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National Guard Maj. Jaime Dodge, MD, sees patients in an outreach clinic in Afghanistan.

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On occasion, I ask audience members to raise their hands if they live in towns of 5,000 or less. I then ask how many know their pharmacists on a first-name basis. With the exception of a few folks, the same hands go up each time.

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Paul Moore
NRHA president

pit stop

5 things I picked up in this issue:

1. Your clinic parking lot can double as a farmers' market, and that abandoned Wal-Mart might make a great wellness center. *page 35 and 48*
2. Riding a bike across Iowa is an extreme way to relax. *page 52*
3. You can get your mail and a mammogram in one place. *page 24*
4. Moonshine is a great way to say thanks. *page 17*
5. A little effort goes a long way for the environment. *page 57*



Afghan families wait for hours for the chance to be seen by a U.S. doctor or medic who can also provide medications and humanitarian supplies.

Health care on the frontlines

By Lindsey V. Corey

Serendipity. That's what Capt. Darren Sommer calls his time stationed near the Afghanistan-Pakistan border.

"I know it sounds crazy and I didn't expect it, but I found my passion over there," he says.

In 2007, Sommer, DO, MPH, started the Khost Physician Training Program. For six months, U.S. doctors trained six Afghan counterparts in primary care and disease prevention with a focus on patient education and documentation as well as continuing education for local health care providers.

A lasting impact

This was the first military-sponsored, American-Afghan training program since the war began.

"It had never been done this way before," Sommer says. "Most of the time, we'd just go in and give them medication. But we didn't want patients to become dependent on our base for services. We wanted to have a lasting impact on health care in cities and villages throughout the region without undermining local health care."

Sommer says well-equipped and fully staffed American clinics in war zones often negatively impact local health care providers.

"If your livelihood depends on these patients and then all of a sudden the Mayo Clinic sets up practice in your small town in Iowa, that's bad for business," he says.

The Army team used pharmaceuticals and supplies to gain physician acceptance.

“We didn’t do direct health care,” Sommer says. “We invited them (Afghan doctors) to work with us in our clinic so their patients see them there. It built credibility because Americans were learning from them. Physicians loved it and word spread.”

To further advance the mission, a clinic was built off base but within a relatively secure area. Afghan patients of any age, gender, ethnicity, socioeconomic and religious backgrounds were welcome. And all care, from check-in to discharge, was handled by Afghan workers.

“We didn’t want it to look like a U.S.-led program,” Sommer says.

“If a dude has the sniffles or just got shot, you’re the end all, be all, cure all. There’s no greater calling, and I loved it.”

Sgt. Robert Hawkins

“The camaraderie between doctors was excellent. I learned as much from them as they did from me.”

U.S. doctors did not treat patients. They only offered mentorship, encouraging Afghan physicians to spend time with patients and take a holistic approach to care. American physicians also provided educational feedback to help Afghan doctors prevent and identify early signs of disease.

“In the Third World, prevention should be the focus as opposed to an MRI machine and cath lab,” Sommer says. “This training would help with diabetes, high blood pressure and depression and do more for the area’s health care in the long run than a big expensive hospital without funding or staff with basic knowledge to be effective.”

The partnership was designed to last just long enough for the first team of Afghan doctors to gain a solid understanding of key primary care concepts. From there, the trainees would become the trainers for a new group of Afghan providers, allowing the model to continue throughout the country without American involvement.

“Between working in a rural migrant clinic in med school and my master’s in public health, I was really in touch with what these provinces needed,” Sommer says. “As we become more global, all physicians should be trained with a broader perspective.”

From base to backpack

Staff Sgt. Nickie Taylor, LPN, and Lt. Col. Bill Smith Jr., MD, also put skills gained in rural America to use in remote areas throughout the Middle East.

Taylor, who worked in a Montana nursing home, suddenly found herself in one of Saddam Hussein’s former hospitals. The portable equipment was

familiar, but the patients and problems were something she’d never seen.

“It was really hard to see these young, young soldiers coming through missing legs or arms or really injured,” she says. “They were just so young, and some didn’t make it. Here, you get that every now and again but not all this trauma and death on a daily basis. It was hard to see.”

Even harder was telling soldiers when a friend of theirs didn’t make it.

“That really isn’t a nurse’s role in the U.S.,” Taylor says. “I just had to go off pure gut. And when it was too much, you had to push it away because there was no time to deal.”

In addition to caring for U.S. troops in Baghdad, Taylor also helped Iraqi patients at the Green Zone hospital. She says language and cultural barriers made it difficult. Iraqi men did not want females to touch them.

“We were warned about that, but it’s still frustrating coming from America where women are independent and trusted to do things, especially as simple as taking them for walks or giving them baths,” she says.

But it was the Iraqi children that affected Taylor most.

“I never expected to take care of pediatric patients over there,” she says. “That was the most difficult thing. One of my last patients, a toddler, died in my arms, and we had no idea where her family was.”

She can’t forget that little girl.

Like Taylor, while practicing back in the United States, Smith often remembers one patient in an isolated village near Pakistan.

Haunted by the Sept. 11 attacks, Smith left two community-based hospitals in Kentucky to re-enlist in the Army. He was called up once and has volunteered for two tours since, during which he provided direct care for Afghan and American patients sometimes from a base hospital and sometimes from his backpack on a mountain in rural Afghanistan.

“I met a young man in his early 20s walking on his hands,” he recalls. “His left leg was withered. He’d had polio when he was 6. If he’d had crutches then, he

continues

continued

would have been able to get about. Instead, all he had were shoes for his hands.

“All this poor fellow needed was crutches when he was a boy, and there I was having to explain that there was nothing I could do. There’s no way of reconciling it. In rural Kentucky or Tennessee, you can still send even the poorest person to a major medical center. In Afghanistan, we were it.”

No greater calling

In Iraq, Sgt. Robert Hawkins was it for one infantry platoon.

The former volunteer firefighter and EMT was deployed to Iraq as a medic responsible for about 25 combat soldiers and any injured insurgents his battalion came across.

“That’s the holy grail for being a medic,” says Hawkins. “If a dude has the sniffles or just got shot, you’re the end all, be all, cure all. There’s no greater calling, and I loved it.”

Hawkins says being a first responder in rural New Mexico helped prepare him for duty.

“When you first get into EMT work you’re very timid,” he says. “Like the first time you see a bone protruding, you might have a bit of a freak out. But then it starts to lose its freak-out value, and you see injuries as injuries no matter how bad.”

But this was a war zone. Hawkins fought with his battalion until medical help was needed.

“There’s nothing you can say to accurately depict what it’s like,” he says. “But when you get real scared in the middle of a car accident... it’s like that all the time. There are highs and lows and some down time, but when things kick off, hold on!”

Instead of an ambulance or helicopter full of equipment, Hawkins carried ammo and a small aid bag.

“Iraq was more rural than even I was used to,” he recalls. “Evacuation times were more of a problem. If someone was injured, we had to load them sideways into a truck while trying to provide care and maybe working under a gunner who is swiveling to keep bad guys from shooting you.”

Hawkins took a bullet to the leg once. It broke the clip so his pouch with bandages and supplies was gone. Even so, he was able to control the bleeding and tend to another soldier on the side of the road.

“Nothing but a good scar (and a purple heart) to remind me,” he laughs.

“The camaraderie between doctors was excellent. I learned as much from them as they did from me.”

Capt. Darren Sommer

But Hawkins knows some scars don’t show. Part of his job as a medic was to conduct in-country mental health screenings.

“Nobody should have to see and witness all that we did,” Hawkins says. “Some guys are probably still haunted.”

Combat zone counseling

Some guys were worried about their wives cheating. Others needed a break from the team they’d been working, eating and sleeping with for a year. And some soldiers couldn’t cope with killing.

In Iraq, these men and women were referred to a two-and-a-half-day combat stress control program.

“If they were getting frayed around the edges, they were sent to us,” says Lt. Col. Dale Levandowski, MD, a psychiatrist who led one of two programs in Iraq in 2005 and 2006.

Participants took part in stress management class, athletic recreation, relaxation training and counseling sessions. The program was also a chance to let the soldiers connect with their support system at home, get some rest and help them sleep.

“We try to support and treat them as early and as close to the frontline as possible,” Levandowski says. “In Iraq it’s hard to tell where the frontline is, but we don’t want to send them all the way to Germany because they get the idea in their head that they aren’t really well. And if we get them too far from their unit, they can’t go back and be functional in it.”

The program, new to this war, is also designed to help prevent post-traumatic stress disorder (PTSD).

“We want to treat them quickly as opposed to waiting for months when they finally come home,” he says. “Time will tell how many still end up with PTSD. It still happens because war is hell, and people experience really bad things. No one’s made a nice war yet, so we’re going to have these problems.”

Sometimes garbage truck noise is too much for his patients. Others can’t sleep and turn to alcohol or drugs back in the States.

“It’s heart wrenching,” says Levandowski. “A lot of young soldiers want to do the right thing, and they go and do like their country asks, and it ain’t nothing like they thought. There’s an 18-year-old, just 18, on a mission doing his thing as a gunner, and when they rounded a corner he’s faced with an insurgent with a grenade in one hand and the other around the neck of a young girl. He’s got to decide whether to save himself and his buddies or potentially kill both the girl and insurgent. They face ugly stuff over there, and it revisits them night after night in their dreams. People live with it all their lives.”

Help at home

About 50 percent of deployed troops report symptoms of mental health disorders. Levandowski estimates less than half of those men and women seek help. Others are referred because relationship and addiction problems arise. And many suffer in silence, he says.

“There’s definitely a stigma,” he says. “It’s just the way the Army is. More people are coming, but I’m not so sure it’s always appreciated or well

understood. If you can see a cast or bandage, it’s real. But if it’s emotional in nature it’s not understood, and the temptation is to call it crazy or cowardly as opposed to a combat-related injury.”

Back home, new veterans are referred to the Veterans Administration (VA) for mental health care.

“The VA is on the cutting edge of PTSD treatment,” Levandowski says. “Unfortunately, they’ve been doing it a long time now. But that doesn’t help you out in the boondocks.”

Which doesn’t make sense, says Hilda Heady, associate vice president for Rural Health at West Virginia University and executive and state program director of the West Virginia Rural Health Education Partnerships/Area Health Educations Centers.

Young rural residents are 44 percent more likely to serve in the military than their urban counterparts. And of the 21 states with higher than the national average of

continues



Afghan citizens line up outside an outreach clinic for medical care and supplies from clothes to baby formula.

continued

veterans, 18 are predominantly rural.

“Recruitments target rural people,” says Heady, a past NRHA president who serves on the Department of Veterans Affairs’ new Veterans Rural

“They face ugly stuff over there, and it revisits them night after night in their dreams. People live with it all their lives.”


Lt. Col. Dale Levandowski

Health Advisory Committee. “A lot of research says they do it for economic reasons, but that overlooks a very strong core value rural people have about service for others. Volunteerism is still alive and well in rural America. Look at rural fire departments. Rural communities depend on volunteers, and the military is another way to serve.”

Not only are rural residents more likely to enlist, they’re also more likely to participate in combat than military personnel from urban areas. Heady recently helped conduct a study for the West Virginia state legislature that found 71 percent of rural National Guard soldiers were assigned combat duty compared to 39 percent hailing from urban areas in the state.

“Rural people already know about access to health care barriers,” she says. “So when the rural veterans return home, if they have an injury or stress reaction, their likelihood to access care close to home is very remote, particularly in the area of mental health care. There’s a critical shortage.”

Heady says providing health care to a growing number of rural veterans will require collaboration between the VA, the Department of Defense and civilian providers.

“A lot of these problems we have are because we’ve never deployed such large numbers of National Guard as we have with this war. There’s just not one system that can do it all,” she says. “All rural primary care providers need to be trained to know what to look for. They generally don’t have a lot of patients with PTSD and traumatic brain injury. We simply have to prepare them to help these folks who are going to be in their communities.” 

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Angela Lutz, National Rural Health Association

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Rural relocation from Afghanistan to Iowa

By Lindsey V. Corey



Jaime Dodge's job interview connecting Iowa, Nebraska and Afghanistan is captured in this screen shot.

Jaime Dodge, MD, didn't dress up for his latest job interview.

He wore dusty fatigues and logged in from a war zone to make his case for a career a world away at Horn Memorial Hospital.

In Iowa, CEO Dan Ellis and would-be colleagues huddled around a computer to get their first glimpse of the guy behind the resume.

"We'd e-mailed and were interested making an offer, but you'd kind of like to talk to the person face-to-face and ask questions before you make a decision," says Ellis. "You worry about whether you can really get a good enough feel for a person on the other end of a CV."

So a recruiter set up the video conference between Afghanistan and Ida Grove.

"I was really just worried about if the connection would hold or if there would be a delay. I only had one set of clothes so that sort of took the pressure off," Maj. Dodge says. "Fortunately, technology had improved or I could have missed out on an opportunity."

Prior to the interview, Dodge's wife Melissa had made the trip across Nebraska to visit the hospital and community of 2,000.

