence.

Communities will need to plan ways to welcome and support this population. Health and health care are important to this group, and they'll push broadband, transportation, health care and present organizational structures.

They will come because community matters, and our role will be to help them to understand what matters to the community: revitalizing rural areas. Plan for, invest in and rejoice in this opportunity.

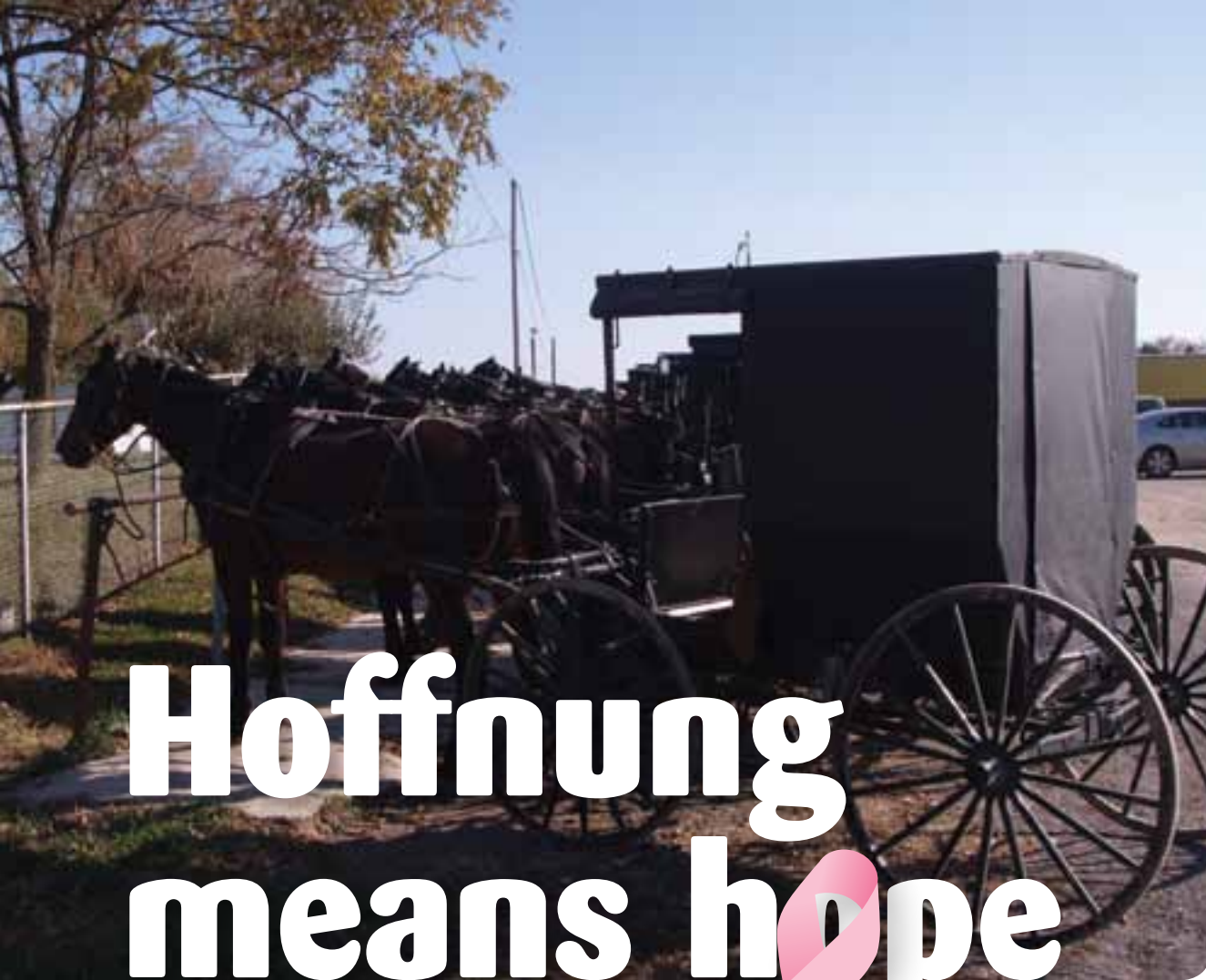
A handwritten signature in blue ink that reads "Dennis".

Dennis Berens
2010 NRHA president

pit stop

things I picked up in this issue:

1. There are 50 mobile clinics providing mental health care to rural veterans across the country. *page 11*
2. A gas station attendant started a rural health career, initially to earn more bread. *page 27*
3. Breast cancer is the leading cause of death in Amish women under the age of 60 in rural Ohio. *page 6*
4. Known as "the brown line," floodwater stains from Hurricane Katrina are still visible on tree trunks in New Orleans five years later. *page 16*
5. NRHA submitted 48 pages of comments regarding health reform in three months. *page 37*



Horse-drawn buggies park near an Amish settlement in Ohio. Photo by Dave Thomas

Hoffnung means hope

Breast cancer project brings awareness and opportunity to Amish and Mennonites

By Lindsey V. Corey

Ella Miller's homemade business cards say "Amish community health worker."

What they don't say is that she's really a quiet connector, carefully navigating word-of-mouth channels, knocking on doors to book breast cancer screenings and humbly sharing her story.

She counts her blessings often.

It comes with her culture, and it comes with working side-by-side with Melissa Thomas, PhD, Ella says.

Ella lives with her three sisters in Ohio's Holmes County as part of the world's largest Amish settlement. She's been cancer-free for 21 years now.

And she's helped with Project Hoffnung since Melissa started bringing breast cancer education and mobile mammography equipment to remote Amish and Mennonite communities in 1997.

"We don't have radios, televisions. It's not out in the open, so people don't understand how important early detection is," she says. "We've got to educate them that it's very necessary to go to a screening, to get a

mammogram. Our ladies don't think it's important, so we work to bring that awareness and let the community know they need to do this to take care of themselves."

Project Hoffnung (or "hope," in the community's first language) delivers the message and opportunity, Ella says.

"I feel we've saved lives," she says. "That's why I do it."

To date, more than 2,000 rural Ohio women have received free clinical exams through the mostly grant-funded program.

"You could say we've come a long way," Melissa says.

Fresh out of undergrad, she was working on a grant

to increase cancer screenings among Appalachian women by developing community coalitions.

She passed buggies on the roads there, but none of the nearby Amish took part in the services.

“I felt badly that they weren’t coming to get the help we set up,” she says. “I was told the Amish wouldn’t participate, that they don’t believe in technology or won’t accept health care, so there’s no use talking to them.”

“I work with the most humanly loving, respectful group of people, and they’re all there to help women save lives. There’s no greater honor.”

Doretta Thomas, Project Hoffnung community health worker

Melissa didn’t listen.

She’d never met an Amish person before, but a local nurse introduced her to 12 Amish women.

“I just asked if they’d like to learn about breast cancer, and that began the relationship that continues today,” she says. “Getting support is all about getting to know them one community at a time and earning their trust.”

Searching for similarities

The health disparities researcher spends a lot of time building relationships. Ella’s settlement has 200 separate church districts representing various beliefs, and Melissa sought consent for Project Hoffnung from all 200 male bishops.

One visit felt like a business transaction, Melissa remembers.

“The bishop was very distant and didn’t want to talk to me,” she says. “So I went back, this time with my parents. What a difference it made knocking on a bishop’s door with my dad and mom beside me. My dad spent 15 minutes talking about how much he loved eating chicken, and the bishop talked about how much he loved raising them for another 15 minutes, and in the next 30 seconds we had his blessing and the program planned.”

With the Amish, it doesn’t have to be about technology; it’s about trust, she learned.

“Just like any group of patients, some prefer traditional treatment, while others try alternative or holistic methods,” Melissa says. “We feel it’s a bigger issue to educate and empower them so they can make a decision. We try to provide a bridge between the respected beliefs of these cultures and the modern advances in breast cancer care.”

Ella points out that there is a lot of diversity from one Amish or Mennonite community to the next, but “aversion to technology isn’t the issue; awareness is.”

“There are so many similarities that we don’t focus on the differences between our cultures,” Melissa says. “The women we’ve met are trying to do what’s best for their family and their health and sometimes just lack the

Caring for Amish patients

Melissa Thomas, PhD, had never met an Amish person 14 years ago. Now she works with the culture daily and offers this advice to other health professionals.



