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Winter 2009 National Rural Health Association

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Correction The Breast Cancer Detection Center of Alaska, featured in the fall *Rural Roads*, is located at 1905 Cowles St., Fairbanks, Alaska, 99701. For more information on the nonprofit center, call 907-479-3909, e-mail bcdc@acsalaska.net or visit bcdcofalaska.org.

National Rural Health Association

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On the cover

Margarita Llinas, MD, sees a patient at Bingham Memorial Hospital in Blackfoot, Idaho.

Write us

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

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

Facelift fanfare

Love the *Rural Roads* facelift. It looks great, and the stories were exceptionally well-written.

Way to go!

Wendy Opsahl
University of North Dakota Center for Rural Health communications coordinator

rural roads

A fighting chance
War zone health

Real tooth fairies
The rural race to the White House
Mountains, moose and mammograms

Million copy request

Linda Matessino from Innis Community Health Center in Innis, La., received her fall copy of *Rural Roads* this morning and was ecstatic over the quality of the publication. She has requested "a million" copies. Ha!

Thank you!

Emily Tiller
Robert Rose Consulting project manager

Digging the design

I'm seriously digging the version of *Rural Roads* I downloaded. The design is clean, modern and readable.

Ads will really stand out. The style leaves one a lot of room to work with, which is generally not the case. Props to your designer.

Sean Morrison
Tripping up the Stairs Creative Services owner/designer

Share your story.

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

Contact Lindsey Corey at editor@NRHArural.org or 816-756-3140 to share your ideas and experiences.

Editorial suggestions must not be advertisements.

Rural faces new challenges and opportunities

With this new year dawns a new federal administration and promises of change. The challenges faced by this administration will shape the direction of rural health and the NRHA's national agenda more so than the platforms of those we elected.

Headlines of the past year focused on the most dramatic presidential election many of us can remember. This year may match the excitement, but for different reasons.

The economic climate threatens our access to capital for health facility construction and renovation; lines of credit to cover paychecks while waiting on insurance reimbursement; the cost of delivering goods, services and people to and from our rural communities; the cost of living in our rural communities; the capacity of our universities to educate a rural health workforce, and. . . the list goes on.

NRHA is paying attention and encouraging members of Congress to keep rural needs and rural innovations in their focus. Stay tuned.

–Beth Landon

Beth Landon
NRHA president

pit stop

5 things I picked up in this issue:

1. Rat research can lead to a career in rural health. *page 28*
2. Delivering your own baby counts toward midwife certification. *page 11*
3. Obama shoots and scores at the White House. *page 41*
4. Residents of Glendale, Ore., can borrow books and get their blood pressure checked in the same place. *page 16*
5. A-ha moments do happen on Capitol Hill. *page 32*

Internist Margarita Llinas, MD, who attended medical school in Bogota, Colombia, examines a patient at Bingham Memorial Hospital in Blackfoot, Idaho.

Relocation, recruitment, retention

Program brings international doctors to rural America

By Angela Lutz

At Bingham Memorial Hospital in Blackfoot, Idaho, part of the solution to the rural physician shortage comes from the Andes Mountains of South America.

Internist Margarita Llinas, MD, who attended medical school in Bogota, Colombia, arrived at Bingham Memorial in September 2008. Since then, she has realized more than ever the importance of the care she provides, particularly as a native Spanish speaker.

“I am the only bilingual, and there is a large Mexican population,” she says. “It breaks down that barrier and makes a huge difference. I feel I am doing something good for these patients.”

Llinas, who completed her residency at Jackson Memorial Hospital in Miami is also experiencing her first Idaho winter.

“Bogota is in the mountains, so I’m used to the cold,” she says. “But I’ve never lived in a snowy environment.”

Weathering his second winter at Tioga Medical Center in Tioga, N.D., family practice physician Swami Gade, MD, has settled comfortably into rural life. Originally from Andhrapradesh, India, Gade came to Tioga in 2007 after completing his residency at the University of Maryland in Baltimore.

“It was bad the first winter; my wife and I were not used to it,” he recalls. “Now we are more prepared. People in town have tried to keep the roads cleared around my house.”

As one of the only physicians in town, he has also become used to providing care for a variety of patients who would be seen by specialists at larger hospitals.

"In an ER trauma, you usually have a backup, but here you're the only one," he says. "I'm more comfortable now with geriatric populations, diabetic care, emergency care. I have learned a lot of skills."