"She wanted to be his eyes and ears in Ida Grove," Ellis says. "So we treated it just like he was here, gave her the same tour and information, and

she sent video over to Dr. Dodge."

Dodge says he considered leaving private practice in Alliance, Neb., while deployed with the National Guard.

"Sometimes being over there gives you an opportunity to reflect and put things in perspective," he says. "That probably played a role in it."

The family practice physician wanted to devote more time to medicine and less to co-managing a business. And he knew he wanted to continue to serve a rural area.

"I like the challenge and chance to improve a community," Dodge says. "You have patients from babies to 100 so it's challenging to stay current on such a broad area. And you don't have all the resources like specialists and technology in a small town so in some cases you make due with what you have... kind of like in war zones."

He says his experience providing medical care in dangerous areas helps at home.

"It's helped me a lot with trauma care here," he says. "And I feel better prepared for medical outreach to civilians there because I'm used to family medicine all day."

Ellis was pleased to learn Dodge performs C-sections.

"We don't have a general surgeon on site all the time, so that level of security is really important to a rural

"Trying to recruit physicians to rural hospitals isn't always easy, so being open to different angles and receptive to an alternative way paid off for us."

Dan Ellis, Horn Physicians Clinic CEO

environment," he says.

Dodge will replace a retiring physician who worked at Horn Memorial for 30 years.

"Trying to recruit physicians to rural hospitals isn't

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always easy, so being open to different angles and receptive to an alternative way paid off for us," Ellis says. "And his military involvement spoke about the character of the candidate. Serving his country says something about him as an individual and his commitment."

Dodge has been deployed twice and likely faces another 90-day Middle East tour. He says his partners and patients in Alliance have been supportive, but Dodge knows other National Guard doctors in solo practice who've had to take out loans to pay staff while they're overseas or close their offices and start over when they return.

"It's tough, but there are still altruistic doctors who volunteer," he says. "But I don't know what will happen if this war continues for 10 more years and deployments become longer or more often. It's certainly rewarding, but also a struggle because people need you here too." 



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Email: Barbara.york@multicare.org (Fellowship Coordinator)

Answering the call

NRHA members participate in Iraqi health care conference

By Lindsey V. Corey

Wayne Myers, MD, was looking for a few good health professionals to join him in Baghdad.

“Finding them wasn’t easy,” he says. “Ninety percent of the people I asked said I had to be crazy to go there when I didn’t have to. And 10 percent said it sounded like the opportunity of a lifetime. Practically nobody was ambivalent.”

H.D. Cannington and Paul Moore made up the excited 10 percent ready to pack their bags for the Iraqi New Health System Conference.

“I knew the moment he asked that it was something I had to do,” Moore, NRHA president, remembers of the invitation that came in June for the July trip. “The problem in front of me was getting the kitchen pass. At first my wife Carolyn thought I was crazy. But then she was 100 percent supportive of me... even if she didn’t like it in the least.”

Cannington, CEO of Morgan Memorial Hospital in Madison, Ga., had a similar reaction as he read the e-mail from Myers, who volunteered in northern Iraq in 2004.

“I guess I felt like it was what I was supposed to be doing and where I was

supposed to be at that particular time,” Cannington says. “I never really worried about going and coming back. I just thought of it as an excellent opportunity to see how another very, very rural country would deal with the issues of setting up a health infrastructure almost from scratch.”

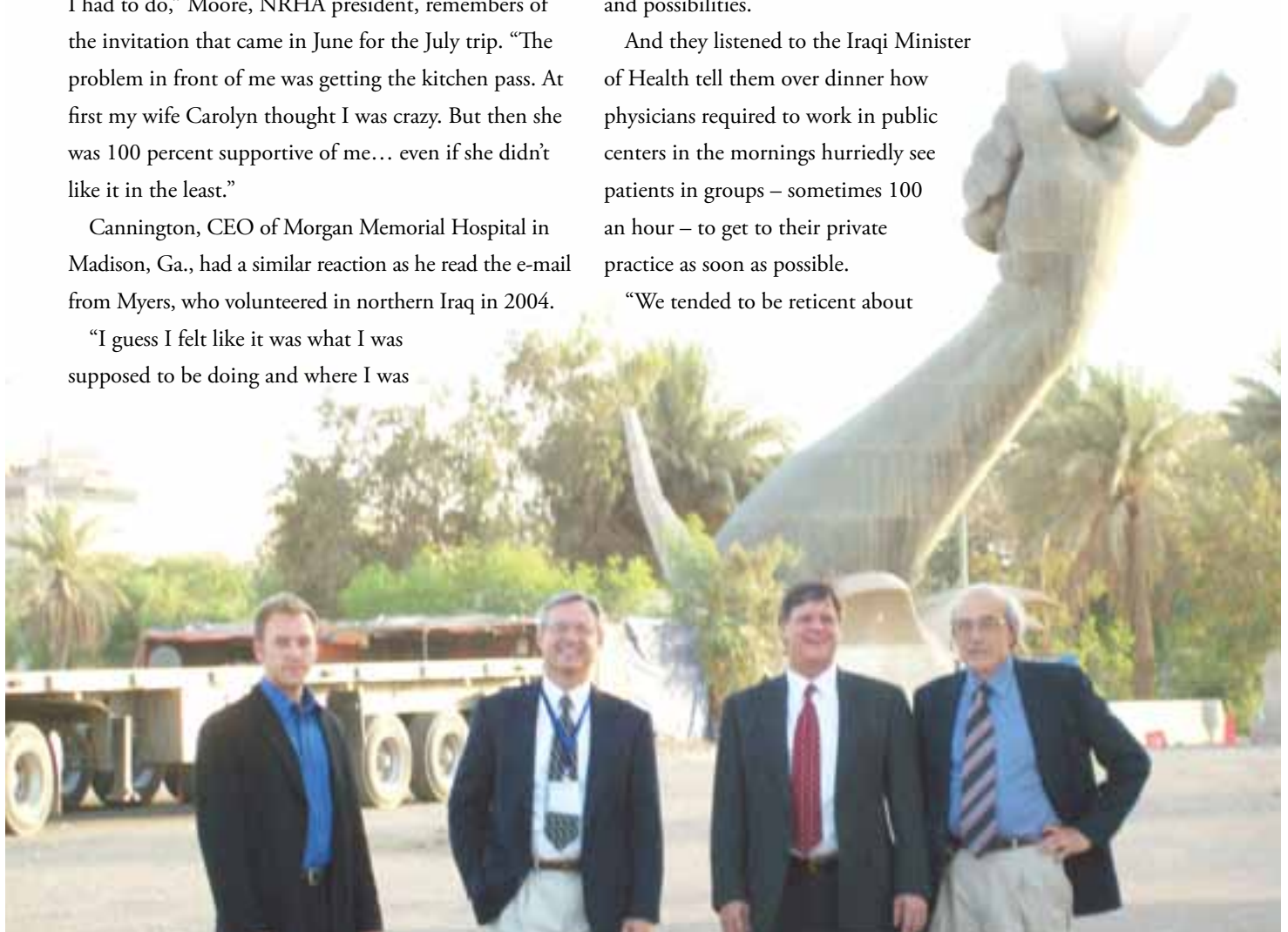
The three long-time National Rural Health Association members were as overwhelmed as their Iraqi counterparts. Everyone wanted to help, but it was almost impossible to know where to begin.

So they listened. Moore, a pharmacist from Oklahoma, listened to the physician who told him he hates pharmacists.

The trio listened and waited for translation as hundreds of participants took turns at the microphone speaking in Arabic about problems and possibilities.

And they listened to the Iraqi Minister of Health tell them over dinner how physicians required to work in public centers in the mornings hurriedly see patients in groups – sometimes 100 an hour – to get to their private practice as soon as possible.

“We tended to be reticent about



Ross Donaldson, UCLA assistant clinical professor of medicine, Paul Moore, NRHA president and pharmacist, H.D. Cannington, Morgan Memorial Hospital CEO, and

volunteering advice to people trying hard to take positive control of their own health care in their own way,” Myers says. “They have no insurance system, so starting one is an enormous deal that will consume part of the country’s economy. Simply tinkering with an insurance system in the U.S. is grounds for hand-to-hand political combat. There are certainly many ways America and Americans can help the Iraqis reform and rebuild their health care, but the big decisions are up to them.”

And they have to start small.

“They’re taking the first baby steps they have to take,” Moore says. “But security was the elephant in the room. If we continue to hear about body counts and IEDs, they can’t address the issues they need to address because they don’t feel safe. It’s great that people are starting to care on a national level, but survival comes first. Over there, you never lose track of the thought that you’re in an active war zone.”

“If we continue to hear about body counts and IEDs, they can’t address the issues they need to address because they don’t feel safe. Over there, you never lose track of the thought that you’re in an active war zone.”

Paul Moore, volunteer

Even so, the volunteers witnessed tremendous optimism.

“I have not seen so many positively excited people in a public meeting for a long time,” Myers says. “There are real possibilities for things to get better because the slate is relatively blank, they have some money, and the prospect for more is good. I think they’ve got at least a fighting chance of putting together a good system, but the sheer magnitude of the changes needed was surprising.”

The country is short on personnel, hospitals and supplies. There’s no insurance or ambulances.

“It’s the simplest things,” Moore says. “We’re over there with all this medical knowledge, and what they really need is clean water, sanitation—good ole public health.”

The Ministry is determined to make radical changes: pay a reasonable wage for public practice, strengthen the private sector by developing an insurance system, expand the domestic production of pharmaceuticals and medical supplies and improve health care financing, education and management.

Cannington found it to be “mind boggling.”


“It’s something I couldn’t imagine before I went there,” he says. “The biggest challenge is going to be getting a consensus on what they need to do and how to go about doing it. The problem I saw was not a lack of desire or money, but that they have never dealt with anything like this before because they’ve been under a dictatorship for so many years. Growing up in America, we’re taught to think things through and make decisions for ourselves. They really don’t have experience in making decisions.”

Moore says that while 400 to 500 people came together with the same overarching goal, fear and mistrust inevitably got in the way.

“There were Sunnis, Shiites, Christians and seculars all trying to work together,” Moore says. “And the leadership seems to be making a sincere effort at re-establishing some sort of primary health care system for the country after years of repression, sanctions and war, but they have huge logistical and geopolitical challenges ahead of them. There is such a history of fraud and sectarian ruthlessness there that while there seems to be a willingness to share some of the control, there’s a reluctance to do anything for fear that it might go bad. And in that country, if it went bad, you might pay for it with your life.”

The NRHA members say they felt relatively safe and valued in Iraq. Myers, who retired from family medicine and now operates a working farm in Maine, says he’s looking forward “to leaving the sheep behind and going back.”

“There’s a kind of dirty, dusty vibrancy to Baghdad,” he says. “We hear about the tragedies, but we tend not to think about the 7 million people going on about their lives doing what they have to do. I’m real interested in helping with health care reform there, to imagine what a difference it could make.”

And Myers is looking for volunteers again. The Iraqi Ministry of Health has asked him to recruit professionals interested in assisting with the country’s primary care plans. For more information, contact Wayne Myers at wwm@midcoast.com. 



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Temporary dental clinics provide lasting benefits

By Angela Lutz

Winter in southwest Kansas can be unwelcoming. Sharp winds blister the plains, quickly whipping snowstorms into blizzards. The roads, unsafe for travel, are whitewashed and empty, and most residents stay indoors.

Such was the weather in February 2003, when Terry Dickinson, DDS, and the Mission of Mercy project arrived.

On that blustery day in Kansas, people not only gathered outdoors, they waited in line, sometimes for hours. Many had braved the blizzard and traveled from across the state to get dental care that was either unaffordable or unavailable in their hometowns.

According to Dickinson, executive director of Mission of Mercy (MOM), this isn't unusual.

"I've never seen anything stop them," he says. "They'll pitch tents and sleep in their cars to be first in line. It gives an indication of how desperate they are for care."

For the past eight years, Dickinson and his team of volunteers at MOM have set up temporary dental clinics across America and provided comprehensive dental services to rural uninsured and low-income populations. Patients are never in short supply.

Dickinson started the MOM project in 2000 in Wise, Va. Wise was once a popular coal mining town, providing good-paying jobs with benefits. When the mining jobs disappeared, the town's economy suffered, and minimum wage jobs with no benefits became common. For many, paying for dental care would mean taking food off the table.

MOM responded directly to this need, recruiting volunteers to provide dental care at a temporary clinic in Wise. The clinic, set up in tents on a fairground, had no air conditioning, but no one seemed to mind the heat.

Services at the clinic include fillings, cleanings, root canals, extractions and dentures, which are prepared at an off-site lab. The clinic even provides meals.

"Every bit of it is free," Dickinson says. "All they gotta do is get there."

For startup funds, Dickinson requested money from the Virginia Healthcare Foundation. He also receives funds through grants and



"They'll pitch tents and sleep in their cars to be first in line. It gives an indication of how desperate they are for care."

**Terry Dickinson,
Mission of Mercy executive director**

donations – there are four or five people and organizations that donate annually – and recently, Virginia Gov. Tim Kaine gave MOM money in his budget.