Translate

The Amish are trilingual, and English is not often the first language spoken. Their primary language, called “Pennsylvania Dutch,” is a German dialect and is only a spoken language. Translation issues can occur, so it’s best to have a native speaker there to help.



Transport

Most Amish use horse and buggy as their primary transportation. While we may complain about the price of gas for our cars, Amish women may have to pay \$50 or more for a driver to get to and from a health care visit. When applying for grants, include transportation costs for the Amish to participate. Plan community programs close to settlements, and make sure the facility has a hitching post for horses.



Relate

While the Amish may avoid many modern technologies we take for granted, it is easy to focus on the differences we have between our two cultures. But we have many similarities in rural America in that we cherish our families, work hard to provide for them and sometimes are a bit wary of outsiders coming into our communities. You may not live on a farm, but the stories from your parents or even your grandparents can become a powerful communication tool in relating to a lifestyle all our ancestors experienced. Focus on the common ground, and be patient in allowing trust to form.



Commit

Sustainability is the key to any community health program. A one-year grant can often do more harm than good. If you go into a community, raise awareness about a health issue, and then leave in a year because funding is gone, you have done little to make an impact in helping the community improve their lives. If you can’t make a long-term commitment to a community through volunteer efforts and a plan to continue after a grant ends, think twice about applying for the funds. Project Hoffnung has had to continue without funding. It helps, but isn’t the driving force behind our program. Religion should be the driving force behind any Amish outreach program.



Doretta, David and Melissa Thomas participated in the Susan G. Komen 2010 Race for the Cure in Cleveland. Founder Melissa attributes Project Hoffnung's survival and success to her parents.

information or access to be able to do that best.”

Melissa learned early on the importance of health education. When Melissa was 12, her Grandma Mazie died of colon cancer that was detected at an advanced stage.

“I have great memories of staying at her farm in the summer. I’d transform her living room into a science experiment. She was so encouraging of that learning, and that really stuck with me,” says Melissa, the first in her family to go to college. “Her death was truly a tragedy and even more so knowing that had she had the right information, she may be alive today.”

Melissa shares that story with hesitant bishops to help them understand her motivation.

She hears stories that motivate her too.

“One day I was feeling particularly sorry for myself and bogged down with paperwork and administrative challenges of the program,” she says. “We were down a volunteer, so I had to educate all the women one-on-one who came in for a screening that day. I was talking about self breast exams with an Amish woman named Nettie. After about five minutes, she

started to cry. She said her daughter had just been diagnosed and was going to die. She knew there was nothing she could do to save her daughter, but she didn’t want to put her family through so much pain again. Her daughter was the same age I was at the time. It really hit home. These people are our family and our friends, not just a community we serve, and it’s such an honor to be invited in.”

A family affair

David and Doretta Thomas followed in their daughter’s footsteps.

“Melissa doesn’t live nearby, so when I started it was selfish because I’d get to spend more time with my daughter and really see what she does,” Doretta explains. “Little did I know how much I would become involved and how much I would love it and how much it would be a part of our everyday lives.”

Conference connections



Camara P. Jones

Meet Melissa Thomas, PhD, and learn more about her work with Amish and Mennonite communities at this year’s Rural Multiracial and Multicultural Health Conference Dec. 1-3 in Tucson, Ariz.

It’s NRHA’s fastest-growing event and the only one in the nation to focus on the health of under-represented rural residents.

You’ll also hear from Camara P. Jones, MD, PhD, the CDC’s research director on social determinants of health and equity. A member of the World Health Organization’s Scientific Resource Group on Equity and Health and former Harvard professor, Jones was featured on the PBS series “Unnatural causes: Is inequality making us sick?”

[Go to RuralHealthWeb.org/mm](http://RuralHealthWeb.org/mm) to view the agenda and register.

It's not your typical family business, she says.

"It's so great to get to work together with your child," Doretta says. "But whenever you get to help save a life in some small way, it's the most beautiful gift you can receive."

"These people are our family and our friends, not just a community we serve."

Melissa Thomas, PhD, Project Hoffnung founder

Doretta, who started by filling in for a volunteer 13 years ago, quickly became one of three community health workers for Project Hoffnung, often travelling more than three hours to educate women for 10 minutes or so before their screening in a Mennonite church. She shows them normal and benign mammograms and a cancerous one too. She explains the importance of both self and clinical breast exams before they get a clinical exam, mammogram, pap test and blood work at no cost. She serves food and chats about growing up on a farm.

"I didn't know anyone Amish until I started this, but now I have many, many Amish friends. A lot of them won't go to a hospital, so this is their only chance, and the screenings are friendly and relaxing, more social than clinical," Doretta says. "That's because I work with the most humanly loving, respectful group of people, and they're all there to help women save lives. There's no greater honor."

When he retired, David joined the volunteer crew too.

"As a joke, I made him business cards that say 'transportation specialist,'" Melissa says. "Mom calls him the chauffeur and gopher. He drives [the women] to and from the screening and is often the first and last person they see. He's a quiet hero, our behind-the-scenes guy, but it's a very strong bond he creates. Without my parents' sacrifices, Project Hoffnung wouldn't be here today."

It hasn't always been easy, Melissa says. The program lost funding in 2005.

"It was devastating, but we'd already made a commitment to serve the community," she says. "We couldn't leave."

Amish cancer rates

Ohio is home to the world's largest Amish settlement, with more than **30,000** residents. Many other Amish communities are scattered throughout rural and underserved regions of the state. More than half the United States have Amish settlements.

While breast cancer diagnosis rates are about half that of other Ohio women, Amish breast cancer death rates are disproportionately higher when compared to local, state and national rates. In fact, the Project Hoffnung team uncovered that among the world's largest and fourth largest settlements, the leading cause of death in Amish women under the age of **60** is breast cancer.


Amish women are much less likely to be screened for breast cancer. In a random sample of Amish women **40** and older in the world's largest settlement in Holmes County, Ohio, only **60 percent** reported ever having a mammogram, and less than a third were compliant with recommended screening guidelines. Despite these low screening numbers, almost **75 percent** reported knowing someone with breast cancer.

The Project Hoffnung Fund was created in 2001 to help cover follow-up care expenses for Amish and Mennonite breast cancer patients throughout Ohio. It is supported with an annual quilt raffle and private donations, and 100 percent of the funds are used directly for Amish and Mennonite health services. Check donations can be made payable to Project Hoffnung and sent to P.O. Box 28103, Columbus, Ohio 43228, or call 877-HUFFNUNG for more information.

So they had a party. Friends helped move files to Melissa's basement and created a "Project Hoffnung World Headquarters" sign.

"We went on a wing and a prayer, but we've always found a way," Doretta says.

Today, Melissa's job as health disparities manager at Ohio Health Research and Innovation Institute supports related research. Susan G. Komen for the Cure provides mobile mammography units. Volunteers like Ella and David never stopped going door to door, bringing food, hosting support groups, cleaning up.

"At the time of my diagnosis, I felt very alone," Ella says. "Not anymore." 





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Oklahoma State University's mobile telemedicine clinic (pictured with school mascot Pistol Pete) provides specialty care to rural communities.



On the road again

Mobile clinics deliver care to rural communities

By Angela Lutz

At a Nelson County, Va., health fair, a man who couldn't remember the last time he'd been to a doctor walked into the Rural Health Outreach Program (RHOP) mobile clinic. After losing his insurance, he had been off his blood pressure medication for several months, and he said his thinking felt foggy.

"We did a health screening and realized that he was a heart attack or stroke waiting to happen," says Greg Tyree, program manager. "We referred him to Augusta Medical Center, and the doctor told him that if he hadn't stopped by the mobile clinic, he would have been gambling with his life."

Another woman working at an Albemarle County migrant camp hadn't seen a physician for

continues

nearly three decades before the RHOP clinic visited her community.

“She hadn’t been to a doctor since she gave birth 25 years ago,” says Jan Wolfe, clinical director. “We did a pap smear, and she had mild dysplasia. We were able to get her the care she needed and provide follow-up, and she’s doing fine now.”

While these patients’ cases may be extreme, their circumstances are hardly unique. The Arrington-based RHOP serves a three-county area in Virginia, including area migrant camps, trailer parks and community centers. Ninety-nine percent of the approximately 300 patients who visit the clinic each year are uninsured and would not likely otherwise receive care.

“Everything I can do in my office in Lincoln I can do in a cornfield in western Nebraska.”