Responding to a need

Llinas and Gade both originally came to America on a J-1 visa, which allows international medical graduates to come to the United States under an educational exchange program for up to seven years. When the visa expires, the physician must return to his or her home country for at least two years before applying for a permanent visa.

But the J-1 visa waiver, also called the Conrad 30 Program, gives physicians the option to stay in the States and work in a federally-designated health professional shortage area (HPSA) or medically underserved area (MUA) for three years instead of returning home.

Since its initiation in 1994, the Conrad 30 Program, named for its creator North Dakota Sen. Kent Conrad, has increased the supply of physicians to underserved areas across the country by allowing each state to recruit up to 30 international physicians each year. Between 2001 and 2007 alone, the program provided 5,732 waivers.

Mary Amundson, assistant professor at the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences, has worked in the area of physician recruitment and retention for two decades. She has also worked closely with Conrad since the program's inception.

"North Dakota has always had a challenge in getting rural health providers, especially primary care," Amundson says. "I learned J-1 physicians were being recruited in the Appalachian regions, and I thought, why can't they come here?"

With the help of Conrad and Sam Meyers, an attorney out of Minneapolis, Minn., they went through the legislative process to recruit J-1 physicians to underserved communities in North Dakota.

"It was a response to a need in the communities," says Amundson.

With 67 percent of American non-metropolitan areas located in HPSAs, all 50 states and the District of Columbia eventually utilized the Conrad 30 Program to help fill the void created by the physician shortage.

"When we started, the communities never had so many applications to choose from," recalls Amundson. "It was awesome. It gave them access to a new pool of physicians."

Tom Brown, senior vice president at Nanticoke Memorial Hospital in Seaford, Del., currently has 17 Conrad 30 recruits practicing at his hospital. Nanticoke Memorial is mostly in need of sub-specialists, and Brown expects many of the available positions to be filled by international candidates. Two of Delaware's three counties are federally designated HPSAs.

"The program increases the pool of available physicians for a small community hospital, and it allows us to have access to that pool," says Brown. "The process allows us to have visibility in front of a group of physicians that otherwise wouldn't have been aware of our existence."

Hospitals in rural Idaho have also struggled to recruit physicians, and they too have benefited from an increase in visibility.

"Ninety-five percent of the state's areas have HPSA designation in the category of primary care," says Laura Rowen, program manager at the Idaho State Office of Rural and Primary Care. "There's not a single community that uses this resource more than others, so the potential for placement is really big."

"There isn't a 'carve-out' in immigration for physicians. It would be nice to have a **health care immigration program** so they don't get bogged down with the red tape."

Mary Amundson, Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences assistant professor

In fact, Llinas still gets job offers almost daily.

"I still receive e-mails from places trying to recruit me," she says. "It's incredible. In Miami, there are millions of internists, but they really need me here."

Community contributions

Providing underserved, rural areas with access to qualified physicians has been a tremendous benefit to hospital administrators, and the communities have benefited as well.

"They bring a different culture to the community," says Amundson. "Bringing a new culture is good for North Dakota, because it's very homogeneous."

Rowen agrees.

"Bringing people from other parts of the world

continues

continued

contributes to the richness of that community's fabric," she says. "The community is opening their arms and has done what is necessary to get (the physician) to come."

To help welcome J-1 physicians and ensure they will be at home in their rural communities, most hospitals require one or two site visits before they hire a candidate.

"I am the only bilingual, and there is a large Mexican population. It breaks down that barrier and makes a huge difference."

Margarita Llinas, MD

Before settling on Tioga Medical Center, Gade visited twice, once for the interview process and again to witness day-to-day operations.

"I wanted to be sure I was making the right commitment," he says.

Rural physician shortage by the numbers

By 2020, there will be a physician deficit of **85,000**.

250,000 active physicians will retire by 2020.

34.9 million Americans live in federally-designated health professional shortage areas where there is less than one primary care physician for every 2,000 people.

67 percent of the non-metropolitan areas in the United States are located in federally-designated health professional shortage areas.

Only **2 percent** of graduating medical students plan to work in primary care, down from 9 percent in 1990.

Ultimately, the community won Gade over, as did knowing his work at the hospital would give him the opportunity to gain new skills and knowledge.

"There was a different physician when I came in, and he seemed quite happy," Gade recalls. "It was a gut feeling. I wanted to do family practice, and rural was ideal for that."