Since MOM is a volunteer organization, the main overhead costs are transportation and supplies. For each dollar donated, they produce \$32 of direct patient services. Each project costs \$15,000 to \$20,000.

"Funding is always a challenge," says Dickinson. "I'm always looking for opportunities."

A valuable service

In the early days of the project, Dickinson was aware what an important service he and his volunteers were providing. He recalls the time a woman in her 20s and her young daughter arrived in a beat-up Chevy after closing time. When told it was after hours, the woman revealed she couldn't afford the gas for a return trip, so volunteers worked late to treat her. As gas prices rise, Dickinson expects such situations will become more common. He already sees more people carpooling.

At another clinic, when a 30-year-old woman and mother of eight showed up after closing time, volunteers



Opposite page, lower left: Volunteer dentists at work at the Mission of Mercy clinic in Wise, Va. Opposite page, upper right: Terry Dickinson, Mission of Mercy founder, takes a moment to relax during a free clinic. Above: Patients wait outside a Mission of Mercy clinic to receive free dental care. At left: Volunteers at the Mission of Mercy project provide a free dental cleaning.

worked late to pull her teeth, all of which were rotten. They also made her dentures free of charge, but when the dentures were ready to be delivered, she had disappeared. They have been unable to track her down.

“It’s amazing how addresses and phone numbers change when we try to do follow-up work,” Dickinson says.

He has also encountered skepticism. When a 22-year-old man in North Carolina needed most of his teeth pulled, his mother was unsure of MOM’s intentions, saying, “People don’t do things like that for free.”

Dickinson’s response: “You tell him to get his rear up here, and we’ll show him and his mother.”

Of course, they “got him fixed up,” and he returned home with a new set of teeth.

Providing free dental care to those who need it is all part of Dickinson’s mission.

“We’re trying to do something for as many people as we can. If they have some type of infection or pain, we want to take care of that,” he says. “If they weren’t seen in the clinic, they would end up in the emergency room.”

Even when MOM doesn’t have the necessary equipment to correct a problem, they connect patients to the services they need. Among the most memorable of these cases was a 52-year-old man who arrived at the Wise clinic two years ago. He had a cleft palate, and as a result he was unable to talk. He dropped out of elementary school, never learned to read or write and was disabled working in coal mines. MOM referred him to a facility that performed the surgery necessary to repair his cleft palate at no cost.

When patients receive such life-changing care, they aren’t shy about showing their gratitude. Five or six years ago, Dickinson treated the wife of one of his volunteers, and each year since she has baked him a blackberry cobbler.

“It’s fresh out of the oven,” he says, “so hot you can’t hold it.”

A grateful patient also once gave Dickinson some homemade peach moonshine.

“It’s pretty strong stuff,” he laughs. “For a cold winter day, it could really warm you up.”

continues

Spreading the word

Despite the clinic's success, Dickinson knows the discussion about oral health care in America is just beginning.

"The MOM project creates a basis for a conversation that needs to occur about what we want to do to help our neighbors," he says, noting that before their experiences with MOM, many volunteers and people in nearby communities had no idea there were people living near them – their neighbors – who struggled daily.

MOM helps alleviate these struggles, but perhaps more importantly, it gets attention. In Virginia, Gov. Kaine and Virginia Department of Medical Assistance Services Director Pat Finnerty have visited the clinic, and the attention and support of these leaders is key to formulating long-term solutions to the oral health care disparity in rural communities, Dickinson says.

The MOM program also draws attention to the limited availability of health insurance. Lack of health insurance is common in communities like Wise, where companies are small and can't afford insurance for their employees. In fact, 70 percent of families without insurance have at least one member with a full-time job.

"Lots of folks are just happy to have a job," Dickinson says. "It doesn't seem right that they have to then struggle to get health care."

"Having a full-time, experienced dentist who is available to serve our children and our community is truly a blessing."

Linda Matessino, Innis and Livonia
Community Health Centers executive director

Since 2000, Mission of Mercy has expanded to Arkansas, Colorado, Connecticut, Iowa, Kansas, Maine, Nebraska, North Carolina, Texas and West Virginia, and roughly 75,000 patients have been served. The Virginia MOM project returns to six locations annually and stays at each for a couple of days, including Wise, where one fourth of the patients consider the clinic tents their "dental home." This year, volunteers in Arizona, New Jersey, New Mexico, Pennsylvania and South Carolina are planning to start MOM clinics.

Services have also expanded, and in addition to comprehensive dental services in Wise they now offer full medical exams, including sight and hearing, gynecological services, mental health and smoking cessation assistance. Most of the volunteers for these services come from medical schools at area universities, as well as the local Lions Club.

The number of volunteers has also increased. When the project began, Dickinson would ask local dentists to recruit volunteers. Now, volunteers contact him, and many sign up online.

"Once word gets out, volunteers aren't a problem," Dickinson says.

MOM boasts an 80 percent volunteer return rate. The volunteers are so numerous and dedicated that many put up signs when they leave for lunch to reserve their spots at the clinic.

To anyone wishing to start a similar project, Dickinson insists "you gotta have somebody who's passionate."

He personifies this passion. Before starting the MOM project, he had a successful practice in Houston for 30 years, but "for some reason, things didn't seem to be complete."

In 1996, he began searching for something that had more of an impact, a journey that led him to Wise.

Dickinson's hard work and compassion was recognized in May at the National Rural Health Association's Annual Conference in New Orleans, La., where he received the Rural Health Award for Practitioner of the Year. The setting was fitting: Dickinson led the first dental clinic to reach those affected by Hurricane Katrina.

"I believe we're here to be of service, to help folks," he says. "I'm a truly blessed individual to find something like this that can help other people in a major way."

Smiles to Go

While MOM provides care mostly for adults (only 5 percent of its patients are children), innovative dental clinic Smiles to Go provides mobile access to oral health care for six elementary schools in Louisiana's Pointe Coupee Parish and has had more than 800 visits since opening its doors in November 2007.

"Children's dental health is suffering in this parish, as well as in our state and nation. Access is a critical barrier to receiving this care," says Linda Matessino, executive director of the Innis and Livonia Community Health Centers that run Smiles to Go.

In addition to visiting schools, the clinic sometimes performs free oral health screenings to educate the community and identify existing oral health problems.

According to Joan Welch, DDS, full-time dentist for the mobile clinic, dental caries is the most common chronic disease suffered by children, five times more prevalent than asthma and seven times more prevalent than hay fever. Twenty-five percent of children in the United States have never seen a dentist by the age of six, and it is estimated that more than 51 million school hours are lost annually due to dental-related problems. Traditionally, these statistics are even worse in low-income children, who have a significantly greater amount of untreated dental decay, Welch says.

“This is especially true in our population,” says Matessino, a resident of Pointe Coupee Parish, a designated health care provider shortage area (HPSA) and a medically underserved area (MUA) where “accessibility to dentists who will accept the Medicaid card for dental services is a challenge.”

Compounding the problem, dentists will rarely see uninsured children, and transportation is a significant barrier.

“Parents can’t always take off work to get the proper dental care that children need,” Matessino adds.

Breaking barriers

“That’s where we come in,” Welch says. “We bring the dental care services directly to the children at the school site, where we are seeing as many as 40 children a week.”

“Our program’s motto for business is to create the access, and they will come,” adds Matessino. “This approach sets us apart from other programs around the nation.”



The Smiles to Go mobile dental van travels to schools in Louisiana’s Pointe Coupee Parish.

The mobile

dental clinic operates within the framework of the Innis Community Health Center, a federally qualified community health center, to reduce the barriers of access, transportation and affordability of dental care.

Welch is a Louisiana native and graduate of Xavier University in New Orleans. After receiving her doctorate of dental surgery from the Meharry School of Dentistry in Nashville, Tenn., Welch enlisted with the United States Public Health Service Corps. She has held several positions as chief dental officer in duty stations across the nation, most recently serving as the dental director for the Crossroads Rhode Island homeless health center in Providence.

A commander in the United States Public Health Service Corps, Welch is on loan to the Innis Clinic as a Service Corps ready responder for a three-year period. She was excited to return to Louisiana to start the unique program.


“Dr. Joan Welch is one of the many highlights of this program,” says Matessino. “Having a full-time, experienced dentist who is available to serve our children and our community is truly a blessing.”

Matessino’s Innis clinic was able to obtain grant money to purchase the mobile unit and uses its operating funds to finance the program. The mobile clinic houses two stations fully-outfitted for dental services. Although smaller than a private office, the clinic’s space is used efficiently and operates with state-of-the-art equipment, offering both preventative and restorative dental treatment, as well as cleaning and dental exams.

Smiles to Go is scheduled to be at each of the elementary schools in Pointe Coupee Parish for a period of three to four weeks at a time. This allows each school and administration to work closely with the program to serve as many children as possible.

“The administration, staff and children all get to know us and have really integrated us into their daily school life,” Welch says. “Being on their campus for weeks at a time has enabled me to reduce the fear factor usually associated with a dentist visit, not to mention that I am able to reinforce to them the importance of cleaning their teeth every day.”

Although the mobile dental clinic has been operating for less than a year, Matessino is already looking at options to grow. Long-term plans include offering services to schools in other rural parishes and to businesses and plants in Pointe Coupee Parish. Matessino will also focus on expanding the dental education program, initiating more in-classroom dental education and planning a tobacco and smoking cessation initiative.

“We are excited to watch this program develop and grow,” Matessino says. “Protecting these smiles is protecting their future.” 

Tara Haney and Emily Tiller contributed to this article.

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One village at a time mammograms across Alaska

By Lindsey V. Corey



Jennifer Cowan, Mary Lee Kreger, Jacqueline Barsis, Naomi Barker and Charlotte Harvey wear “peace, love, cure” and “girl fight” shirts they made to welcome the Breast Cancer Detection Center technician and patients to the Planned Parenthood of Alaska clinic in Soldotna.

[There’s no such thing as a typical day in rural health.](#)

But it takes a different kind of resilience to wait out a stubborn volcano or set up shop in the village post office.

Alaska’s erupting mountains, blizzards and fog may slow Jackie Stansfield down, but they haven’t stopped the Breast Cancer Detection Center (BCDC) technician yet.

“You have to be pretty flexible,” she says from the center’s Anchorage headquarters, where she awaits a third attempt to get past a spewing volcano on the way to Dutch Harbor. “It’s very sporadic. Some places you can plan on that and not much else.”

But she doesn’t mind. Stansfield knows the women will wait, just like they do every year for free mammograms from the machine that sometimes arrives by barge or plane before Stansfield can.

“They actually remember my name after a year,” she says, “which is really nice because that means you’ve made an impact. I mean, how many people remember their nurse’s name? It’s a lot more rewarding than if I was just at a regular clinic. These women are very, very grateful we get there.”

BCDC has two mobile analog machines and relies on donated transportation to get the machines – and often the technicians – to villages beyond the road system. They must use analog units because newer digital machines can’t withstand the harsh temperatures or being jostled en route.

So technicians bring film back to Anchorage for processing, and results are sent to the village clinics for follow up.

“This can be another frustration,” says Odette Butler, BCDC executive director. “The technicians have to travel with a box of film that cannot get exposed. Airport security sometimes, understandably, wants them to open their bags. And the girls are always adamant, refusing not to and explaining themselves. But for awhile security was another issue stranding our staff. We basically have to wait for the technology to catch up with us. I’m hoping for something they can just carry in a backpack one day. We could do so much more.”

Since 1976, the nonprofit center has provided more than 20,000 mammograms regardless of ability to pay. BCDC does file insurance for patients who have it but relies mostly on fundraisers.

Most of the rural Alaskan women wouldn’t be able to have the test without BCDC’s traveling technicians because of their remote residences, low incomes and lack of insurance, Butler says.

“Each trip is catered to the community,” she says. “We keep the clinic open around the clock if that’s what it takes to get everyone in. And ladies will come in at midnight because it’s their only chance.”

Three thousand a year line up in clinics and post offices and churches across Alaska.

“It’s mostly word of mouth,” Stansfield says. “Whenever anyone new shows up in these villages, everybody notices. It becomes kind of an event.”