Thomas Stier, readjustment counseling technician

And according to Tyree, most RHOP patients also struggle with a lack of transportation, inability to take time off work, illiteracy or cultural differences. But breaking down these barriers and offering health care where others “can’t or won’t go” is all part of RHOP’s mission.

“We believe that everyone should have access to health care,” he says. “That gets a lot of lip service, but we try to flesh it out in the real world and make it happen.”

Up the mountains and into the woods

An extension of Blue Ridge Medical Center, the RHOP mobile clinic was founded in 2004 when the community health center’s administrators wanted to expand services. Funding was procured largely through grants, and a van was outfitted to provide complete physicals, acute and chronic care, blood and urine analysis and referrals.

“We wanted to be able to provide services off-site,” Wolfe says. “We figured the mobile clinic would be a way to increase the number of patients we could see.”

The large Ford van features a full exam room but does not require a special license to drive.

“It gets us up the mountains and into the woods,” Wolfe explains. “It’s basic, but it gets us where we need to be.”

Coming from a banking background, Tyree joined the RHOP team in 2009 because he wanted to do something “more helpful to the community” for people who weren’t fortunate enough to have the resources to stay healthy.

And almost immediately, he saw the value of the services the clinic provides.

“Every day I go home knowing I’ve helped someone and made a difference in their lives,” he says. “When people are healthier, they’re

happier, so it’s not just physical. It’s emotional and even spiritual. We’ve seen people’s self-esteem improve and seen them rise up when they realize they can be healthy.”

Travel staff typically includes a nurse practitioner, a registered nurse and two to four community health promoters. Sometimes University of Virginia medical students also come along for the ride. Due to funding, weather and travel constraints, the staff can’t get to many locations as frequently as they’d like, so they’ve come up with other ways to be proactive about keeping rural populations healthy.

“One part is the Wellness Passport Program,” explains Tyree. “We enroll people into a yearlong relationship where we give them a free medical exam and try to encourage better behaviors and health outcomes.”

Catering primarily to low-income and uninsured patients, the passport program’s main participants are farmers and migrant workers. RHOP staff communicates with them quarterly via phone call to check in on their progress and track results.

“The challenge is getting them to take responsibility and ownership for their health,” Tyree says. “They see a huge difference in their lives when they do that. Some people neglect [their health] for so long that they become embarrassed, and it becomes a source of shame for them. But we are proactive and compassionate, and we get them the help they need.”

Outreach and advocacy

Two years ago the Department of Veterans Affairs (VA) also started taking care on the road to provide counseling to rural veterans. There are now 50 mobile vet clinics serving as extensions of the 300 vet centers across the country.

According to Thomas Stier, a readjustment counseling technician based out of Lincoln, Neb., the mobile vet centers see veterans from every conflict since World War II and provide them with readjustment assistance for combat-related stress and transition back to home, family and career, as well as substance abuse counseling and referrals. Each clinic has a master’s-prepared counselor or social worker on board.

“Outreach is our main mission,” Stier says. “We are

out there in the far reaches of our areas serving veterans who don't normally have the opportunity to drive to a vet center."

Stier's mobile clinic serves the entire state of Nebraska and western Iowa. In order to reach out to the many veterans in this vicinity, the 38-foot-long office on wheels is on the road as often as the weather permits.

"It's an office designed to go everywhere there's a road," Stier says. "Everything I can do in my office in Lincoln I can do in a cornfield in western Nebraska."

In addition to stops at veterans' fairs, state fairs, VFW conventions and legion centers, the clinic also makes an appearance at welcome home, or "yellow ribbon," events.

They will stay at these events as long as necessary, which Stier says can be anywhere from one day to a week, or perhaps indefinitely.

"We believe that everyone should have access to health care. That gets a lot of lip service, but we try to flesh it out in the real world and make it happen."

Gregory Tyree, Rural Health Outreach Program manager

"We're there at the military base when the troops are coming home from overseas," he says. "We're there to say welcome home, thanks for your service, here's what the vet center can do for you."

As a six-year Marine reserve and Iraq war veteran, Stier knows firsthand the necessity of reaching out to other veterans.

"I love being around vets, and I want to serve other vets," Stier explains. "The VA pushes to have vets in these offices because we've been there, and we know what it's like. Someone will come in and say, 'Remember that feeling when the landing gear hit



Patients aboard Oklahoma State University's mobile clinic can communicate with specialists thousands of miles away via telemedicine technology.

American soil?' And it's a feeling you can't describe, so you want someone who can say, 'Yeah, I do remember that.' You have to experience it."

Filling the gap

The mobile vet clinic helps fill the gap in mental health services for rural veterans, but many small towns lack specialty services for the general population as well. Mobile clinics are also ideal for filling those gaps.

Since 2005, the Oklahoma State University (OSU) mobile clinic, based out of Tulsa, has provided specialty care in the northeastern part of the state, visiting five locations monthly as well as attending health fairs and community events.

Utilizing telemedicine, the 39-foot bus, which contains a full exam room, can connect to specialists up to thousands of miles away to provide cardiology services, prenatal care, behavioral health consults and HIV/AIDS follow-up care, among other services.

"As long as there's a horizon, the clinic can function," says Bill Pettit, DO, OSU associate dean for rural health and mobile clinic medical director. "The current clinic has the ability to do everything but touch – you can look in eyes, ears, nose, throat and listen to heart, lung and bowel sounds. You have a top-quality dermatological camera, ultrasound capabilities, vital signs, electrocardiogram and retinoscope."

continues

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– Brock Slabach, Senior Vice-President, *National Rural Health Association*



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continued

The clinic is staffed by a paramedic, an electronics and office assistant and a third-year OSU medical student. As dean of the Center for Rural Health, Pettit requires all students to spend a day in the mobile clinic becoming accustomed to telemedicine and interacting with patients, who range from children to retirement home residents. They also provide care to Oklahoma's large tribal population.

Tatum Caldwell, OSU Department of Medical Informatics assistant telemedicine director, says the clinic's patients have been "overwhelmingly responsive."

"We get letters from patients explaining how much time they've saved, and how they were apprehensive at first but the quality of the video call puts them at ease," she explains. "We've had stroke programs where people's lives have been saved by visiting the mobile clinic. A single mom was able to get a job instead of having to travel so much to care for her sick child."

When it comes to saving travel time, Caldwell says HIV and AIDS patients are some of the most grateful, as their treatment requires many follow-up visits. Thanks to the mobile clinic, which connects to the Ryan White Clinic in Tulsa, patients no longer have to take a day off work to see their doctor and can more easily maintain confidentiality.

"They feel secure, and it's a good measure to protect their privacy," Pettit says. "In dealing with such a delicate disease we provide them an avenue for confidentiality that allows them to maintain their work and family lives. There's still such a stigma, even in 2010."

Because many of the rural communities the clinic visits have a practicing primary care physician or other mid-level provider, a physician assistant or a general internist, Pettit says they don't provide general practice services such as physicals or flu shots.

"We work with local physicians and communities to provide specialty services," he says. "We want every rural provider to survive."

The sustainability of their telemedicine clinic and other similar networks, however, is an issue about which Pettit worries.


"Mobile telemedicine clinics can't bill for services," he explains. "Nobody pays for that service itself."



Oklahoma State University's mobile clinic features a full exam room.

Reimbursement goes to the health care provider. We also need to address interstate provision of services by licensed professionals. Currently I can't call a doctor in Washington who might be the top specialist in the area unless he's also licensed in Oklahoma."

And resolving these policy issues to promote sustainable telemedicine is, according to Pettit, important not only to rural patients, but to physicians as well.

"We're getting less and less sub-specialty physicians who want to do 'windshield time' driving out to rural places," he says. "[Telemedicine] makes physicians feel less isolated away from the specialty world." 

More on mobile

Learn more about how communities are reaching out to provide health care to underserved migrant populations at NRHA's 16th annual Rural Multiracial and Multicultural Health Conference Dec. 1-3 in Tucson, Ariz.

Visit RuralHealthWeb.org/mm to register.

There's still oil in the Gulf

Rural residents struggle with uncertain future

By Angela Lutz



Six months after the explosion of BP's Deepwater Horizon offshore oilrig, long-term effects of the oil spill on the Gulf Coast and its residents are still uncertain.

Six months later, oil still shimmers atop the water like rusted gunmetal. It clogs the wetlands and chokes the marshlands, leaving wildlife homeless, injured or dead. It keeps thousands of offshore drillers and fishermen out of work, men and women who, in the past, have gone out on their boats with broken backs to haul in shrimp and crabs to provide for their families.