Gade enjoys visiting with others in the community of 1,100, and he's learning how to golf. He doesn't hunt or fish, however, and both are popular where he lives. He also says the lack of international neighbors has been one of the hardest parts of adjusting to rural life.

"That's one thing that would make it hard to keep a physician for a long time," he says. "But the community here welcomes you so well you get over that. Looking at advantages and disadvantages, you have to give up something."

Gade isn't the only doctor who has struggled with limited cultural diversity in rural America. According to Rowen, the lack of an international community makes retaining physicians beyond their three-year obligations more difficult.

"Within these small rural communities, it's difficult for doctors to culturally identify," she says. "They'll fulfill their service obligation, and then they'll look to go to a larger population center where they can find cultural opportunities to make them feel more comfortable."

But at Nanticoke Memorial, more J-1 physicians have stayed after their three-year commitments than have left. Brown sees several reasons for his hospital's successful retention.

"The location is ideal because of its proximity to metro areas and the beach," he says. "Also, when we bring a J-1 physician onto our medical staff, they cease being a J-1 physician and just become a physician. We make no distinction between J-1 and American physicians."

Brown also insists all physicians, including U.S. doctors, visit the hospital

Sen. Kent Conrad (center) visits with farmers in North Dakota. Conrad initiated the J-1 visa waiver program in 1994.

before making a decision to work there. He encourages them to make two visits, "one for us to decide, and another for them to come and look around again to be sure this is really what they want."

"They don't choose us because we accept J-1 applicants," Brown adds. "They choose us because we're the best place. This is the hospital they wish to practice at. I hope they approach it thinking this is a place they can stay beyond the three years. We try to approach it that way too."

Reauthorization

Retention isn't the only challenge facing the Conrad 30 Program. At the federal level, the program has to be reauthorized annually. It is up for reauthorization again in March.

"It's frustrating that we have to work so hard to get a program implemented and to sustain the program," says Amundson, who provided written testimony on behalf of the program to the Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law last June. "And it's very difficult to make the necessary changes to increase physician supply."

Last year, plans to make the program permanent didn't pass during reauthorization. But Amundson hasn't given up, and this year she hopes "something will be done to make it good for five years or permanent."

Stricter regulation of immigration programs has also made it more difficult for J-1 physicians seeking a waiver.

"There isn't a 'carve-out' in immigration for physicians," Amundson says. "They're lumped in with everyone else. It would be nice to have a health care immigration program so they don't get bogged down with the red tape."

In response to more stringent immigration policies, many physicians are opting to go to Australia and New Zealand, where it's easier to get a waiver.

Compounding the problem, many physicians still coming to America are using the H1-B visa, which doesn't have the stipulation requiring them to serve in an HPSA or MUA. Instead they can go to a facility anywhere in the country. It's also easier to attain than the J-1 visa waiver.

"It shrinks the pool," says Amundson. "I have seen some of the largest vacancies since 1991 in the last seven years. Communities have had to re-think the way they deliver care and utilize more nurse practitioners and physician assistants because they can't find a physician."

Amundson and Conrad are trying to combat the shortage of J-1 candidates created by the H1-B visa.

"Sen. Conrad has worked hard to propose new legislation that would allow H1-Bs to be exempt from the immigration cap if they come in on a J-1 visa and serve in an underserved area," Amundson explains. "It didn't pass, but we're going to try again."

Swami Gade, MD, checks patient Arlene Thorson's vitals. Originally from India, he is the only physician at Tioga Medical Center in Tioga, N.D.

Finding new ways to recruit American physicians is part of the solution to the shortage as well, but in the past it has proven difficult.

"The way it (the Conrad 30 Program) is utilized in Idaho is as an option of last resort," says Rowen. "Communities have to prove they've tried to fill vacancies with an American physician for a minimum of six months. After they've pursued that option, they can look at a J-1 candidate."

Delaware also requires hospitals to spend at least six months trying to recruit an American physician before seeking a J-1 candidate, but as Brown points out, "in recruitment, that's a blink of an eye."

"There's a general recognition there's a physician shortage," he adds. "The last three times I tried to recruit (an American physician for) this position, I failed. Why would it be different now?"

The limited availability of American doctors is another reason the Conrad 30 Program is so vital to the health of rural communities, Amundson says.

"The biggest issue is not only how do we increase the supply of American physicians trained in family medicine, but also how we increase the supply of J-1 physicians ready to serve in underserved areas," says Amundson.