Staff at Planned Parenthood in Soldotna, three hours from Anchorage “on a good day,” make the BCDC visit a celebration, says clinic manager Jacqueline Barsis. This year they created “girl fight”



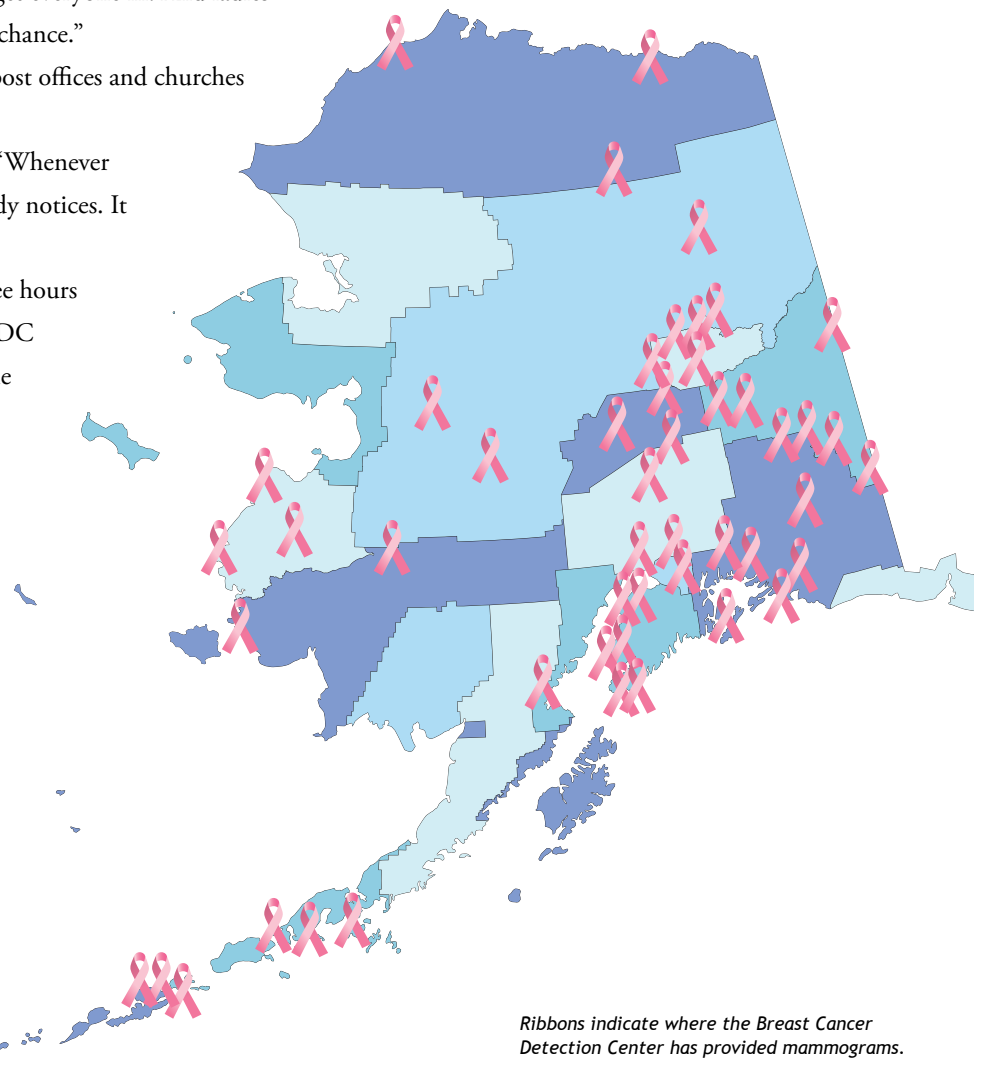
Mammogram machines are transported to remote Alaskan villages by barges and planes.

T-shirts. Last year, they handed out 300 pink tennis balls purchased from a company going out of business.

“There are still a bunch of dogs running around Soldotna with pink tennis balls,” Barsis laughs. “We make a big deal out of it because it’s such an important service. Women tell us we’re life savers and that they never would have done it without this program.”

Stansfield usually stays in Soldotna for three days, working through lunch and into the evenings. Barsis says women from down the block to an hour away come in for the breast cancer screening.

“The last patient was almost in tears because she was so relieved and thrilled she was able to have a mammogram,” Barsis remembers. “They’re long days, but they’re fun and filled and people are so happy. It’s pretty amazing.”



Ribbons indicate where the Breast Cancer Detection Center has provided mammograms.

In recognition of Breast Cancer Awareness Month, *Rural Roads* takes a look at projects preventing, treating and providing follow-up care in rural areas.

Prevention *Age is just a number*

The White River Breast Care Alliance (WRBCA) provides free clinical breast exams, mammograms and surgical consultation to women under 40 who don't have insurance coverage for these services.

Thanks to a grant from the Susan G. Komen Breast Cancer Foundation, the alliance has also covered the costs of breast biopsies and surgeries for women in eastern Arkansas since 2005.

"The great thing about our program is that age doesn't matter," says Brenda Kennedy, RN, project director. "Most state programs are only for women 40 and older and, a lot of times, even good insurance won't authorize tests for younger women. Mammograms are expensive, and most younger women require an ultrasound too. It could run into thousands of dollars pretty quickly."

Kennedy says it's vital that young women receive education and treatment early. The alliance serves about 350 women annually, like the 28-year-old who had a mastectomy or the 14-year-old who needed a breast incision.

"Especially with the price of gas and food, health isn't a priority out here," she says. "If we didn't have this program, a lot of women at high risk for breast cancer or with breast problems wouldn't get screened, and the later it's caught, the worse it can be."

Kennedy, who works for White River Rural Health Center which administers the program, says it's been marketed to the center's 10-county service area, but women often come from three hours away.

"The need is so great," she says. "And since we've been at it for a few years, our notoriety is spreading so we can have a further reach."

Clinical exams are given at 17 White River locations, and mammograms and other services are provided through program partners who charge WRBCA less to ensure the \$89,000 annual grant goes further. The alliance also arranges for transportation to follow-up appointments.

Treatment *Oncologists on the road*

Community Cancer Care (CCC) has been partnering with rural hospitals in Indiana for 25 years.

"Way back then we got a lot of hassle saying we couldn't do this kind of work in rural communities," says CEO Sara Edgerton. "But people have come around and realized you can do wonderful work in good communities with good programs."

Today, CCC sends oncologists to 21 hospitals that can't afford to have full-time cancer specialists on staff. They work with local physicians and nurses to treat patients close to home. Ninety-five percent of cancer care can be done locally, Edgerton says.

"We have a real commitment to providing specialty care to people no matter where they live," she says.

CCC offers diagnosis and treatment, prevention and detection initiatives, symptom management intervention, quality-of-life programming, hospital oncology reimbursement training, cancer registry services and continuing education for health care professionals.

In each participating community, local doctors and the oncologist assigned to that area meet monthly to discuss cases.

"We're all working in concert to make sure the patient gets the best care," Edgerton says. "And we really try to make sure if a patient can be seen locally, they are."

Recovery Supporting survivors

Of the more than 10 million cancer survivors in the United States, 2.3 million are breast cancer survivors.

Karen Meneses, PhD, RN, recently received a five-year, \$2.6 million grant from the National Cancer Institute to study the effectiveness of interventions aimed at improving the quality of life for women recovering from breast cancer in rural areas.

“The rural focus came out of need,” says the University of Alabama at Birmingham School of Nursing professor and associate dean for research. “I’m always looking at who has the greatest need. And there is next to nothing out there for rural patients. You have to work hard to find them, and they’re harder to access for research so the information is pretty nonexistent.”

The study will include 440 survivors throughout Florida where Meneses previously completed a study on post-treatment patients in both urban and rural areas. Half of the counties in Florida are designated rural.

“Rural women are particularly vulnerable to being lost in transition from treatment to survivorship,” Meneses says.

They lack access to health care providers and survivor services. Meneses’ previous study discovered that rural women must travel at least an hour to a cancer center.

“It is important for us to know how to help these women because, no matter how much we extend people’s lives through our medical breakthroughs, we must work daily to help them maintain their quality of life,” she says. “We can’t let them fall through the cracks anymore.”

Participants, each one to three years post-treatment, are given information to read followed by a series of phone calls with oncology nurses, including Meneses.

“We can’t do face-to-face because of the distance, but the phone is sort of like a home visit the way doctors used to do it,” she says. “Our attention is completely focused on this woman, and we give her as much time as she needs.”

The first three calls focus on lingering physical effects from treatment and help women differentiate between a routine symptom and something that requires a doctor’s visit. The second set of interviews revolves around relationship changes and helps the survivors communicate with co-workers, family and friends. And the final calls address the importance of follow up care.

“By educating and supporting these women, they will take on maintenance of their own health,” Meneses says. “They don’t always realize recovery takes a long period of time.”

— Lindsey V. Corey



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According to the National Cancer Institute, 260,950 women will be diagnosed in 2008 with a women’s cancer. More than half of the women will be diagnosed with breast cancer, followed by endometrial, ovarian, cervical, vulvar and vaginal cancers. The institute estimates nearly 70,000 women will die from these cancers this year.



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izations (Nursing Education, Healthcare Informatics, and Case Management).

In partnership with the National Rural Health Association, American Sentinel University is in the process of surveying the membership of the NRHA to determine educational needs with an eye on developing courses that serve the needs of rural health care professionals. In addition, NRHA members will receive an additional 5 percent discount on tuition that is already significantly lower than the industry average for online, accredited programs. For more information visit www.americansentinel.edu.



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Therapy pets lend a helping paw

By Angela Lutz

When Rose Gagne stopped by a pet shelter in Homer, Alaska, she had no idea she'd be leaving with a valuable healing resource.

Shiloh, a tiny Shih-Tzu with golden fur, has been an ideal therapy dog in the long-term care facility at South Peninsula Hospital for nearly five years.

"It's like he was trained to do this work," says Gagne, unit clerk. "He's become part of the family."

Similarly, when Gwen Brogdon brought a tomcat named Cally to her skilled nursing facility at Woodruff County Health Center in McCorry, Ark., the community instantly welcomed him.

"Some will scoop him up and take him to their rooms and keep him as long as he'll stay," says Brogdon, the facility's administrator. "He helps create a more home-like atmosphere."

Therapy pets are not uncommon. In fact, research

shows interaction with animals helps alleviate the loneliness, helplessness and boredom that can accompany residence in long-term care facilities.

"Long-term care can cause people to zone out," says Gail Furst, founder of K-9 Healers, which provides dog obedience and pet therapy training in

"It's like he (the dog) was trained to do this work. He's become part of the family."


Rose Gagne,
South Peninsula Hospital unit clerk

Branchport, N.Y. "Dogs cause positive memories and allow people to start recalling their past lives."

As a therapy dog, Shiloh's main role is companionship. He spends his days visiting the residents in their rooms, and many keep treats on hand for his visits.

"Right now he stays with one lady. She sleeps in her recliner, so he has her whole bed," laughs Gagne.

And Shiloh is intuitive.



Therapy pets make great companions for all ages.



Pet therapy is part of a transformation trend in long-term care settings.

He spends most of his time with sick or dying patients, sensing their need for comfort.

“He’ll sit with them and stay with them until they’re gone,” says Gagne.

Furst has also seen how dogs create positive change in long-term care. Since 1996, she has been teaching obedience and pet therapy training classes at nursing homes.

“A lot of people are amazed. They think the environment should be more like a hospital, and that’s what we try to get away from.”

**Gwen Brogdon,
Woodruff County Health Center administrator**

She got her start with therapy pets through the First Strike program, which creates awareness about the connection between animal cruelty and other violent crimes. Her goal was to work with kids in the community who lacked role models or companionship and teach them respect for animals and for life. Moving the classes to nursing homes seemed like a natural next step.

“The main things missing for residents in long-term care are children, music and animals,” says Furst.

The residents observe the classes, which she describes as free entertainment.

“They watch the dogs pull the owners into the room at the beginning to the time they sit politely at graduation,” she explains.

In addition, certified therapy dogs make the rounds to visit bed-ridden patients. Furst has seen the “loving touch” of the dogs bring relaxation and lower blood pressure.

“Many patients smile and show reactions when they’re normally unresponsive,” she says.

And the pets encourage social interaction. Residents leave their rooms to socialize with the animals and each other. When the animal lives at the facility, as Cally and Shiloh do, the residents and staff work together to help care for the pet.

According to Brogdon, pet therapy is part of a larger culture change including transformation of long-term care from institutional to more home-like settings. But she still encounters people who are surprised they have a resident cat.

“A lot of people are amazed,” she says. “They think the environment should be more like a hospital, and that’s what we try to get away from.”

The trend also motivates Furst. She is an advocate of the Eden Alternative, which encourages companionship and the opportunity to give meaningful care to other living things.

continues

Therapy pets 101

Want to learn more about therapy pets and how they are helping to change the long-term care landscape? Check out these resources:

K-9 Healers

www.k-9healers.com

Founded by Gail Furst in 1996, K-9 Healers provides obedience classes and pet therapy training for dogs, as well as a variety of programs in children's and long-term care facilities.

Eden Alternative

www.edenalt.org

A nonprofit organization founded by Dr. William Thomas in 1991, the Eden Alternative is based on the belief that aging should be a continued stage of development and growth rather than a period of decline.

Humane Society First Strike

www.hsus.org

The First Strike campaign was created in 1997 to raise public and professional awareness about the connection between animal cruelty and other violent crime.

Culture Change

www.culturechangenow.com

This web site contains practical information and guides on how to transform a nursing home or long-term care facility from an institution into a community.

continued

"First you introduce plants to long-term care, and everyone works together for care," describes Furst. "Eventually, they will move from a plant to a fish and from a fish to a cat or dog."

Most residents' reactions to therapy pets are positive. Brogdon has only encountered one resident who "disliked the cat." As a result, she contacted the ombudsman who decided the residents' rights weren't infringed upon by Cally's presence.