With their livelihoods gone, they don't know where to turn. Like the wildlife, these Gulf Coast residents are lost.

Health care providers are also struggling to deal with the aftermath of the April 20 explosion of BP's Deepwater Horizon offshore oilrig, which killed 11 people and sent oil spewing into the Gulf of Mexico at an approximate rate of 60,000 barrels per day.

Sharon Marie Chester, licensed clinical social worker at St. Bernard Health Center in Arabi, La., population 8,093, provides mental health care to St. Bernard Parish, one of the areas hit hardest by the spill. In rural cultures people tend to keep their troubles to themselves, she says, so it hasn't been easy.

"I'll ask people what they need, and they'll look at me like I'm stupid and say, 'I need a job,'" she says. "All the therapy in the world is not going to get

these people the jobs that have been taken away from them."

To illustrate, she refers to a photograph of a baby tern, one of many Gulf species affected by the spill. The young bird is trapped in a pool of oil on the shore, its white feathers slicked with brown and its eyes dark. It stretches toward two minnows its mother deposited only inches away from its beak, unable to escape the sticky puddle to reach its meal.

"As a second responder, the primary emotion I'm challenged with is helplessness," Chester says. "Like the [mother] tern, that's all I feel capable of doing to help these people. I feel very powerless."

Cleaning up "down the road"

But feeling overwhelmed hasn't slowed Chester down or stopped her from reaching out to the community she has adopted as her own.

“New Orleans is the hometown of my heart,” she says. “It’s a place like no other I’ve been. The people here are so open. You can’t be a recluse here and get away with it. You’ll pull your blinds, and people will knock on your door and say, ‘Hey, I like your curtains.’”

Chester also feels an affinity for the rural residents on the outskirts of town in the bayous and swamps, a place the locals call “down the road.” Fishing has been a way of life there for generations, and it’s become more than just a means to put food on the table; it’s their cultural identity.

“Once the spill hit them, it wasn’t a matter of their willingness and ability to work. It was like being in an airplane that’s rocking and trying to get your stability.”

Sharon Marie Chester, St. Bernard Health Center licensed clinical social worker

“That’s all there is down the road, is fishing and the oilrigs,” Chester explains. “There’s a stigma against them in greater New Orleans as uneducated, but they have PhDs in fishing and knowing the soil. They know the depth and scope of livelihood-based information. Once the spill hit them, it wasn’t a matter of their willingness and ability to work. It was like being in an airplane that’s rocking and trying to get your stability; you can’t do it.”

According to Chester, the spill “absolutely devastated” an area still struggling to rebuild and regain footing after losing everything in Hurricane Katrina in 2005. The effects of the storm, one of the worst disasters in U.S. history, are still apparent in and around New Orleans five years later. Stains left by floodwaters are still visible on the trunks of the 300-year-old oak trees in Chester’s neighborhood; tales of loss echo through the blocks of empty, boarded-up homes belonging to people who never returned.

“Every single one of these houses has a story,” Chester says. “People are still grieving that they no longer have an innocent place to live where they’ve been for generations. They have already been through things most of us can’t imagine, and then here comes the oil spill.”

Further up the road and west of New Orleans in Loreauville, population 938, Nancy Schneider,

Raymond F. Schneider Memorial Clinic nurse practitioner, has seen the spill hit her community in a kind of domino effect. Much of the economy in her small town is based on support services that supply the oilrigs, so though the well has been capped since July and fishermen are getting back to work, the six-month moratorium on exploratory drilling in the Gulf, issued in late May, is hitting other industries hard. The Institute for Southern Studies estimates it will result in more than 8,000 lost jobs and \$500 million in lost wages.

“People are generally worried about the industry returning,” Schneider says. “If the rigs aren’t working, neither are they. When the moratorium came through, they worried that Southwest Louisiana would just dry up and go away.”

Born and raised in Loreauville, Schneider named her clinic for her father, who was the town’s primary care physician for 40 years. She knows the people and she knows the town, and she’s watched her resilient neighbors clean up and move on after numerous hurricanes, most recently Hurricane Rita in 2005 and hurricanes Gustav and Ike in 2008. But she is worried about the long-term effects of the oil spill.

“We’re born and raised with hurricanes here, so we know to be prepared,” she says. “With a hurricane, you can see light at the end of the tunnel, and afterward you know you can clean up and rebuild. But after the oil spill we couldn’t wash it out and keep going. There’s oil in the water; there’s oil in the wetlands. People are still worried for 50 years from now – what will happen to hunting, fishing, the oil industry?”

Uncertainty becomes certain

As unanswered questions pile up, so do stress and mental anguish. Anxiety and depression are common, often manifesting themselves in panic attacks, anger, alcoholism and substance abuse. These problems are especially apparent in men, who, according to Chester, are “extremely unlikely to seek help even when they have severe medical problems.”

“Men don’t like crying,” she says. “They get overwhelmed; they can’t breathe; they feel like they’re having a heart attack. They lie in bed and can’t do anything but look at the ceiling. Men interpret many negative feelings as anger. They lash out more at their families, so the kids and wives are feeling it. And so much of it is legitimate.”

Chester reaches these underserved populations through consults in a primary care setting, where many women drag their husbands to treat symptoms they don’t know are psychosomatic, such as heart conditions and bleeding ulcers. Oftentimes she’ll have only a brief visit with a patient, so the most she can do is teach them some breathing techniques and let them know services are available.

“There’s a lack of [mental health] education, so if they hear the word ‘psychosomatic,’ they’re offended,” she says. “We have to deal with people in

continues

their environments. We have to go down the road and not expect to cram our white, middle-class mores down the throat of a culture. We have to be in the community and present things to them in a way they will be willing to receive it.”

According to Shannon Ragusa, corporate director of community relations at Medical Management Options (MMO), a Baton Rouge-based company that owns eight community mental health centers and manages five others across the state and in Mississippi, many of their patients after the spill have either never had mental health issues or never sought care.

“With a hurricane, you can see light at the end of the tunnel, and afterward you know you can clean up and rebuild. But after the oil spill we couldn’t wash it out and keep going. There’s oil in the water; there’s oil in the wetlands.”

Nancy Schneider, Raymond F. Schneider Memorial Clinic nurse practitioner

But stress has taken its toll on St. Tammany Parish, one of the Gulf communities MMO serves. According to Ragusa, as of September, 33 people in St. Tammany had committed suicide in 2010, more than any parish in the state.

“I can’t say it’s linked specifically to the oil spill or hurricanes, but regardless it’s a critical issue here,” Ragusa says. “A lot of times we’re working with people who haven’t experienced mental illness or depression, so they may not know the symptoms.”

In order to spread the word on services available and decrease the stigma attached to mental illness, MMO staff has started conducting monthly events open to the public on suicide risk and prevention and the signs and symptoms of depression. The events are held everywhere from schools to police and fire departments.

“People are joining together to educate people and let them know resources are available,” Ragusa says. “A lot of times people don’t want to tell people what they’re experiencing. They keep quiet about it. We’re trying to let them know these are normal experiences, and there’s help.”

And according to Rusty Phillips, who worked as director of outpatient services at Jennings Behavioral Health following Hurricane Rita and now

provides consulting services, the staff’s presence in the communities and familiarity with rural populations are huge advantages that enable them to “go in, pick up and start doing the work.”

The hurricane and oil spill victims “just wanted somebody to listen to them,” he says. “They were trying to find jobs, trying to provide for their children, and they just didn’t know how to deal with the feelings that they had. We were able to go in and work directly with these people. We were able to provide the resources because we’re already there in the communities.”


The cloud before the storm

As the cleanup continues and the mainstream media move on, residents of Gulf communities continue to feel the continuous, dull ache of loss, as well as the fear of an unknown future. Six months after the spill, some fishermen are heading back to work, while others have taken jobs with BP cleanup crews.

“On the one hand, they’re glad to have work, but on the other they say, ‘Why should we clean up your [mess]?’” Chester says.

And according to Chester, workers have learned that their income from the cleanup will be deducted from any lost-wages settlements with BP, meaning many of them are essentially working for free.

She also worries for the future because Gulf Coast Claims Facility Administrator Ken Feinberg, who is in charge of claims for costs and damages caused by the spill, “will not consider reimbursement for mental health treatment unless there is a physical injury,” Chester says. Because the majority of rural Gulf residents are uninsured, St. Bernard Health Center is looking for grants to continue providing mental health care to this vulnerable population.