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Only part of the solution

There is an understanding among rural health care providers who utilize the Conrad 30 Program that without it, they would have to change the way they deliver health care.

"You would see a severe limit to access to care," says Amundson. "Some facilities would no longer be able to provide the services they currently provide."

"It would make our ability to recruit physicians nearly impossible," adds Brown.

But, as Rowen points out, "there's still a lot of unmet need out there."

"(The program) is not the answer in and of itself; it's just part of the answer," she says.

As another part of the answer, Amundson is considering ways to attract U.S. doctors to primary care.

"I wish the pendulum would swing back to the primary care physician," she says. "Many of our young people are choosing sub-specialties because of lifestyle, money factors and the call schedule. For the most part, you can't blame the young physicians for wanting to have a life outside of work."

Gade has seen young doctors wear out from working too hard, and another reason he's happy at Tioga Medical Center is he isn't expected to carry an unreasonable workload. They also allow him four weeks of vacation a year, giving him time to visit his family in India.

"Without vacation, you get overwhelmed," he says. "Especially right now, I'm the only physician. That's why physicians can burn out pretty quickly, when they don't know what they can or cannot handle."

To address this problem, Amundson is looking for ways to "accommodate (the physicians) without compromising care."

"A lot of places are looking at part-time and hospitalist positions," she explains. "Also, how do we eliminate some of the heavy call? There's a lot we could do if we find people and resources."

Basic requirements to apply for a J-1 visa

- Participants must have sufficient funds to cover all expenses or must have a sponsoring organization that will provide full support.
- Participants must have the required education for the particular program they are entering.
- Participants must have a good understanding of the English language or must be entering a program for non-English speakers.

For more information on the J-1 visa and J-1 visa waiver, check out the Rural Assistance Center at www.raconline.org or the National Rural Recruitment and Retention Network at www.3rnet.org.

Rural midwives deliver

By Lindsey V. Corey

Top: Gretchen Spicer with 11 cousins she delivered for three mothers.

Above: Spicer weighs a newborn.

Midwives, especially the rural ones, have tales to tell.

Instead of fish stories, they've got baby stories.

There's the 11-pounder who landed in and filled Elaine Wakeland's lap.

Gretchen Spicer helped a mother in labor for 64 long hours. She also hiked through snow for a half mile in wind chills of 40 degrees below zero for a prenatal visit.

And Gail Murphy stayed on the island for five months straight to be sure she didn't miss a birth. They've delivered babies in backseats, on a ferry and by flashlight.

"A typical day for a midwife?" Murphy laughs. "There's no such thing."

Murphy was taking the 20-minute ferry ride from Washington's Vashon Island to Seattle when she heard a woman's water had broken on board.

Minutes later she delivered Joseph Tillikum, named for the boat on which he was born.

"At the time, I'd never met her, but now I see his mom all the time at the grocery store," Murphy says.

A licensed midwife for 14 years, Murphy is the only obstetrics provider serving the island of about 11,000 people. Ferries are Vashon residents' only connection to hospitals in Seattle and Tacoma, Wash., but not for a five-hour period in the middle of the night – and sometimes not in time. So Murphy lives on the island and only cares for island patients.

She took a six-year break from midwifery after her divorce because she couldn't leave her children home alone, but recently an expecting couple offered to pay her licensing fees and help with insurance costs so Murphy could deliver their baby at home on the island.

"People were begging me to come back, and the timing was right," she says. "I was born to do this."

Murphy hasn't needed to advertise her return to midwifery.

"Everybody knows where to find me," she laughs.

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"Proof is in the pudding"

Murphy delivers nearly half of Vashon Island's newest residents.

Nationwide, 7.4 percent of infants were delivered by certified nurse midwives in 2005, according to the National Center for Health Statistics.

"Midwives play a really important role in rural health care both in communities and on reservations, and we expect growth that will help with health care costs and the shortage of providers," says Leslie Ludka, American College of Nurse Midwives senior technical adviser and a certified nurse midwife.

Each year, midwives attend more births while the number of family practice physicians providing maternity care has decreased due in part to malpractice insurance rate increases, according to the American Academy of Family Physicians.

Rural doctors also choose not to take obstetrics cases because of on-call requirements and not having a backup provider. So many small-town hospitals have discontinued labor and delivery services, leaving rural women, already dealing with access issues, fewer options.