"It was worth the little bit of friction," she says. "So many residents really enjoy it."

To prevent friction, Furst always checks with staff to be sure no one is fearful of the animals. On the whole, she says, reactions to the dogs are "absolutely positive."

Furst's therapy dogs are trained; Shiloh and Cally are not. But all agree a certain temperament is required for therapy pets. Shiloh, for example, is territorial in a non-aggressive way.

"He barks at strangers and other dogs," says Gagne. "He knows who belongs and who doesn't."

Furst provides aptitude tests on puppies to determine if they are suitable for work as therapy dogs. In her classes, she uses "loving obedience" to train the dogs.

"We use food and praise," she says. "We work with the dog's temperament instead of trying to change it. We don't use fear or yelling."

Not all of the dogs who graduate her class are suitable for therapy work, and some owners simply leave with a well-behaved companion.

Gagne would recommend a therapy pet to "any long-term care or children's facility."

"It brings comfort and joy," she says.


Furst agrees, and in addition to her work in long-term care,

she recently started a reading program

for students in libraries and schools.

"The dogs lay patiently while students read to them,"

she says. "It's a great

incentive for children to learn to read." 



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Hospital tunes in, tones up

By Lindsey V. Corey

Bob Springstead's first date with his wife was his last day of high school.

He weighed 230 pounds.

"Who doesn't wish they could weigh what they did in high school?" Springstead says.

But at 40, he tipped the scales at almost 400 pounds and had a closet full of clothes ranging from size 2x to 5x. The Fremont, Mich., attorney was taking blood pressure and cholesterol medications several times a day and wearing a sleep apnea mask to get through the night.

"I knew I had to do something and was strongly considering bariatric surgery," he remembers. "It looked like the only real option."

But Springstead's insurance company required one year of supervised diet and exercise before covering costs of the procedure.

"There went my easy way out," he says. "But I think it was kind of fate."

Gerber Memorial Health Services (GMHS) was about to open Tamarac, the Center for Health and Well-Being, right there in Fremont.

"It sounded like a friendly, non-competitive and non-judgmental place to go," Springstead remembers. "And I figured it would help me meet the insurance requirement."

So in December 2007, he signed up, completed a health assessment and developed a workout plan with a personal guide like all new members. He kept a food log that no longer included his favorite pizzas and visits to the local Chinese buffet and an exercise journal he updated daily with his visits to Tamarac.

Twist of fate

By January, Springstead had lost nearly 40 pounds with the help of a dietician and a trainer as part of Tamarac's small group exercise program. Then came a letter from the weight-loss surgical center. Insurance guidelines had changed; he could have the surgery immediately.

"It was an interesting twist," he says. "I'm a chicken when it comes to doctors. Hate the dentist, can't look when they draw blood. So I was really scared about the surgery but had thought of it as my only choice... But this was actually working. I was watching what I ate and



Bob Springstead celebrates his weight loss with Gretchen Bush, Tamarac fitness manager, and Jenny Lohmeyer, his personal guide at Tamarac.

working out every morning. That had to be better than having my stomach cut up."

Springstead lost 136 pounds in nine months and is on target to reach his high school weight before his original one-year personal deadline. And why stop there?

"I found a good tailor, and they just keep cutting chunks out of my suits," he says. "I just keep my eyes on the prize. Every time I turn around, there's an opportunity to blow it. But I think about how I'll be happier when I meet my goal than any one day of cake or ribs."

It's about more than the scale to Springstead. He's proud that he no longer needs prescription medication, can go on bike rides with his daughters and recently completed a 5k charity race with plans to double the distance soon.

continues

continued

People in Fremont, population 4,200, have noticed.

“It’s a big deal for a small town,” Springstead says of Tamarac. “I think it will slowly change our community. It’s really touching a lot of people, and it’s bound to continue to catch on.”

The center has enrolled more than 2,400 members, surpassing the three-year goal in just seven months. The first-year goal was reached in less than one month. Some days, 60 people sign up.

“We’ve proven that a rural community can do unique, fun, beautiful and new things,” says Jenny Babcock, Tamarac director. “We sort of launched a ‘yes we can’ mentality here.”



Bob Springstead and his brother Gary participate in a 5k race in Fremont, Mich. Springstead says Tamarac helped him prepare for the charity event.

50 percent of people’s health is determined by their lifestyle. That’s where Tamarac steps in.

Chronic disease is caused by or aggravated by two risk factors:

- Obesity: diabetes, heart disease, stroke, hypertension, asthma, cancer, etc.
- Sedentary lifestyle: angina, heart attack, cancer, depression, sleep apnea, stroke, etc.

Michigan’s staggering statistics:

- Ranked third worst state for obesity
- 62 percent of residents are considered overweight or obese
- 50 percent of adults reported exercising less than 30 minutes a day
- 24 percent of citizens smoked in 2002

In sickness and in health

The vision for Tamarac came out of need. GMHS, a 77-bed hospital organization, reassessed its financial plan in the midst of a health care and economic meltdown. The hospital, like many, was struggling with shrinking reimbursement and rising expenses in the early 2000s. Michigan was also suffering due to the sputtering automobile industry.

Gerber Memorial, Newaygo County’s only hospital, had always made its mission (and money) caring for the sick. But, then-president Ned Hughes envisioned a “health care” entity. GMHS would no longer simply wait to provide the best “sick care,” it would help people stay healthy, focusing on prevention and wellness in the first place. With obesity and lifestyle-related diseases, such as diabetes, on the rise across the country, the transition made sense.

“When it was just about sickness, we were missing the other end of the spectrum,” Babcock says. “It was time to look at the individual holistically.”

Tamarac would be a place for the community to become healthy, a place where professionals encouraged and supported each member’s desire to become healthier in mind, body and spirit.

It was to be a place where people wishing to live a fuller, longer life, like Springstead, would find the tools and expertise to help.

And they were careful to create a medical wellness center, not just a fitness club, so those visiting after surgery or trauma would be rehabilitated and then transitioned to maintaining and enhancing work that had already been accomplished. There’s still a close alliance with hospital personnel, and area physicians often refer patients to the facility.

“Who wants to be 400 pounds at a place where everybody else doesn’t need to be working out with all the mirrors and that whole thing?” Springstead says. “Tamarac isn’t like that. Sure, there are people in fabulous shape, but it’s for all kinds so you don’t

feel self-conscious trying to get in shape. I've never once felt uncomfortable there."

Rethinking Wal-mart

And that says a lot for a former Wal-mart, Babcock says. Tamarac received national Leadership in Energy and Environmental Design certification for making green choices in design and construction of the 45,000-square-foot facility.

"Our favorite comment is 'this used to be a Wal-mart?'" she says. "It was a community eyesore, but now you can't recognize it."

Springstead, who crosses over a babbling brook at Tamarac's entrance each day, says "you forget that it ever was a Wal-mart."

"I'm still surprised every morning that I look forward to getting up and working out," he says. "That's due to the great facility, variety of equipment and classes and fabulous people."

Not only did Gerber Memorial find a use for a vacant building, it created 30 new jobs. Tamarac employs 80 people from long-time hospital workers to those who teach spin classes a few times a week.

Membership dues are \$45 a month including all classes and use of the warm water pool, and the hospital and community foundation offer need-based scholarships. Gerber Products Company, the baby food corporation based in Fremont, closed its on-site gym and provides Tamarac memberships for staff and families so they have better equipment and more options. And Tamarac partners with other local businesses like grocery stores for healthy cooking classes.

Tamarac brings in additional revenue from members and non-members through its Two Worlds Café, a healthy restaurant named for the center's focus on inner, spiritual health and outer, physical health. There's also a retail shop with Tamarac logo wear and amenities and a spa, which offers laser hair removal, facials, massages and other services.



A former Wal-mart is transformed into Tamarac's wellness facility.

"Consumerism is driven by the baby boomer population who want to look good and feel good as long as possible," Babcock says. "It's about more than Botox. There's also a reflective meditative space within the spa area that helps maintain inner peace. Our spa attracts clients from all over."


Tamarac also offers outside programming, including kayaking, hiking and a labyrinth. And GMHS had its first summer camp for area children.

Today, Tamarac does not yet occupy the entire Wal-mart, and an additional 12 acres were purchased in the original deal, leaving room for growth.

"So there are opportunities to expand, and we're looking at them sooner than planned because of the tremendous interest so far," Babcock says. "We've shown the county that it's not forgotten, and we've become a destination."

The wellness center was named for the Tamarack tree, which grows throughout Michigan. Babcock says it symbolizes strength, growth and renewal. It can reach 90 feet, sheds its needles and regrows them in the spring, and tea made from the tree's bark can be used as a tonic for sore throats, rheumatism and skin ailments.

"The name was a natural for the center's vision," Babcock says.

Gerber Memorial was named the 2008 Outstanding Health Care Organization by the National Rural Health Association. 

Students encourage quitting

By Lindsey V. Corey

While the message that smoking is bad has reached millions, methods to quit aren't as prevalent.

So four students set out to help one overlooked audience.

"As we explored literacy statistics and the smoking cessation resources that were readily available, it became clear that there are many smokers with limited literacy and a scarcity of materials that target this population," says Stacia Kutter, first-year medical student at Florida State University (FSU).

Kutter and fellow medical students Kendall Riley and Tiffany Vollmer and FSU marketing graduate student Tatiana Fernandez collaborated on a self-help guide designed for smokers with limited reading skills and a photo novella for Hispanic smokers who don't read English and possibly cannot read Spanish.

The team spent several weeks researching health literacy and learning about tobacco cessation and motivational interviewing from a certified tobacco treatment specialist.

"Literacy is easy to take for granted," Riley says. "Explaining how to quit smoking with minimal words was definitely a creative process."

The students were part of the eight-week inaugural Community Scholars Program developed by Andree Aubrey, FSU Area Health Education Center director, and Gail Bellamy, PhD, FSU Center for Rural Health Research and Policy director, and funded by a state grant.

With two weeks remaining in the program, they traveled to a rural community west of Tallahassee, where they observed a smoking cessation meeting and asked participants to provide feedback on their

project's progress. The students also solicited input on the cessation tool at homeless and domestic violence shelters.

"Perhaps the most important thing that I have learned is that while the addiction



Florida State University staff and students created a smoking cessation brochure targeted at illiterate smokers. Team members include Gail Bellamy, Center for Rural Health Research and Policy director, Stacia Kutter, medical student, and Andree Aubrey, Area Health Education Center Program director.

to tobacco is a universal one, perceptions of tobacco use differ from community to community," Fernandez says. "Consequently, a widespread anti-tobacco campaign is less likely to be as effective as an anti-tobacco campaign that caters to a specific community."

The students are excited to see their revised brochure and pocket card distributed to providers throughout Florida.

"Literacy is an extremely important medical topic that should be addressed at each physician-patient meeting," Riley says. "How is a patient supposed to follow medical directions or take medications appropriately without understanding the words correlating with them?"

The brochure advises patients trying to become ex-smokers to keep their "WITS" about them: Wait. A craving will pass in a couple minutes; Inhale. Take deep breaths; Try. Try to do other things as a distraction like brushing teeth, walking or calling a friend; and Sip. Sip water through a straw.

Gail Bellamy, PhD, contributed to this article.



Nurses with class

College, hospital share resources

By Loren Hill,
Samaritan Healthcare education director



Nurse educator Martha Wong discusses CPR with students.

Big Bend Community College (BBCC) and Samaritan Healthcare in Moses Lake, Wash., enjoy a supportive relationship through a uniquely shared resource.

Samaritan Healthcare operates a 50-bed rural hospital. Nearby BBCC offers a nursing program that graduates approximately 60 certified nursing assistants, 25 licensed practical nurses and 25 registered nurses each year.

Danielle Alvarado, RN, teaches in the nursing program at BBCC during the school year and joins the education department at the hospital during the summer months, and Martha Wong, RN, is a full-time nurse educator. Both are full-time, master's-prepared nurse educators.

“One of the major advantages of the joint educator position is the flexibility it brings,” says Katherine Christian, director of BBCC health education programs.

Each year the college shares in the labor expense by contributing a lump sum equivalent to the benefits expense for the nurse educator position. The school is able to fill a faculty role for a fraction of a budgeted position, while the hospital is able to take an active role in supporting the nursing program to help ensure ongoing availability of quality nursing candidates.

“It amazes me how much the students grow and learn in such a short time,” says Alvarado. “They go from being unsure of their own skills and needing a great deal of assistance to becoming independent and grounded

in providing exceptional nursing care.”

Wong is able to supervise students during clinical rotations at the hospital while simultaneously identifying improvement opportunities for the hospital. In some cases, she is directly involved in implementing the improvement initiatives.

During the summer term at the hospital, Alvarado's time is ideally suited to nursing education projects, such as finding potential guest speakers for in-service programs, updating competencies, developing Internet resources for nursing staff and other endeavors that can be completed within three months.

“In this position I have both the hospital's and nursing program's best interests in mind,” Alvarado says. “I see it as a golden opportunity. This position provides me an innovative way of practicing nursing.”