“I think this is the cloud before the storm,” Chester says. “When and if the true big blow happens, I think it will be very ugly. I don’t think we’ll know the true effects of this for many years, and I’m angry on their behalf.” 

Be part of the solution

NRHA’s Annual Rural Health Conference May 3-6 in Austin, Texas, will feature sessions on how to leverage limited resources to provide mental health care to rural residents. Visit RuralHealthWeb.org/annual to register.



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The exchange rate

NRHA members examine rural health care in Peru through National Guard exchange program

A nine-hour flight, a two-hour bus ride down a dusty gravel road, and the team of American rural health experts found themselves in a remote village in northern Peru, examining Peruvian maternal and child health care.

The team, which included representatives from NRHA, Georgetown University, Atlas Research and the West Virginia National Guard, spent a week in April conducting humanitarian assistance and system assessments on a rural health exchange with the Peruvian Ministries of Defense and Health under the National Guard's State Partnership Program. The program links states and territories with partner countries to foster mutual interests and establish long-term relationships. West Virginia has partnered with Peru since 1996.

Peru experiences some of the same rural health challenges as the United States – access, workforce constraints, limited resources and other social influences impact quality of care. But while larger cities boast modern health care systems, there are fewer rural facilities and limited basic infrastructure (roads, water systems) in the most remote areas.

The team toured rural clinics and a birth house in the Andes foothills. Aside from being a birthing center, the facility also provides checkups and immunizations. Many women walk there, carrying their children four to six hours.

"I have toured rural birth centers around the world," says Hilda Heady, Atlas Research senior vice president and former NRHA president. "No matter their location or circumstance, women want the best care for their



Hilda Heady speaks with residents of a rural village in Peru.

babies. Walking four hours through the mountains to receive immunizations shows great commitment to children's health."

Peruvians have created innovative and practical solutions to address their health care challenges, Heady says. To provide care to the country's most remote residents, mobile teams travel to small villages in the jungle and mountains. Many of the rural clinics are able to serve their communities with little or no physician involvement due to expanded scopes of practice.

As NRHA looks to continue expanding its reach around the world, the experience served as a great opportunity for the association to connect with the Peruvian Ministry of Health, says NRHA CEO Alan Morgan. The visit resulted in NRHA staff and partners coordinating a health reform teleconference in Spanish that drew more than 200 participants from throughout Peru.

"The exchange allowed us to learn firsthand how another country addresses the challenges of rural health," says Ryung Suh, MD, Atlas Research CEO and Georgetown University associate professor of health systems administration. "The Ministry of Health is committed to preventive medicine, health promotion and health education as cost-effective strategies, and we've brought home many ideas to incorporate into our teaching and practice."

– Wendy Opsahl, Atlas Research communications director

Connecting to care

South Dakota hospital brings specialists to small towns

By Dustin Summers, NRHA program services coordinator



Flandreau (S.D.) Medical Center utilizes telemedicine to connect patients to specialists in Sioux Falls, S.D.

From 30,000 feet, they are invisible. They are indistinguishable from the sweeping, open scenery below, these strands of barbed wire strung across the miles of open prairie, fencing off farms and plots of land. These lines are meant to give order to the emptiness, to separate, but from the window of an airplane, they fade into the swaying grass and swollen waterways.

Just as invisible is another type of line meant to connect rather than divide, which has brought dozens of health information technology (HIT) stakeholders to Sioux Falls, S.D. These are lines of information, lines that carry voices and images, expertise and hope to the region's rural towns.

In September, The Helmsley Charitable Trust hosted an e-Exploration event to showcase advances in rural telehealth practices. The event attracted 50 representatives from governmental organizations, nonprofit associations and universities throughout the country that are dedicated to expanding the availability of health information technology services to the country's most isolated and underserved locations.

The Helmsley Charitable Trust, in cooperation with Avera Health Systems and the Good Samaritan Society, designed the day's events

around three stops: a tour of a small rural hospital in Flandreau, S.D.; a visit to the system's hub in Sioux Falls; and a visit to a new assisted living facility incorporating advances in health IT. Each leg of the event allowed participants to see firsthand the impact of these advances in rural America.

"Assembling this many partners with the breadth and depth of expertise as we have here brings us closer to a replicable, sustainable model of health care that can be implemented in rural communities across the country," says David Erickson, MD, Avera Health Systems senior vice president and chief medical officer. "Bringing in experts from the policy world plus Helmsley and the Good Samaritan Society brings great excitement and energy to this issue. We understand that recruitment and retention of physicians are two key factors in building a successful HIT program in a rural environment such as this, and we are hopeful that the innovations on display here will serve as a means to further strengthen the delivery of medical care in rural communities."

"With the model we have in place here, we can build this virtual hospital around any small town hospital. Patients don't have to travel, and thus the culture of medicine can begin to change."

Donald Kosiak, MD, Avera eCare medical director

At the first destination a wireless microphone was passed between the seats, and attendees introduced themselves by sharing stories of their rural backgrounds and connections. The stories included tales of small schoolhouses and secret fishing holes, of fish fries and hog farms, of open roads and forgotten towns. While many stories were humorous recollections, they served

continues

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continued

to reinforce the group's commitment to improving the health care of rural communities.

Flandreau is a blip on the map, a town of 2,400 people 45 minutes outside of Sioux Falls. The streets are quiet and flanked by simple houses displaying American flags and birdbaths. At the end of one of these streets sits Flandreau Medical Center. The brick building could house anything – a post office, a public library, an elementary school. It appears no different than hundreds of other small town clinics or hospitals.

However, this particular medical facility is far from average. From the moment a patient arrives, regardless of time of day or night, he or she is under the care of a team of specialists and nurses. Utilizing video, audio and computer links, health care providers in Flandreau are in constant contact with doctors and nurses in the system's central hub at Avera McKenna Hospital in Sioux Falls.

Here, doctors and nurses monitor and field inquiries from the small clinics and hospitals scattered throughout the Dakotas, Nebraska, Minnesota, Iowa and Wyoming. A patient brought into the E.R. in a small hospital will receive care from local providers, but they can always press the red "help" button on the wall behind each patient's bed. Once activated, a camera and microphone link the examination room to specialists assembled in Sioux Falls.

One of those specialists is Avera eCare Medical Director Donald Kosiak, MD.


"For hundreds of years, we built the concept of rural people coming to the big city to receive specialty care," he says. "With the model we have in place here, we can build this virtual hospital around any small town hospital. Patients don't have to travel, families and significant others do not have to travel, and thus the culture of medicine can begin to change."

Care within this system is not limited to dedicated medical facilities. With the help of the Good Samaritan Society, home health care for the rural elderly is also being reshaped. The final stop on the e-Exploration tour was an assisted living facility, where residents enjoy a heightened degree of independence made possible by the incorporation of health care technologies.

Every morning, clients self-test their blood pressure and bodyweight. Monitors in the living quarters track residents' daily routines. Sensors in the mattresses measure their sleep quality. Staff analyze the generated data and search for irregularities that indicate a detrimental change in an individual's health. The end result is a living environment that affords a higher degree of independence while assuring family members that their loved ones are properly cared for.

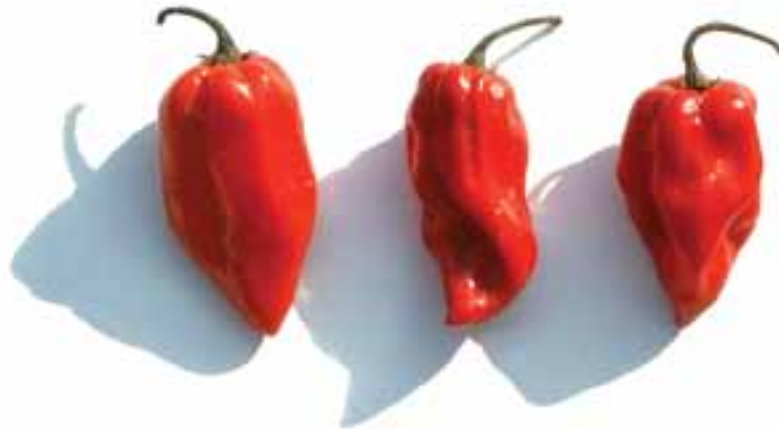


Emergency department personnel demonstrate admitting a patient to Flandreau Medical Center as part of the Helmsley foundation's e-Exploration event.