"It's nobody's fault," says Wakeland, a certified nurse midwife at Natchez Trace Health and Birth Center in Waynesboro, Tenn., population 2,100. "The area is just so small there's really no maternity or pediatric care nearby."

Wakeland's career began as a nurse in an Indianapolis neonatal intensive care unit, but the self-proclaimed small-town girl says she wanted to be there at the beginning "and catch the babies" like her grandmother, who was a midwife after immigrating from Germany.

"As far as rural health goes, we need this," she says. "As far as women go, they are looking for this, and they deserve options no matter where they live."

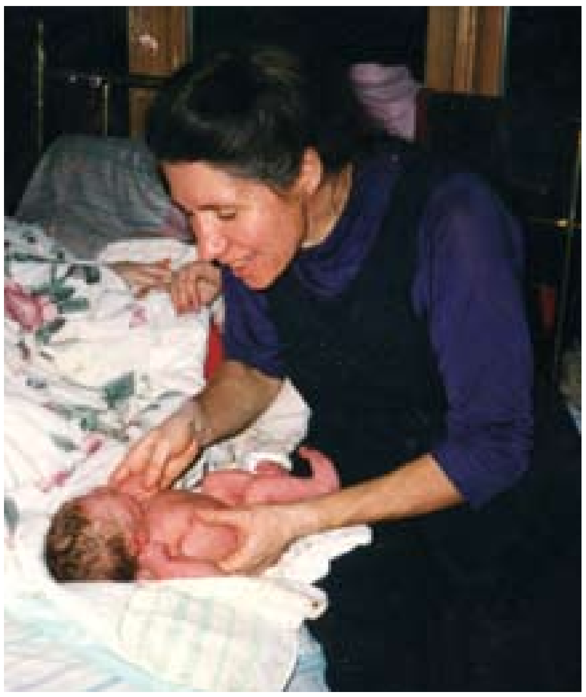
Seventy percent of women seen by nurse midwives are considered vulnerable because of their age, socioeconomic status, education, ethnicity or their rural residence, says Ludka.

When the only doctor's office in Winters, Calif., population 6,900, ceased offering maternity care, the staff donated its clinic space in the evenings to CommuniCare Health Centers midwives to see local patients when most get off work at the nut sorting factory, tomato farms and orchards.

CommuniCare's perinatal program serves only Medi-Cal (California's Medicaid program) patients at five clinics throughout Yolo County, which is primarily agricultural land outside the population centers.

Barbara Boehler, CommuniCare's director of perinatal services and a midwife herself, started the comprehensive program 27 years ago at the federally qualified and migrant health center.

Visits can last a couple hours because mothers-to-be meet with health educators, social workers and nutritionists in addition to midwives or nurse practitioners providing maternity care. As needed, pregnant women are referred to depression, diabetes and dental care.



Gretchen Spicer conducts an exam about an hour after she delivered the baby in a rural Wisconsin home.

"Hopefully, it's a lot better than going to a gynecologist," Boehler says. "We have all these additional services which you generally don't get in private practice. We spend the extra time assessing their situation so we can direct education throughout the pregnancy to each woman's needs. This way they feel very connected with their care."

> "It's so rewarding to see a woman transition from **pregnant to parent**."
> Carolee Hall, certified professional midwife

Sixty percent of CommuniCare's patients speak only Spanish, so most staff are bilingual including three out of the four midwives, who delivered nearly 600 babies at Sutter Davis Hospital last year.

Boehler is proud that 95 percent of CommuniCare mothers leave the hospital breastfeeding, and 11 percent require cesarean births. More than 31 percent of U.S. births are C-sections, according to the National Center for Health Statistics.

"You can have a really fancy program, but the proof is in the pudding," says Boehler. "Our patients are the highest risk in the county, but they're well taken care of. It's the real outcomes that make a difference in

the health of mothers and babies. I get to work with wonderful people committed to this idea that caring and support and good medical care makes a positive impact on families. And the way in which we practice has given us extraordinary results."

Boehler is now working with her second generation of new moms.

> "As far as rural health goes, we need this. As far as women go, they are looking for this, and they **deserve options** no matter where they live."
> Elaine Wakeland, certified nurse midwife

"I remember their mothers who weren't so sure about breastfeeding, but their daughters are saying 'of course, I'll breastfeed'," she says. "I believe we've positively affected the health of my neighbors. We've changed the culture of how people think about childbirth here."