The allocation of projects to Alvarado allows Wong, who is dedicated year-round to the hospital, to focus more of her time on ongoing programs, such as nursing orientation, advanced cardiac life support, a trauma nursing core course and other routinely scheduled courses and incidental needs.

The shared educator arrangement has been in place between Samaritan and BBCC since 2002. In addition to the tangible benefits, an equally valuable benefit has been the partnership between the two organizations.


When the college was in temporary need of a clinical instructor during one of the summer terms, the hospital released the nurse educator to fill that need for the school. This year, when student census was slightly lower, BBCC agreed to a shared schedule for the nurse educator during the spring quarter, allowing the hospital to get an early start on projects while still utilizing the nurse educator for labs and testing at the school.

“The position strengthens both organizations,” says Christian. “It brings both clinical and academic resources together and facilitates communication between the college and the hospital.”

Angela Lutz contributed to this article.



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Health information system improves hospital efficiency

By Angela Lutz



From the point of care, clinical data drives revenue cycle processes to optimize financial outcomes.

Information technology (IT) has become a necessity in the hospital workplace.

But many hospitals, especially small rural and critical access hospitals (CAH), do not have access to the full-time, qualified IT staff required to operate and maintain a health information system (HIS). Financial constraints also create a barrier.

As a solution, many hospitals are forming alliances and outsourcing their IT support.

Republic County Hospital (RCH), a county-owned, nonprofit, 25-bed CAH in Belleville, Kan., is one of 29 CAHs in Kansas and Nebraska that has turned over its IT functions to Midwest Health Systems (MHS) in Hays, Kan., since its inception in 2003.

“Midwest provides IT support for critical access hospitals, many of which couldn’t afford full IT direction or network management,” says Ken Abendshien, IT director at MHS.

MHS contracts with Siemens to supply MedSeries4 (MS4) software, a web-based, full HIS solution. They add to that service by providing small rural hospitals access to the software and data center operations. All the hospitals need to supply are a workstation and manpower to register patients. MHS provides servers, backups and disaster recovery, all in a central location.

“We take care of technology-based knowledge not available in small communities,” says Abendshien.

Before handing over IT functions to MHS, Republic was using a homegrown system developed by Hays Medical Center. When the year 2000 threatened to make that technology obsolete, RCH switched to the MS4.

The staff approved.

“It made their jobs much easier and more consistent,” says RCH CFO Barry Bottger.

The capabilities of the MS4 include the clinical suite, allowing physicians and nurses wireless access to patients’ charts and the ability to send orders to the pharmacy, lab and other clinical departments electronically; the patient management suite, providing relevant demographic, insurance, provider and diagnostic information to speed the scheduling process; and the general financials suite, tracking revenue, costs and profit.

The ease and wide range of use has made the MS4 popular among the hospitals MHS serves. Before the 29 hospitals gave IT control to MHS, management polled hospital employees.

“They liked MedSeries and created the data center,” says Abendshien.

At RCH, Bottger says he doesn’t remember the “growing pains” of switching to and learning to use the MS4, which has an implementation time of six to nine months. He has especially noticed positive results in the staff and billing office.

“It makes processing claims more efficient,” he says.

Abendshien also praises the operational efficiency of the MS4.

“Its power is the fact it operates on a relational database model, which provides the ability to replicate the model for each additional facility,” he says. “It’s a single set of program structures but 29 autonomous data sets.”

According to Abendshien, the technology has been successful because of this ease of support.

“When you look at multi-entity types of environments where every hospital is a separate county-owned organization with a different board of directors, MedSeries has the ability to manage that process,” he says.

Based on recent statistics, the MS4 can help reduce medication errors by up to 50 percent and account receivable days by up to 25 percent. This makes it beneficial to both patient and staff satisfaction.

Beginnings & Passages



These were
the values
I had been
searching for
since starting
practice.

It's the rural life for me

By Jarrod Shapiro

I arrived in Madras, Ore., population 6,585, after leaving a busy suburban podiatric surgical practice. My aim was to pursue the kind of medicine I had envisioned while in medical school.

I was immediately struck by the strong sense of community both within the hospital, Mountain View Hospital District, and the town itself. Surrounded by the open spaces and breathtaking vistas of Central Oregon, I immediately fell in love with the area. This was the place my wife and I wanted to raise our 3-year-old son.

Having lived in large cities (New York, Phoenix, San Francisco and Detroit) for much of my life, I was surprised at the sheer friendliness of the public. People's willingness to give us information or even a friendly smile and hello was a change from our prior experiences.

I also found surprises in my hospital system. Instead of a hospital behind the times, I encountered vibrant, creative and knowledgeable caregivers striving despite limited funds to provide top-quality health care. In fact, the one concept I heard more than any other was: What is best for the patient? This philosophy was embodied in the clinic managers of the multi-specialty practice where I work. During a conversation in which I recommended an expensive – possibly non-insurance covered – skin graft, the issue boiled down to the question “is this best for the patient?” These were the values I had been searching for since starting practice.

Small town life, though, is not without its challenges. Chain stores are not a major part of the local business community, which leads to higher prices for everyday items like groceries. It is often necessary to stock up on items from out-of-town stores. Likewise, practice in a small hospital does present certain hardships. For example, certain specialty procedures as well as some specialists are not available locally. As such, I occasionally have to send patients out of town for some of their medical care.

As a young physician new to rural practice, I have found the rewards greatly outnumber the disadvantages. The strong sense of community, independent sensibilities and sheer friendliness of the town is a fresh change from my prior experiences. The urban doctor has finally come home.

Jarrod Shapiro, DPM, AACFAS, is a podiatrist and staff physician serving Madras, Ore., since July. He joined the NRHA in 2008.

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

Innovative rookies and seasoned professionals share their experiences.

A can-do attitude, shared vision and dogged determination are absolute necessities.



The Casanova Jack experience By Gary R. Steinbach

My initiation into rural health care started with a phone call from Casanova Jack, Mayor of Stanley, Idaho, in 1972. I was working for the Idaho Hospital Association in my first career position, and his challenge was to find a way to provide medical services for Stanley's 49 residents and 250,000-plus seasonal visitors. At that time, Stanley had no financial resources, medical personnel, ambulance or dedicated clinic space. And the closest hospital and medical community was 70 miles away.

In developing an emergency medical delivery system, our first step was to take advantage of the recently expanded Idaho Nurse Practice Act, which established the role of the nurse practitioner. We recruited a registered nurse and sponsoring physician, and training was organized at the University of Utah's School of Medicine and funded by an Idaho foundation.

With a medical provider secured, it was now up to residents of Stanley to raise funds to complete the components of the delivery system. This included acquiring an ambulance, locating and equipping clinic space and training volunteer emergency medical technicians (EMTs). Through fundraising events ranging from bake sales, cover charges for dances at Casanova Jack's Casino Club and private

donations, the clinic start-up was funded within a year. A 1960 ambulance was donated by the Mountain Home Air Force Base, and more than half of Stanley's residents became certified as EMTs.

Thirty-two years later, the Custer County Medical Clinic continues to serve this remote mountain community. The Casanova Jack experience taught me several key success factors for rural health care development: a can-do attitude, shared vision and dogged determination are absolute necessities; health care services must pool and leverage resources with funding sources and public and private entities; and services must incorporate evidence-based and best practices.

Fast-forward to today. I've repeated these fundamentals serving rural hospitals in Montana, New Mexico and Colorado. Presently at the Telluride Foundation, we are developing a preventive health care delivery system that combines the same shared vision and resource development principals from the Casanova Jack experience.

Gary R. Steinbach, MHA, is the preventative health care administrator at the Telluride Foundation in Telluride, Colo. He joined the NRHA in 2008.

Advice from our experts

A Veterans Administration facility is more than a two-hour drive from my home. Do either of the presidential candidates have a plan for improving rural veterans' access to care?

Rural Americans have consistently served in the military at rates higher than their proportion of the population. Though only 19 percent of the nation lives in rural America, 44 percent of U.S. recruits are from rural communities.

The disproportionate number of rural service members creates a disproportionate need for veterans' care in rural areas. Distances and geographical barriers prevent many veterans from receiving basic health care benefits from Veterans Administration (VA) facilities. Preventative and follow-up care can be extremely burdensome and sometimes impossible.

The presidential candidates have divergent proposals for improving quality and access to health care for rural veterans.

Sen. John McCain has proposed a "veterans' care access card." With the card, both low-income veterans and veterans who have incurred injury or illness during military service could utilize local private health care facilities to receive care. According to McCain, the card would allow veterans to choose their local providers rather than to drive sometimes hours to a VA facility, and is meant as a "supplement" to current VA care, not a replacement of existing programs.

Sen. Barack Obama's plan focuses on increasing the number of local veteran centers and expanding current rural VA facilities. Obama opposes what he calls "outsourcing" of critical services of the VA, but supports giving "the VA the tools and flexibility to contract with other providers in any remote area of the country." Contracting would be permitted under his plan if the VA determines access is inadequate and a new VA facility is impractical. Obama also calls for strengthening the VA's telemedicine infrastructure to "expand the delivery of high quality health care to rural veterans."

The NRHA has long called on the Administration and Congress to adopt both of the above plans. Quality local care, with a provider they know and trust, is available but inaccessible to most rural veterans. The NRHA has consistently advocated for collaboration between the VA health system and existing private rural providers.

Additionally, the NRHA has fought for increasing the numbers Veterans Centers, Outreach Health Centers and Community Based Outpatient Centers in rural areas. These facilities provide excellent care but are insufficient to meet the demands of the growing

Quality local care, with a provider they know and trust, is available but inaccessible to most rural veterans.

veteran population. Soon voters will choose our next president. The NRHA urges that person to act on both proposals – only then will the promise of health care to our rural veterans be better fulfilled.

*Maggie Elehwany, JD
NRHA Government Affairs and Policy
vice president*

What entices young students to work in rural America?

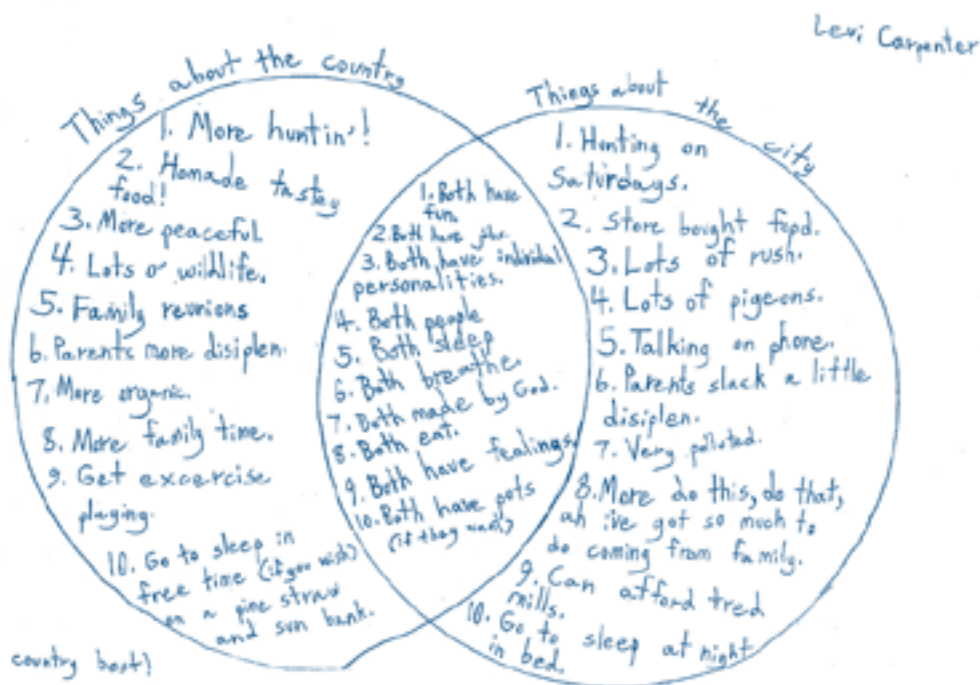
Rural students are more likely than others to become rural health professionals because of the values a rural culture instills.

Young doctors retaining rural values will seek their professional rewards in rural terms. Those with urban values will seek urban rewards.

Levi Carpenter, a third grader from Sylacauga, Ala., created a Venn diagram distinguishing rural life, urban life and the overlap after reading the Aesop's fable "The Country Mouse and the City Mouse." There is a bit of the "country mouse" in Levi – he lives in the country outside of Sylacauga, population 12,500.

At the core, we are the same, but the environments, activity options, social demands and types of rewards differ.

John Wheat, MD, with Levi Carpenter, third grade



How can I make giving shots less painful?

What can cause fear in a grown man and weeping in a child? A shot, of course. This problem is of such universal concern that new products and techniques are being developed to create a painless injection.

One successful technique involves utilizing counter pressure, with a small-gauge needle going between the pressure points. Cryotherapy and topical lidocaine can also be used to numb the area, and some recommend pre-medicating with Tylenol 30 minutes prior to an injection.

For infants, some sweetened water just prior to an injection can lessen pain. Dentists utilize jet injection and computer-controlled anesthesia systems for painless injection delivery in both the pediatric and adult populations. Skin patches that deliver medication are in the works, as are needles made of non-metal polymers.