The event showcased the efforts and dedication of the Helmsley foundation and its partners in rural communities. The integration of technology into rural health settings is not a simple task. It takes time, creativity, education and perseverance. One specific model cannot serve as a common cure-all remedy for this complex issue; however, the model of compassion and care on display in the small hospitals and clinics in rural South Dakota and surrounding states can serve as the model for the HIT innovations of the future. 

hot topics

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NRHA anticipates the Arizona immigration law (SB 1070) may have unintended consequences on multiracial and multicultural people seeking needed care, creating a greater burden on Arizona's health care delivery systems.

The conference will include activities designed to increase awareness and explore strategies to address the law's impact on public health.



Small hospitals join NRHA to fight CMS' direct supervision proposal

When Tim Putnam arrives at Margaret Mary Community Hospital each morning, he faces decisions and difficulties unique to rural hospital CEOs like him.

In addition to workforce and economic woes, a new concern has emerged for Putnam as he tries to ensure access to health services in Batesville, Ind., population 6,414.

The Centers for Medicare and Medicaid Services (CMS) recently released regulations requiring a supervising physician be “immediately available” and “not otherwise occupied” during the entire course of a procedure in order to receive reimbursement for certain outpatient therapeutic services.

The direct supervision requirement would necessitate significant changes in daily operations at Margaret Mary and other critical access and small prospective payment system (PPS) hospitals.

“The best-case scenario,” Putnam says, “will be that we see an increased demand for physicians, which, because of the workforce shortage and therefore the need to offer competitive salaries, will in turn lead to an increased financial burden on hospitals.”

He's also concerned small hospitals will be forced to limit the timeframes in which they can offer outpatient services.

“Patients would have to rearrange their schedules to accommodate that of their local hospital, rather than vice versa,” he says.

Putnam's worst-case forecast paints a bleaker picture.

“It will more likely mean that hospitals will be forced to discontinue offering these services altogether,” he says.

CMS provides reimbursement for three levels of supervision in current law: personal, direct and general. For highly intensive procedures, personal or direct supervision is the accepted requirement, but for less-invasive procedures, such as administering an IV drip, general supervision levels are considered acceptable practice.

After making this decision in its 2010 Outpatient Prospective Payment System final rule last year, CMS faced significant push back from NRHA staff and members, including Putnam, other organizations and individual hospitals, and a litany of politicians on Capitol Hill.

In response, CMS announced it would delay enforcement of this rule for critical access hospitals (CAHs) until it could reassess the issue for next year's proposed regulation.

“NRHA was pleased with this temporary decision, but we also voiced our concern about the need to include small, rural PPS hospitals that often face the same barriers,” says Maggie Elehwany, JD, NRHA government affairs and policy vice president.

In its most recent proposed regulation, CMS planned to alter this rule to only require direct supervision at the initiation of the procedure, after which point the general level is acceptable.

“While this change represents a step in the right direction, it will have little effect on small rural hospitals that would struggle to comply with direct supervision requirements even at the initiation of service,” Elehwany explains.

For CAHs specifically, this represents a significant deviation between the safety guidelines included in their CMS Conditions of Participation, which deem these outpatient therapeutic procedures as safe, and reimbursement they receive.

“This change will therefore lead to increased financial burden on rural hospitals and decreased patient access,” Putnam says, “all while providing zero effect on overall patient safety and quality.”

The final regulations outlining the final changes for 2011 are expected soon, and if significant improvements are not presented a legislative solution will be pursued.

— Danny Fernandez, NRHA government affairs manager



Tim Putnam

Beginnings & Passages



Dan, Lukas, 4, Gavin, 2, and Karen Kroll on vacation in Colorado.

Working in rural health allows you to really get to know your patients.

Scholarship spurred interest in rural pharmacy

By Karen Kroll

I was interested in helping people and enjoyed high school chemistry, so my guidance counselor suggested I apply for the Nebraska Rural Health Opportunities Program (RHOP) scholarship for pharmacy.

Being part of RHOP opened my eyes to the many possibilities a rural practice offered. It showed me that rural pharmacists have to know about multiple pharmacy functions, and you never know what the day will bring. Working in rural health allows you to really get to know your patients and their families. This was all very intriguing because I love to try new things and know the people I live and work with.

I serve as pharmacy director at Thayer County Health Services, a 19-bed critical access hospital in Hebron, Neb., where my husband grew up. I oversee a long-term care pharmacy that provides medications for our local nursing homes and a separate pharmacy that provides for the hospital and clinics. I am involved in dispensing medicine directly to the patient, compounding chemotherapy so the patient doesn't have to travel over 100 miles for treatment, working directly with the doctor to provide the best care, or helping in the E.R.

The innovative atmosphere of this hospital is incredible. We are constantly moving forward to provide the best care and safety for our patients. We contract with St. Elizabeth's Hospital Pharmacy in Lincoln, Neb., to provide after-hours order verification, a huge benefit to our facility because we only have a pharmacist on staff during regular business hours. We also use bedside bar coding and electronic medication administration records to provide the best care for our patients. We are currently working on computerized physician order entry and connecting to our nursing homes electronically to increase patient safety.

After practicing in a rural area and getting to know my patients, I am confident I made the right choice. I am originally from a small town of less than 500 people. I knew who lived in almost every house. You can let your kids ride their bikes to the pool or go for a walk without worry. We are proud to raise our sons close to family and friends and to give them the same small-town experience we were lucky enough to have. It's a true pleasure.

Karen Kroll, Pharm.D., is Thayer County Health Services pharmacy director. She earned a Rural Health Opportunities Program scholarship in 1999. For more on the Nebraska program, see page 34.

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Darrold Bertsch

What started as just a job became a passion

By Darrold Bertsch

Growing up in a rural area of the Dakotas, I never imagined my career path would lead me through the ominous challenges we experience today in the delivery of health care.

It started 35 years ago when I decided that working in materials management delivering medical supplies and lab specimens at a South Dakota hospital was a much better fit for me than pumping gas and changing tires.

My first boss, Lyle, will still say today that I was not a “poster child” for the perfect interviewee. When asked why I wanted to work at the hospital, I said, “I need the bread, man.” I learned early on, however, just how rewarding and challenging working in health care was.

Whether it's the physician, business office, ancillary and support services staff, nurses or that young guy in materials management who took the 70-year-old housekeeping supervisor to work every morning in his jacked-up, red '66 Chevy Caprice, we all play a key role in the health care team.

I've been blessed with the opportunity to grow professionally throughout my career, which has taken me from South Dakota to Arizona and back to my roots in the frontier areas of North Dakota I now call home. I'm the CEO of Sakakawea Medical Center, a critical access hospital in Hazen,

N.D., located in the heart of the local energy industry and within earshot of some of the most robust expansion the oil industry has seen in quite some time.

As is the case with a large percentage of critical access hospitals across the country, we are in a rural area and provide many of the health and wellness-related services needed by the individuals in our community and service area. Often our facilities are the safety net provider of primary care services and one of the largest employers, contributing positively to our local economy. I have the unique opportunity to provide many of the health care needs to those who are privileged to call rural America home.

When the day is done, we know we're making a difference in the communities we call home. We'll most likely leave our keys in our vehicles and our houses unlocked, and we'll wave to a passerby with a full complement of digits exposed.

That's just the way it is here in rural America, and we're proud of it.

Darrold Bertsch is CEO of Sakakawea Medical Center in Hazen, N.D. He joined NRHA in 2009.



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– Alan Morgan, NRHA CEO



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– Beth Landon, 2009 NRHA president

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2011 NRHA president
Kris Sparks

5 questions: Get to know 2011 NRHA president Kris Sparks

1. What excites you most about serving as NRHA president?

My predecessors have given me a strong organization to work with. I am most looking forward to continuing to grow the membership and their involvement in NRHA. The health reform Grassroots calls (conducted by NRHA's government affairs team in Washington, D.C.) were a brilliant way to get NRHA connected to its members across the county. I want to find more opportunities to engage our talented members.

2. What are the main challenges facing rural health care in the next year?

I think the greatest challenge will be responding to health reform. What will accountable care organizations or value-based purchasing or insuring most of the people in the country mean to all our programs?

A lot of programs have been created to solve problems created by national legislation that didn't understand rural. I would like NRHA to be prepared for the unintended consequences of health reform.