Meeting a need

In Tennessee, Wakeland partners with a family practice physician to increase services for low-income rural women. Expectant mothers choose the doctor or midwife, knowing either way the doctor is available to perform C-sections and circumcisions while Wakeland handles childbirth classes and lactation consulting. The duo also offers well-woman gynecological care.

Most Natchez Trace patients travel more than an hour to the clinic and birth center, and very few are within 30 miles.

"The poverty here is unbelievable; they have nothing," Wakeland says. "We're missionaries here. Some people can't afford the gas to get here, and some don't even have clothes to take the baby home in, so our nurse puts together gift packs. It's real out here."

While some of Wakeland's poorest patients have no other option, her practice also attracts women from Alabama, where there are more restrictions on midwifery.

Some religious groups also prefer midwife-attended births in clinics or at home rather than in hospitals.

"I'm pretty sure I delivered every Jehovah's Witness in Wayne County because they don't want any interventions and know we won't make them," Wakeland says.

Eighty-five percent of the births Spicer and her partner Lindsey Kroll attend are in Amish homes with no electricity and sometimes no running water.

"It's such an honor to be allowed into the communities," Spicer says of the six Amish and two Mennonite communities she regularly serves.

The former paramedic carries a bag full of flashlights and batteries and often has to climb to a hilltop in the middle of the night to check cell phone messages to ensure another mother doesn't need help.

"A big benefit of midwifery care is knowing my partner or I is available 24 hours a day from the first visit to the last," she says.

Twice last year, only a team of horses could get Spicer to Amish women in labor. Flood routes have to be checked and rechecked, and she can't call the Amish to cancel prenatal or postpartum appointments when the weather gets in the way.

"Sure there are challenges, but there are also lovely things out here," Spicer says. "If it's taking awhile, sometimes I can take a walk down by the stream. I've even noticed horses at the window watching."

One of Gretchen Spicer's Mennonite patients reads postpartum information with her 3-week-old baby.

The pregnancy partnership

Delivering babies in rural Wisconsin winters is a family business. There was the time Spicer's car was stuck in a snowdrift. Then Kroll's vehicle got stuck, so Spicer's husband came to the rescue and got the midwives to the laboring woman.

"He slept in the car and waited that night," Spicer remembers. "He's also gotten up in the middle of the night to shovel the driveway not because I got a call, but because someone was due, and you just never know."

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Midwives never know when they'll get a call from a frantic father-to-be or a worried mom.

"You're really on call all the time," Wakeland says. "When I first started, I would hold off on doing everything, but then I never did anything."

Now, she's trying to ensure her wedding day will be covered, but a honeymoon isn't likely, she says.

Carolee Hall, a certified professional midwife from Rainier, Wash., population 1,500, says midwifery is a difficult but gratifying lifestyle.

Midwife math

Midwives attended more than 306,000 U.S. births – or 7.4 percent – in 2005.

70 percent of women seen by nurse midwives are considered vulnerable because of their age, socioeconomic status, education, ethnicity or location of residence.

96.7 percent of certified nurse midwife-attended births were in hospitals: 2 percent were in freestanding birth centers. 1.3 percent were in client homes.

Midwife-attended hospital births were most frequent among American Indians/Alaskan Natives (18 percent) and Hispanics (8.2 percent).

Nurse-midwifery is legal in all 50 states and the District of Columbia.

The number of U.S. midwives has more than doubled in the last 10 years.

The United States has 50 accredited midwifery education programs. 25 offer distance learning.

The American College of Nurse Midwives, a professional organization with 6,400 certified members, has set goals to add 1,000 newly certified midwives practicing in America by 2015 and for midwives to attend 20 percent of births by 2020.

Source: American College of Nurse Midwives

"We've changed the culture of how people think about childbirth here."
Barbara Boehler, CommuniCare Health Centers director of perinatal services

"Being on call and taking the extra time with our clients can be challenging, but the time commitment is a lovely part of our job," she says. "It's so rewarding to see a woman transition from pregnant to parent."

Spicer remembers her youngest daughter telling her she was working on a story titled "A Midwife's Daughter, a Tale of a Neglected Child."

"She was only partly joking," Spicer says. "It's really hard for kids. You miss a lot. But now that I'm delivering their babies, my kids like it really well."

Midwives' families understand that often holidays have to be put on hold.