Regardless of what method you use, keep plenty of smelling salts on hand for that grown man.

*Lt. Tracy Branch, MPAS, PA-C
U.S. Department of Health and Human Service
Region VII minority health consultant*

Need advice?

Send your questions to
editor@NRHArural.org.



Sen. Tom Harkin campaigns with presidential hopeful Barack Obama in Iowa.

Obama: The hope in health

By Sen. Tom Harkin

Sen. Barack Obama represents the largely rural state of Illinois, and he spent many months campaigning across rural Iowa in the run-up to the presidential caucuses early this year. So he has an in-depth understanding of the unique challenges facing rural health care, and he has offered an aggressive, comprehensive agenda to address these challenges.

A fundamental problem facing citizens in rural America is access to affordable, quality health care. Obama is committed to signing legislation by the end of his first term that will provide every American with health coverage. But this, by itself, will not meet the health care needs of rural Americans if their hospitals and clinics are closing and they cannot attract and retain doctors, nurses and other health professionals.

A root cause of the crisis in rural health care is the fact that the Medicare and Medicaid funding systems have historically penalized rural areas. Health care

providers in rural states often get reimbursed at a significantly lower rate than their counterparts in urban areas, frequently making rural practices unaffordable for physicians.

Obama became well acquainted with this problem while in Iowa, which ranks last among the 50 states in Medicare reimbursement rates and faces a chronic shortage of quality health care providers in rural communities. Obama is committed, as president, to creating a more equitable Medicare and Medicaid reimbursement structure.

Obama also has a plan for attracting more health care professionals to rural America. He will create a loan forgiveness program for doctors and nurses who work in underserved rural areas. In addition, he will encourage the expansion of state-of-the-art health professional online education courses to reach professionals in rural America.

He advocates an array of initiatives to reduce health care costs for small businesses, including a 50 percent refundable small business health tax credit to cover small businesses' health insurance premiums.

By contrast, Sen. John McCain opposes universal health coverage, and he would reduce incentives for employers to provide health insurance. He advocates offering tax credits to help people purchase private health insurance, the same inadequate approach that President Bush has advocated fruitlessly for the last eight years. This would leave millions of rural Americans uninsured or underinsured and would undermine the existing employee benefit system.

Tom Harkin is a democratic senator from Iowa.



Sen. Tom Coburn

McCain: the experience in health care

By Sen. Tom Coburn, MD

As a practicing physician in Muskogee, Okla., I've seen firsthand the challenges facing rural health care in America. As rural health professionals understand all too well, the economics of health care have made it next to impossible for small and even medium-sized towns to support the array of physicians and health services our communities need. In my own specialty of obstetrics, this trend has been particularly alarming.

In this challenging climate, rural health professionals will have a choice this November between two presidential candidates who have radically different approaches to health care. Sen. Barack Obama has spelled out, in very stark terms, his desire to see a government takeover of our health care system. Sen. John McCain, on the other hand, wants to use market

forces to empower individuals with freedom and choice.

The consequences of getting major health care reform wrong would be catastrophic to both rural health care and our entire health care system. For many of my fellow doctors, adding even more red tape and government controls on their practices will only further encourage them to leave the profession. Exacerbating our already serious doctor shortage could not come at a worse time as millions of baby boomers near retirement age.

McCain's approach would put patients and doctors back in charge of health care and restore the doctor-patient relationship that has been nearly severed by third-party health insurance and government bureaucrats. A market-based system would unleash the power of innovation and competition and make health care more affordable and accessible in all areas of our country.

One of McCain's key reforms would involve transferring health care tax benefits to individuals rather than employers. His plan would do that by providing every American with a tax credit of \$2,500 per individual (\$5,000 per family) to buy their own insurance plan. Switzerland, hardly a bastion of conservatism, has used a similar individual-based model where costs are 50 percent less than in America with better outcomes.

McCain's plan is based on common sense principles that work in the real world. Rural America can't afford to gamble on a government-run health care system that would decimate our health care system, beginning in rural America.

Tom Coburn is a republican senator from Oklahoma.

journneys

Who influenced your career choice?

Elizabeth Matuk's neighbors inspired her to open a clinic



Elizabeth Matuk and daughter Lynne Bettles at the desk Matuk's husband built for The Village Clinic.

After more than three decades as a nurse practitioner working in a variety of settings, all in cities or towns, I told my husband I wanted to go where I was really needed – somewhere like South America. He advised me that I could, but I would be going alone. Well, I was certainly not going to give up on more than 30 years of marriage to go serve the underserved, so I put that idea aside.

We decided to retire to a town of 700 in southern Oregon, and after being in Chiloquin for about a year, I realized I had come to an underserved area, and I had the ability to change that.

So I bought land in our town, reconfigured a modular building, placed it on the lot and named it The Village Clinic. My daughter Lynne, who is a registered nurse highly skilled in many aspects of health care and has great administrative skills, drove from here to Utah to purchase and bring back a whole clinic's worth of equipment for a huge discount from a practice that was closing.

Together we painted, made curtains, bought country-style chairs and a rocker for the waiting room, made a kid's corner, hung pictures inside and put plants on the front porch. We landscaped, built fences and got the permits, inspections, licenses, insurance, reimbursement contacts and all the other necessities for opening a business.

We had a grand opening during which one of the Native American community leaders offered a blessing on the clinic, which was open to all. We hired two additional staff people, a receptionist who was the salt of the earth and able to take on the complexities of getting reimbursement from a myriad of plans as well as eventually collecting from clients.

Since the community is very poor (the second poorest in Oregon in 2000), we charged low fees and never required payment at time of service. I've been paid with eggs, vegetables, baked goods, elk and venison as well as the normal currency.

“Our philosophy was to care for today's needs today.”

Elizabeth Matuk

We saw all patients without appointments since illness and injury are not scheduled events, and our philosophy was to care for today's needs today. We advertised in the free local newspaper and by word of mouth. By the end of the first year, we had 4,800 visits, and days were getting fuller each month. After the first year we saw about 6,000 visits a year. We were open six days a week and didn't close for lunch.

After one year, we were asked to open a small satellite clinic in the church hall of a town 45 miles north, and we provided care to that community

once a week for several years and hired a part-time family nurse practitioner to cover the main clinic as well. After two years, we proudly became a certified rural health clinic.

Because we saw our role as a community service not necessarily restricted to health care, we hosted a farmers' market in our parking lot every Wednesday afternoon in the summers. It was a place where locals could sell produce and crafts and was a community gathering spot. We grilled burgers and hot dogs, and folks drove by, stopped, picked up what they wanted, sat on the porch and chatted, and went home. We charged no fees for a booth – we just saw it as a fun community-building service and also an advertising tool.

The waiting room always had coffee and tea as well as the local paper. Some folks just came in, sat in the rocker with their coffee, chatted with whoever was there or read the paper, then went on with their day. The rocker was almost always the first to be occupied. Being a dog breeder and handler, I had lots of dog photos around the clinic, prompting one 5-year-old to ask “Mom, are you sure this clinic is for people?” It was homey, and we loved it.



The Village Clinic waiting room, sign and parking lot where farmers' markets took place.



The clinic thrived for six years, at which point I sold it in order to retire. My daughter and I still have folks come up to us and say “We really miss you,” or “You were the best thing that ever happened to our town.”

We have made many friendships through our experience, and we both feel we really did have the honor of serving the underserved right in our own backyard.

Jill Bumpus found her calling on college mission trips

I have a deep love for rural areas and rural people. I grew up in a multi-generational farm family near an Illinois town of 200. But what focused my energy was going on a weekend mission trip to Harlan County, Ky., during my freshman year of college. I was pretty much dragged along by some friends, because my perspective was, “I know rural poverty, why bother?” But I fell in love with the people and the culture. I couldn't get enough.

The biannual trip was organized by students, dedicated and impassioned about the people and helping new students to fall in love with loving people. We'd clean elderly people's houses knowing the next day they'd be dirty with coal dust again. But it was more about the visit than the cleaning. If a group of students went into Betty's house, we knew they'd leave changed.

Our trip didn't cost a lot, it was innovative, and it's where I got my feet wet doing grassroots work coordinating volunteers to help people.

Now I'm working on my master's and helping with research relating to Appalachian health disparities at East Tennessee State University.

I think I could be in a city for awhile, but I function better with space, and I relate to and understand people

continues

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journeys

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in small communities. Rural rejuvenates me.

I'm a big helper and have a passion for meeting unmet needs, which also brings me back to rural people. I believe we can address needs by working together, and that's what I hope to always do.

Sarah Roberts' mentor led her to Alaska

A family physician had a tremendous influence on my decision to become a family doc myself. His name is James Hubbard, MD, and he practices in Ironwood, Mich., a community of about 4,000 people whose clinics and hospital system serve nearly one quarter of the entire Upper Peninsula of Michigan.

During my eight-week rural family medicine rotation as a part of the Upper Peninsula Rural Physician Training program, I had an amazing, life-changing and inspirational experience with him, in part because of his humorous approach to the mundane nature of office visits, the ability to see the full scope of family medicine and his excellent teaching and insight.

I know in my heart that he helped me to choose family medicine as my career, and his emphasis on rural medicine has even led me to Alaska for residency. He is an advocate for his patients and an inspiration to students like me.

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medical scopes allow for real-time video images of dermatology problems, ear, nose and throat examinations, just to name a few.

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- Misys e-Prescribe: automation of prescription submission/refills with appropriate patient safety checks
- Misys Services: turnkey implementation/interfaces/training/support

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Jeffrey, Tessa and Maria Perotti on vacation in Durango, Colo.

Six things you should know about NRHA member Jeffrey Perotti

- He is a member of the NRHA Rural Health Fellows program.

This yearlong program provides 12 individuals with leadership training and the opportunity to learn about rural issues through team projects. Perotti recently completed his first team project writing a policy paper on retention of rural health providers.

“The benefit of the program has been learning about rural issues, an area I had no exposure to before, and working with my other 11 fellows, all of whom I’ve learned from,” he says.

- He is the community outreach director for the Indiana University School of Optometry (IUSO).

In this position, Perotti oversees the majority of the school’s outreach activities, which provide vision and eye health services at a four-clinic rural health program, three prisons, a five-clinic urban partnership

and a homeless shelter. He also serves as director of the grant-funded Eye Care Community Outreach program, which has provided more than 2,000 eye examinations and 1,200 pairs of glasses to reduced-income and uninsured individuals in central Indiana since its inception in 2004.

- He completed the 2008 Register’s Annual Great Bike Ride across Iowa (RAGBRAI).

This seven-day bike ride is the longest, largest and oldest touring bicycle ride in the world, according to its web site. The route averages 472 miles, beginning along Iowa’s western border on the Missouri River and ending along the eastern border on the Mississippi River.

To train, Perotti rode 50 to 100 miles a week April through October, including a weekly 70-mile ride to prepare for the longest, 80-mile stretch of RAGBRAI. Perotti has also participated in Ride the Rockies and Ride across Indiana, which is 160 miles in one day.

- The most challenging part of Perotti’s job is “coordinating all the pieces.”

In addition to providing comprehensive eye care services at IUSO’s outreach clinics with the assistance of students, he recruits and schedules doctors (they currently have seven volunteer optometrists), coordinates billing, follows up on eyeglass orders and patient referrals, helps write grant applications and ensures “the patients I see with our students receive the best possible care.”

- He plays guitar to relax.

Perotti played briefly in a band, but now he uses music to relax and spend time with his 20-month-old daughter, Tessa. His favorites include Buddy Holly, Jonathan Richman, Smokey Robinson and Spoon – “anything with a great melody and a bit of an edge.”

- The most rewarding part of his job is interacting with the patients and helping students develop their skills.

“Our students are consistently well-rooted, fascinating individuals who excel at patient care. Our patients have many of the same qualities and are extremely gracious at expressing their thanks for the services we provide, which makes the job very rewarding,” Perotti says.

– Angela Lutz

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

Member notes

Speranza Avram left her position as executive director of the Northern Sierra Rural Health Network in northern California after 12 years. Avram and her husband are moving to the San Francisco Bay area, and she will be re-activating her consulting business with a focus on rural health program planning, telemedicine and building successful rural health collaboratives. Avram has been a member of NRHA since 1995.

Raymond Biondo, MD, of North Little Rock, Ark., received the 2008 Arkansas Medical Society Asklepiion Award. The award is given each year to a physician who has promoted the art and science of medicine and the betterment of public health, embodied the values of leadership, excellence, service and integrity, and enriched patients, colleagues and the community through dedicated medical practice. Biondo has been a member of NRHA since 2006.

Ron Davis, CEO of Titus Regional Medical Center in Mount Pleasant, Texas, has helped revamp the nonprofit district hospital through improvements in technology, patient care and employee satisfaction over the course of his four-year tenure. Davis has been a member of NRHA since 2007.