3. What are your favorite free-time activities?

Vacations have primarily centered around golfing excursions or going to horse shows with my daughter. For both of these I am more moral support than participant. I do play golf, but not so well. Our vacations always involve spending time with good friends.

4. What led you to your career at the Washington State Department of Health's Office of Community and Rural Health in Olympia?

I was hired in 1990 when Washington State University's rural health programs were first developed. I love the work.

I often say that I have the best job in state government because I can help people. It may be something small like figuring out how to work through the bureaucracy of the state or federal government or connecting a critical access hospital to help in dealing with a potentially violent employee.

5. What are your favorite parts of working for rural America?

What I enjoy most is the people. Rural folks aren't in it for the money or glory; they are sincerely trying to help their neighbors and their community. I love supporting that passion.



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Members on the move

Myers receives Legacy Award

Wayne Myers, MD, received NRHA's Legacy Award July 22 at the annual Quality and Clinical Conference in Portland, Maine. The first of its kind, the award was intended to recognize Myers' contributions to health care in rural America and around the world.

"Healthy people in healthy rural communities summarizes my goal in various jobs for 40-some years," Myers says.

He joined NRHA in 1991 and served as president in 2003.

Hart to lead Center for Rural Health

In September, L. Gary Hart, PhD, became director of the University of North Dakota (UND) Center for Rural Health and a professor in UND's School of Medicine and Health Sciences.

"I am extremely pleased that we have been able to recruit someone of Dr. Hart's stature," says Joshua Wynne, MD, UND School of Medicine dean. "He is a nationally recognized expert in rural health care delivery and has a particular expertise in health care workforce issues. Because of his expertise, he will be of great help as we develop our health care workforce plan for North Dakota."

Hart most recently served as director of the Arizona Rural Health Office and public health professor at the University of Arizona.

He has been an NRHA member since 2007.



Labette Health Board of Trustees President Vince Schibi introduces Jodi Schmidt as the new CEO during a reception in her honor.

Schmidt moves across Kansas for CEO role

Jodi Schmidt, NRHA's Hospitals and Health System Constituency Group chair, recently became Labette Health's CEO in Parsons, Kan.

She had served Hays (Kan.) Medical Center for 22 years.

"In my first few weeks, I've found the hospital staff and entire community to be very welcoming," Schmidt says. "Certainly Labette Health faces the same challenges as other rural providers, but I'm enjoying the opportunity to work with a great group of people."

Schmidt, who has been an NRHA member since 1991, was one of 108 applicants nationwide.

News briefs

NRHA awarded Rural Training Track grant

NRHA recently became the grant recipient of the Rural Training Track (RTT) Technical Assistance Demonstration Program administered by the Health Resources and Services Administration's Office of Rural Health Policy.

"This grant will help to provide more research and analysis regarding RTT programs around the country, as well as help identify what some of the key policy issues are in these areas," says Amy Elizondo, NRHA's program services vice president. "It will also allow NRHA to work with our member experts to sustain and strengthen training new physicians receive as they prepare to practice in rural, underserved areas."

Employing the structure of existing programs, this project will:

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- establish a network of organizations and experts in the field;
- create state coalitions and convene meetings;
- build an online portal with tools, information and timely access to technical assistance;
- assist in developing new models and programs while sharing best practices;
- initiate a process for identifying and training new leaders; and
- gather data to publish a report and guiding document.

Lead by NRHA and anchored by project directors and field offices in Idaho, Ohio and Washington, D.C., the program will connect RTT program directors, faculty and staff with state offices of rural health, a rural assistance center and a rural research center in an effort to bolster existing RTTs and foster the growth of new programs.

NRHA members take part in bi-national celebration

The U.S.-Mexico Border Health Commission (BHC) celebrated its 7th Annual Border Bi-national Health Week (BBHW) the first week in October in conjunction with the 3rd Mexican National Health Week and the 10th Annual Bi-national Health Week.

The border-wide celebration brought together public health officials and community leaders from the region and nations, including NRHA members. Activities included more than 100 fairs, forums, training events and other health promotion and educational activities geared toward obesity and diabetes prevention.

Since the launch of NRHA's Border Health Initiative in 2008, NRHA has worked to highlight rural health issues on Capitol Hill and best practices along the U.S.-Mexico border.

"We're pleased that an organization as important as NRHA joined our efforts during BBHW 2010 to help grow the relationship between this mostly rural border region and NRHA," says Dan Reyna, BHC general manager and NRHA member.

These combined sponsored events are a joint collabo-

ration of the BHC, the U.S. Department of Health and Human Services, the Mexican Secretariat of Health, and the 10 U.S.-Mexico border states, which include 44 U.S. counties and 80 Mexican municipalities.

Health care helps rural development

Health care is often the biggest employer in rural areas, but it doesn't necessarily want to be. Another employer to boost economic development and provide insurance, bolster the tax base, and hire spouses of health care system employees would be beneficial.

USDA's Rural Development has articulated seven strategies for economic development, most of which can and should have a connection to the local health care system. Those strategies include:

1. Strategic partners. Health care leaders understand strategic planning and community engagement.
2. Capital markets. Health care is key to attracting new investments.
3. Regional food systems. In a growing number of communities, hospitals are serving locally grown produce.
4. Regional collaboration. Health leaders have become experts at this.
5. Community building. Hospital and clinic staff and board members are already active in strengthening their communities.
6. Alternative energy. Health care is already a major user of alternative energy.
7. Broadband. Health care will only continue to grow its use of broadband and related technologies.

To learn more about USDA resources, contact your rural development state director at www.rurdev.usda.gov/recd_map.html.

– Beth Landon, 2009 NRHA president

NRHA partners with Emory University in prostate health study

NRHA recently announced the grant award recipients of a study conducted in partnership with Emory University and the Centers for Disease Control.

continues

continued

The study, “Attitudes and perceptions surrounding prostate cancer amongst rural men,” examines behaviors and beliefs commonly displayed by rural men and their significant others concerning prostate health. It began last year with research sites in Durham, N.C., and southwest Georgia.

This year, the study continues with NRHA’s collaboration in the selection of two additional sites. Focus groups consisting of rural men and their significant others will be convened in the Mississippi Delta and in rural Virginia. These sites will allow researchers to gain further insight into the misconceptions and attitudes surrounding prostate cancer.

Prostate cancer is the second most common form of cancer amongst males, according to the National Cancer Institute. The study NRHA is partnering on will focus on African-American men, the group with the highest incidence of prostate cancer. Both research sites will construct their focus groups later this year in an attempt to closely examine attitudes pertaining to prostate health within this segment of the population. The project will be completed next September.

Nebraska pipeline program celebrates two decades



Students work on a dummy during a University of Nebraska visit.

In its 20 years, the University of Nebraska Medical Center (UNMC) Rural Health Opportunities Program (RHOP) has graduated 323 students. More than half of them currently practice in rural Nebraska, and 71 percent of graduates have

worked in a rural community at some point.

Looking to address the shortage of health care professionals in rural Nebraska, UNMC medicine and dentistry faculty conceptualized the program with Chadron State College educators in 1989. In 1990, the first high school seniors from rural areas matriculated

accelerating advocacy

NRHA staff, members seek rural-relevant meaningful use rule

The Centers for Medicare and Medicaid Services (CMS) released final regulations relating to its stage one meaningful use guidelines for electronic health records (EHR) over the summer.

The final rule, while still not perfect for rural providers, included positive changes from CMS’ original proposal.

First, it made critical access hospitals (CAHs) eligible for the program’s Medicaid incentives. The regulation also relaxed previously restrictive computerized physician order entry (CPOE) requirements to allow orders entered by certain non-physicians, such as pharmacists, to count toward a hospital’s CPOE threshold.

Still, NRHA is concerned that rural hospitals and eligible providers will not receive many of the program’s intended benefits.

A recent NRHA-conducted survey of 265 CAHs nationwide

showed that, based on CMS’ proposals prior to the positive changes above, at the most only about 30 percent of CAHs would qualify for meaningful use incentives.

“With many CAHs working hard to implement HIT systems, we believe this number could increase to about 50 or 60 percent based on the final regulation’s changes, but this still leaves about half of all CAHs out of luck,” says Brock Slabach, NRHA’s member services senior vice president.

At a recent hearing in the U.S. House of Representatives, Greg Starnes, NRHA member and CEO of Fayette County Hospital in Vandalia, Ill., was part of a panel of experts to testify. Starnes played a critical role, serving as the only rural representative to adopt EHR while at the same time dealing with the difficulties faced by rural providers, Slabach says.