"Thanksgiving is the big one," Murphy says. "There are always, always babies born on Thanksgiving. My own was one of them. We had dinner, a baby boy, then pie and birthday cake."

Four of Murphy's midwife friends made it in time to help because there was little traffic during holiday meal time. But her daughter arrived too quickly, so Murphy delivered the infant herself while in midwifery school.

"They told me my baby could count as my first of 50 managed births," she laughs. "I know firsthand how important it is to be close to people's homes."

Excluding the ferry surprise, all births Murphy attends are in the mothers' homes.

"If I were in Seattle, I'd have two partners and be on call a third of the time and have a life," Murphy says. "But I wouldn't have the community."

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Morningstar's medicinal blend

Nurse's coffee shop offers more perks than just lattes

By Angela Lutz

Top: At Morningstar Coffee House, guests can check out a book, enjoy a cup of coffee or even get their blood pressure checked.

Above: Misty Morningstar, RN, opened her coffee house in a renovated hardware store.

On an average day at Morningstar Coffee House, anything can happen.

When owner Misty Morningstar arrives each morning to open up, the shop is freezing and empty. As the regulars arrive and throw some logs on the fireplace, the room becomes warm and lively. Over their morning coffee, the group sits around the fire and discusses politics, last night's happenings and their plans for the day.

"The same people come in every single day," says Morningstar. "I try to encourage them and give them a little bit of hope."

As the afternoon wears on, travelers stop in to use free wireless Internet service. After school, students go online, chat or do some homework.

In these respects, Morningstar Coffee House sounds just like any other coffee shop.

But to the residents of Glendale, Ore., population 915, the coffee house provides more than just lattes; it also helps fill the roles of a doctor's office, pharmacy, library and community center.

"It is my heart's desire to serve the community I live in," Morningstar says.

Filling the gap

Morningstar, who has worked as a registered nurse in long-term care and nursing facilities since 1993, opened Morningstar Coffee House in a hardware store she and her husband renovated in 2004. Glendale is 50 miles from anywhere that will hire a nurse, and as a mother, she wanted to work in the town she called home.

Her decision to open a coffee shop was inspired by memories of her grandmother in Georgia.

"People would come to her all day long and sit at her table with a cup of coffee," recalls Morningstar. "Everyone loved that woman because she would just listen to them."

Besides the coffee house, the main businesses in Glendale are the bank, a small grocery store and a one-pump gas station. A dentist comes a day and a half a week, but there are no other medical providers, the nearest of which is 45 minutes away. When Morningstar worked at a nursing home in Roseburg, Ore., she had to wake up at 3:30 in the morning to make it on time.

"Because they're off the interstate, they're pretty isolated," Morningstar says of Glendale. "By the nature of their location, they're incredibly strong characters. Things aren't as easy as they are when you live in town. You have to try a little harder."

Morningstar Coffee House serves as a library for Glendale, Ore., and its neighboring communities. The coffee house also holds community music nights and sometimes hosts concerts.

As a registered nurse working at a coffee shop in an isolated town with no medical providers, Morningstar gets some interesting requests.

"When people know you are a nurse and they need help, even when you are making lattes, it's always interesting," she says.

"When people know you are a nurse and they need help, even when you are making lattes, it's always interesting."
Misty Morningstar, RN, coffee shop owner

At the shop she's been asked to check blood pressure, look at rashes, remove stitches. One traveler ran out of blood pressure medication and couldn't get a refill until a medical professional checked her out, so Morningstar examined her.

Sometimes she makes house calls, like the time a worried woman needed help setting up her husband's breathing equipment in the middle of the night. Another time she intervened when a woman at the grocery store had a panic attack.

"We walked across the street, brought her over, checked her vitals and gave her decaf coffee, and she went on her way," says Morningstar. "She just needed a place to calm down."

Morningstar has also responded to emergency situations, like when a man in his car had a gastrointestinal bleed in front of the coffee house.

"He passed out, his foot hit the gas and he hit the guardrails in front of the train tracks," she says. "We heard his car peeling out and went to help him."

On another occasion, an older woman failed to show up for the writers' group that meets at the coffee house on Fridays. Morningstar and some members of the group went to check on her, and it turned out she'd suffered a stroke and couldn't get out of bed to call for help.

"It was kind of a blessing we met here, or we might not have found her," Morningstar says.

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Left: Misty Morningstar, RN, and her husband, Paul Farnham, co-own Morningstar Coffee House.
Right: Misty Morningstar, RN, takes a quick break during a typical busy day.