Ned B. Hughes Jr. retired in August from his position as CEO of Gerber Memorial Health Services (GMHS) in Fremont, Mich. Hughes became president and CEO of GMHS in 1985. He has also served as vice president at Des Moines General Hospital, associate administrator at Dayton Children's Medical Center and assistant administrator at Toledo Hospital. Hughes has been a member of NRHA since 2007.

Robert Moser, MD, of Tribune, Kan., has been appointed by Secretary of Veterans Affairs James B. Peake to serve on the Rural Health Advisory Committee, joining NRHA past presidents Bruce Behringer and Hilda R. Heady. The Rural Health Advisory Committee will advise the top leaders of the Department of Veterans Affairs about health care issues affecting veterans in rural areas. Moser has been a member of NRHA since 1995.

Ed Pitchford, president and CEO of Charles Cole Memorial Hospital in Coudersport, Pa., was named to the Pennsylvania Rural Health Association's board of directors in June. He also promotes rural health issues as a member of the executive committee of the hospital and in the Health Systems Association of Pennsylvania Small and Rural Council's public policy committee. Pitchford has been a member of NRHA since 2007.

Randall J. Stasik has been named president and CEO of Gerber Memorial Health Services (GMHS) in Fremont, Mich. He is a seasoned health care executive with an extensive career in leadership and management of hospitals and health care systems, including 17 years at the Borgess Health Alliance System in Kalamazoo, Mich. GMHS received a National Rural Health Association Rural Health Award for Outstanding Health Care Organization in 2008 and has been a member of NRHA since 1987.

Pam Stewart Fahs was promoted to professor at Binghamton University in upstate New York. She also currently holds the Decker Endowed Chair in Rural Nursing at the Decker School of Nursing at Binghamton, which has the only PhD in rural nursing in the country. She teaches research and theory at both the doctoral and master's levels and researches cardiovascular health in rural populations. Stewart Fahs has been a member of NRHA since 1996.

John Supplitt, senior director for the Section of Small or Rural Hospitals at the American Hospital Association, received the Rural Health Resource Center's Technical Assistance and Services Center's Forrest Calico Leadership Award for his extraordinary leadership and support of rural hospitals. He has worked on behalf of the American Hospital Association's small or rural hospital members to identify, develop and advance their unique health care interests, issues and perspectives since 1993. Supplitt has been a member of NRHA since 1994.

Send your career updates to editor@NRHArural.org.

New NRHA members

Susan M. Antol
Diana Autaubo
Brent Barron
Pam Bartley
Anselm Beach
James Beal
Josh Bell
Maggie Blackburn
Sarah Bruins
Jack Cameron
Michael Carroll
Paul Caudill

Chuluunbaatar
Choijamts
Automme Circosta
C. Stanely Collins
Joshua Cusick-Lewis
Richard Cutts
Tina Davis
Chris Delamain
James Doherty
Sarah Dotson
Stewart Ferguson
Marcia French

Alexei Gavriline
Jonna Giles
Carol Giffin-
Jeansonne
Merle Glasgow
Linda Grgurich
Gregory J. Hardy
Richard Hartman
Sarah Hazel
Deborah Holzmark
Jessica Hunt
Ruth Jacobs

Kevin Jacobson
Kirsten Kammerzell
Karl M. Kilgore
Pat Kouwabunpot
Kim Kurokawa
Timothy Landon
Marc Lemon
Jana Lindsey
Arman Lorz
Concepcio G.
Martinez
Craig Mathews

Mollie McDermitt
Rhonda Meyer
Heather Moore
Guy Nesbitt
Terry Nimnicht
Tina Pickvet
Semmes Ross Jr.
Lisa Schiller
Barbara Sleeper
Jeff Speaks
Patricia Suh
Ryung Suh

Juanita Swinney-
Griffith
Elvira Szigeti
Melanie Taylor
Dennis Tesreau
Cruz Torres
Carol Trujillo
Amy Vega
Kevin Wahr
Angelia Williams
Candi Zizek

News briefs

Medicare legislation with \$2 billion rural health package becomes law

On July 15, President Bush followed through on his threat to veto H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008. Fortunately for rural America, both the House and Senate voted to override the veto, and the bill became law. The House voted to override the veto by a vote of 383 to 41, and the Senate followed suit with a vote of 70 to 26.

H.R. 6331 provides critical dollars to rural America and eliminates the pending 10.6 percent cut in Medicare payments to physicians through December 2009. The rural health care provisions total more than \$2 billion.

“This legislation’s progress is a significant victory for rural America. I thank each and every one of our members who took action to protect rural Medicare patients and providers and ask that they continue to fight for the health of rural seniors,” says Alan Morgan, NRHA CEO.

For more information on the bill, visit www.RuralHealthWeb.org.

NRHA Quality and Clinical Conference a success

The National Rural Health Association’s annual Quality and Clinical Conference took place July 15 through 17 in San Diego, Calif. Topics included the provision of quality rural HIV/AIDS clinical care, mental health issues and medication safety, as well as a question and answer session with quality improvement experts and the opportunity to earn continuing education credits. The 66 attendees also had the opportunity to enjoy beautiful weather and beaches.

“I felt very fortunate to have been able to attend the conference,” says Katrina Gardner, NRHA student

member at University of North Dakota School of Medicine. “It is always energizing to hear about innovative ideas in rural health from practitioners across the country.”

The 2009 Quality and Clinical Conference will be July 21 through 24 in Park City, Utah. Watch www.RuralHealthWeb.org for details.

Florida Community Health Centers receives grant from Blue Foundation for a Healthy Florida

Residents of Hendry County, Fla., will have more support accessing health-related services thanks to a grant from the Blue Foundation for a Healthy Florida, the philanthropic affiliate of Blue Cross and Blue Shield of Florida. Florida Community Health Centers (FCHC) recently received \$87,124 from the Blue Foundation to expand its Health Navigators Program.

As a federally qualified community health center, FCHC provides primary medical and dental care to residents in the communities surrounding Lake Okeechobee and the Treasure Coast area.

The two-year grant will enable FCHC to hire a bilingual health navigator to assist uninsured Hendry County residents in applying for Medicaid, Temporary Assistance for Needy Families, food stamps, social security and child support enforcement programs.

“Many people in our community can’t speak or read English,” says Edwin Brown, FCHC president and CEO. “Because of this, they are overwhelmed with the often complicated process of applying for health care benefits.”

The Blue Foundation for a Healthy Florida is dedicated to making a constructive contribution to the health and well-being of all Floridians, especially the uninsured and underserved. This grant is one of 14, totaling more than \$1 million, that the foundation presented to nonprofit health clinics and community outreach programs across Florida.

Ten states activate substance abuse screening and brief intervention codes

Ten states have activated new substance abuse prevention and treatment health codes for screening and brief intervention of Medicaid-eligible patients. The states will reimburse doctors and affiliated medical professionals who screen their Medicaid-eligible patients for a spectrum of substance use behaviors and disorders.

Iowa, Maryland, Minnesota, Montana, Oklahoma, Oregon, Tennessee, Virginia and Washington have activated American Medical Association common procedural terminology codes or Centers for Medicaid Services HCPCS codes for screening and brief intervention, with a tenth state, Wisconsin, conducting screening and brief intervention as part of a comprehensive package of health services for pregnant women.

“These states have taken an historic step in transforming substance abuse in the United States,” says Bertha K. Madras, deputy director for demand reduction in the White House Office of National Drug Control Policy. “This innovative approach will help diminish the public health burden of substance abuse in each respective state and catalyze preventive medical procedures in a cost-effective and sustainable manner.”

To learn more about the procedures, visit www.whitehousedrugpolicy.gov.

SAMHSA launches homelessness resource center web site

The Substance Abuse and Mental Health Services Administration (SAMHSA) has launched a new homelessness resource center web site. The site is designed to support individuals working to improve the lives of people affected by homelessness who have mental health conditions, substance use disorders and histories of trauma.

Topics such as how to reach out to the homeless, the transition from homelessness, health care, self care and housing are included to promote recovery-oriented and consumer-centered homeless services.

“The new homelessness resource center web site provides a platform for creating an interactive community of providers, consumers, policymakers, researchers and public agencies at federal, state and local levels working to prevent and end homelessness,” says Terry Cline, Ph.D., SAMHSA administrator.

Visit www.homeless.samhsa.gov for more information.

Colorado Rural Health Center hosts rural health conference



Attendees at the Colorado Rural Health Center's Annual Conference visit exhibit booths.

The Colorado Rural Health Center (CRHC), Colorado's nonprofit state office of rural health, held the 17th Annual Colorado Rural Health Conference June 18 through 20 in the Rocky Mountains' Copper Mountain Resort. More than 170 people participated in this year's conference, “Tradition and Transition: Rural Health Responding to Change,” and NRHA Senior Vice President of Member Services Brock Slabach presented a keynote session. Workforce shortages and health care reform were also hot topics at the conference.

In 2009, CRHC will host four, smaller regional conferences. For more information on these conferences and the CRHC, visit www.coruralhealth.org.

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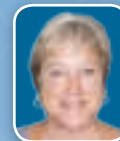
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Top 5 reasons to attend the NRHA Rural Minority and Multicultural Health Conference

1 The NRHA Rural Minority and Multicultural Health Conference is the only one of its kind

No other health care conference has a larger gathering of rural health professionals committed to improving access to quality health care for rural minority and multicultural populations.

2 Enjoy cultural ceremonies
The conference will kick off with an American Indian ceremony and wrap up with a Hispanic ceremony.

3 Attend practical sessions you won't find anywhere else
The variety of unique session topics include women's health, harmonious living through nutrition, health disparities and culturally-competent practices and models.

4 Visit Albuquerque
Experience the rich culture and heritage of the Southwest. Albuquerque winters are mild, so come dine on New Mexican cuisine and escape the cold. For more on what to do in Albuquerque, visit www.itsatrip.org.

5 Network and discuss solutions with your peers
Learn the barriers and challenges to linking economic development and health care in rural minority and multicultural populations, and forge partnerships to overcome these challenges.

3 great places to find grants

- Grants.gov
- The Rural Assistance Center at raconline.org
- The Robert Wood Johnson Foundation at www.rwjf.org

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Web sites like eFax (www.efax.com) and Myfax (www.myfax.com) help eliminate paper waste by allowing you to send faxes digitally from your e-mail account.

The 14th annual Rural Minority and Multicultural Health Conference is Dec. 11-12 in Albuquerque, N.M. Visit www.RuralHealthWeb.org to register.

Be clutter free

An organized office increases efficiency and peace of mind.

If you have just 10 minutes: de-clutter.

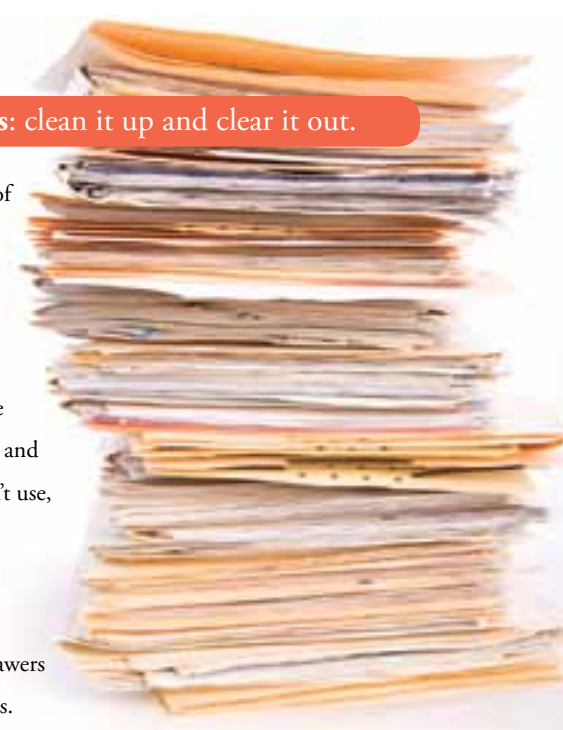
Throw out anything that doesn't work – pens, highlighters, that perpetually-jammed stapler. Sort through business cards and notes that have accumulated, and toss any you don't need. Get books and reference materials off your desk and back in their places.

If you have 1 hour: attack those stacks of paper.

This may seem like an overwhelming task, so chip away at it an hour or two at a time. Have a pen, file folders and labels on hand. Throw away or recycle as much as possible, and categorize and file the rest. Don't forget to clean up your digital desktop as well – deleting unnecessary files frees up your computer's memory and makes it easier to find the files you do need.

If you have 4 hours: clean it up and clear it out.

Is there a table or stack of boxes you trip over on the way to your desk? What about that desk lamp with the burnt-out bulb, or the files spilling out of your file cabinet? Take an afternoon and clear out anything you don't use, make a list and replace anything that has run out, or browse an office supply catalog for file cabinets, drawers and stackable shelving units.





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Early registration discount deadline:
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Rural Medical Educators Conference

May 4, 2009
Miami Beach, Fla.
Early registration discount deadline:
April 3

NRHA Annual Conference

May 5-8, 2009
Miami Beach, Fla.
Early registration discount deadline:
April 3

Quality and Clinical Conference

July 21-24, 2009
Park City, Utah
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