“Health information technology plays a significant role in fixing longstanding access barriers in rural America’s health care infrastructure,” Slabach says. “So it’s essential we ensure meaningful use guidelines are developed with rural in mind.”

at Chadron State College and were simultaneously pre-admitted to UNMC programs of their choosing.

Within a year, Wayne State College joined RHOP, and today high school students applying to the program can choose between medicine, pharmacy, dentistry, dental hygiene, clinical lab science, nursing, physician assistant, physical therapy and radiology programs at UNMC. And the state colleges grant tuition waivers to students during their undergraduate years. There are currently 207 students with an interest in rural health at various stages of the program.

“We see ourselves as a 500-mile wide campus,” says UNMC Chancellor Harold Maurer, MD. “RHOP is highly successful in populating rural Nebraska with health care practitioners.”

The College of Dentistry has been most successful in placing RHOP graduates in underserved areas. Thirty-one of the 43 dental grads, or 72 percent, are practicing in rural Nebraska.

Patrik Johansson, MD, UNMC College of Public Health rural health education network director, says the program’s 20th anniversary is an opportunity to celebrate its achievements and “address the increasing health care professional shortage in rural Nebraska through the growth of new pipeline programs.”

The University of Nebraska-Kearney (UNK) and the UNMC College of Medicine established a curriculum at UNK to prepare students for medical school tuition-free. In addition to admitting high school students who will go on to physician training, that program has a non-traditional track for students with some college experience who are working full-time. Five students began the Kearney-based program this fall.

NRHA border health meeting addresses disparities

The fourth meeting of the NRHA Border Health Initiative took place Sept. 20-21 in Arlington, Va. Representatives from the Office of Rural Health Policy (ORHP), the Health Resources and Services Administration, NRHA staff, the United States-Mexico Border



The fourth NRHA Border Health Initiative meeting was Sept. 20-21 in Arlington, Va.

Health Commission, and other key stakeholders from the four U.S. border states attended.

The NRHA Border Health Initiative began in 2008 as a means of outreach from NRHA to the underserved, rural areas along the U.S.-Mexico border. This region faces many of the same disparities and barriers to care as other rural areas, but issues along the border are compounded due to complex social and economic variables, making the struggle to improve health care even more daunting.

The agenda for the two-day meeting included presentations from the Pan-American Health Organization, the Office of Minority Health, ORHP, the U.S.-Mexico Border Commission, and an update from NRHA government affairs staff pertaining to border health advocacy issues.

“Each meeting has allowed the initiative to grow and to mature. Looking back over the last two years, we have consistently been able to bring the right people to the table and have begun to effectively address the diverse health disparities prevalent in the border region,” says NRHA CEO Alan Morgan.

The next Border Health Initiative meeting is planned for the summer of 2011.

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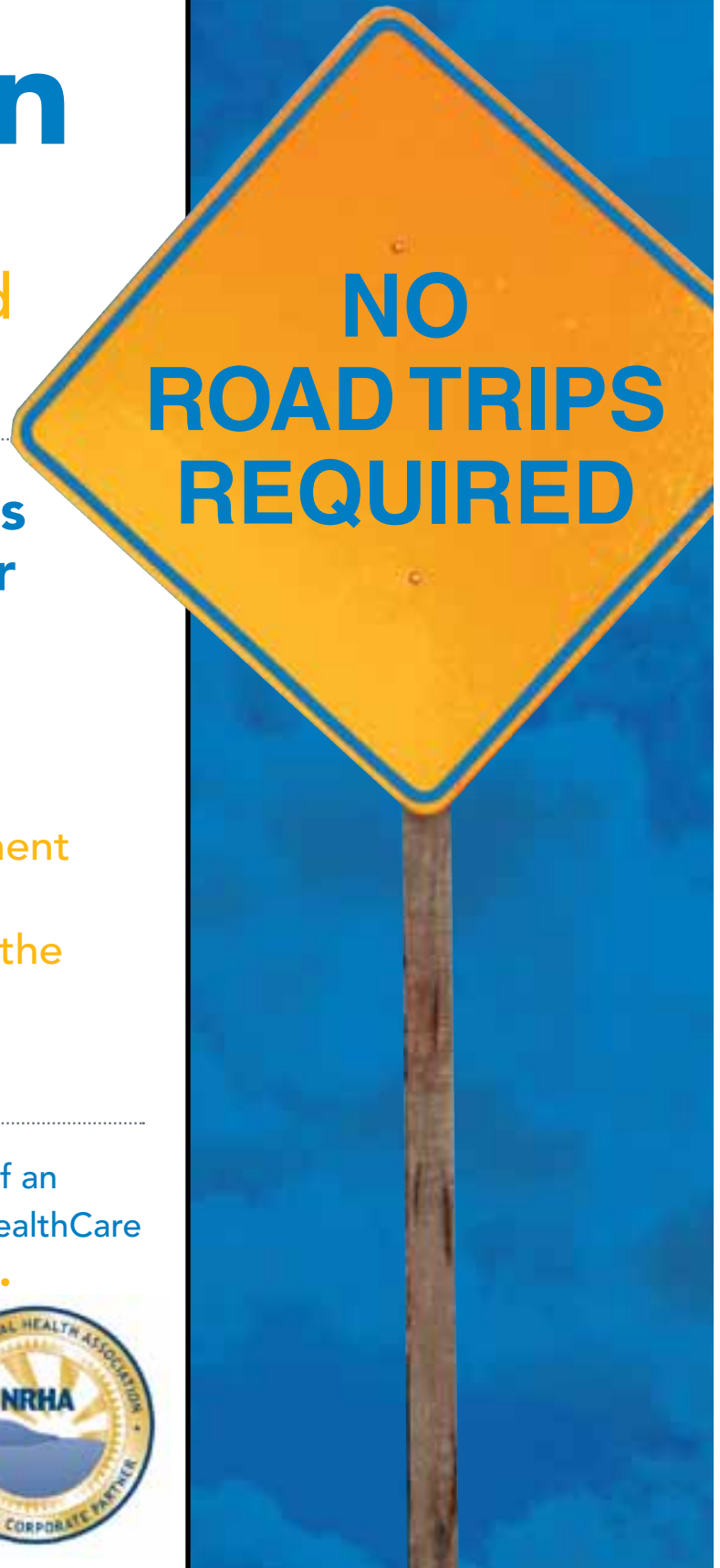
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Regulatory rundown

In the last **3 months**, NRHA has read through **3,431 pages** of the Federal Register and submitted **7 letters** with **48 pages** of comments to the Administration's planned regulatory efforts, including:

- Centers for Medicare and Medicaid Services (CMS) outpatient prospective payment system CY 2011 proposed rule
- CMS inpatient prospective payment system FY 2011 proposed rule
- CMS critical access and PPS hospital telemedicine credentialing and privileging changes
- CMS meaningful use final rules
- CMS physician fee schedule proposed rule
- Federal Communications Commission rural health broadband proposed rule
- Health Resources and Services Administration health professional shortage area/medically underserved area proposed rule



shifting gears

Green caffeine

First morning stop the coffee shop? It's easy to make your morning pick-me-up a little more eco-friendly.

- Instead of using a disposable paper or Styrofoam cup, bring your own reusable thermos. Bonus: your coffee will also stay warmer longer.
- Known as "java jackets," those cardboard coffee cup sleeves can be easily replaced by a cloth, knit or even silicone alternative. See www.treehugger.com.
- Whenever it's available, drink fair trade coffee, which is certified to help promote equitable and sustainable trading practices with producers in developing nations.

Off the beaten path

Giant doctor's bag



Photo by Erika Nelson, World's Largest Things Inc.

Just off **Route 4** in **Newark, Del.**, population **28,547**, sits a **10-foot-tall doctor's bag** made of steel.

It might have been **forgotten by a giant on his way to a house call**, but it seems right at home on the front lawn of Apex Medical Center. It also features a **massive stethoscope** hanging over the side in which visitors can recline.

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- 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
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Austin, Texas

Annual Rural Health Conference

May 3-6
Austin, Texas

Quality and Clinical Conference

July 20-22
Rapid City, S.D.

Rural Health Clinic Conference

Sept. 27-28
Kansas City, Mo.

Critical Access Hospital Conference

Sept. 28-30
Kansas City, Mo.

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