By providing medical services that would otherwise be unavailable in Glendale, Morningstar Coffee House serves as a reference point for care.

"We are the good Samaritans who fill in the gap between calling 911 and getting them going," she explains.

When someone in Glendale calls 911, it is often Morningstar's two oldest children who are the first responders. They handle the fire and emergency medical services in town.

"It's a community effort," Morningstar says of the emergency response team. "It brings everybody together."

In addition to providing medical care, Morningstar has forged a partnership with Trinity Valley Pharmacy in Grants Pass, Ore., to provide home delivery of pharmaceuticals. Glendale's nearest pharmacy is 30 miles away.

At the coffee house, Morningstar enrolls new customers, who are primarily older people and families, and faxes their documents and prescriptions to the pharmacy, where they are filled and delivered at no extra cost. If a customer is not at home, the medications are kept at the coffee house for later pick up.

Countrified Barnes and Noble

Among Morningstar's goals for her business was to provide "a place that was not a bar or church where adults and kids alike could hang out and be comfortable."

"I came from a residential care facility that had activities scheduled every week, so I try to schedule community activities in the shop," Morningstar says.

Once a week, Glendale residents can pick up their groceries at the coffee house when everything from produce, meat and bulk items to office and kitchen supplies is shipped from Costco Wholesale in Eugene, Ore. About 70 families use the service.

"When the Costco guy came in and said they were going to start doing that, I grabbed him and hugged him and kissed him," laughs Morningstar. "It's very in-demand – I could probably have a store that just does Costco."

The coffee house also hosts occasional music nights. Morningstar plays piano at the local Presbyterian church, and her daughter is studying to be a piano technician. As a result they have five pianos in the store. Last year, the Cascade Brass Quintet from Bend, Ore., played a show at the coffee house and "packed the place out."

"It's the neatest thing to have music where there wasn't any," Morningstar says.

Other than providing medical services, perhaps Morningstar's biggest contribution to the community is the small library she has cultivated in the coffee house. The library grew out of need – Glendale doesn't have one, and in the neighboring county, the libraries closed from lack of funding.

> "It is my **heart's desire** to serve the community I live in."
> Misty Morningstar, RN, coffee shop owner

"I would go for a walk and see people sitting in front of the television every single night," she says.

When she began setting up her library, she remembers someone asking her, "Why are you putting up a coffee shop with books in it? No one reads in this town."

"They're gonna," Morningstar replied.

The idea caught on, and now people go to Morningstar Coffee House to buy and borrow books.

"We're like a countrified Barnes and Noble," she jokes.

Always looking toward the future, Morningstar says she is seeking a medical practitioner to come to Glendale "even a day and a half a week," and she recently attended the annual Oregon Rural Health Conference for this purpose.

In the meantime, she and her daughter are paying for a group of high school students to complete the First Responders program, an advanced first aid class with some emergency medical training, such as airway management. The Morningstars also teach CPR and first aid "right there in the coffee house."

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Making harm history

Campaign connects hospitals to improve quality

By Angela Lutz

Kathy Duncan likes to talk about what's going right in rural health care.

Over the last two years, Duncan, RN, faculty expert from the Institute for Healthcare Improvement (IHI), has seen thousands of rural success stories through IHI's 5 Million Lives Campaign.

"We want to get the good news on the front page instead of all the bad stuff," she says.

With a goal of preventing 5 million incidents of medical harm over two years, the campaign came to a close in December with participants in all 50 states and more than 4,000 hospitals enrolled, representing 80 percent of the hospital beds in the United States. More than 1,500 of those were rural facilities.

"Critical access hospitals are wonderful innovators for change," says Duncan. "They have a smaller number of patients and employees, so once they get someone in the hospital excited about quality improvement, they can do some great stuff."

The campaign sought to protect patients from medical harm through the implementation of 12 interventions. When the successful 100,000 Lives Campaign ended in June 2006, IHI took its six interventions and, according to Duncan, "beefed them up a bit and put them on steroids" for the start of the 5 Million Lives Campaign that December.

The interventions have succeeded in reducing harm and saving lives.

"About 122,000 lives were saved between '04 and '06, and the hospitals are right on track with continuing to improve at about that same rate," Duncan says.

Green pins mark the critical access hospitals enrolled in the 5 Million Lives Campaign, and red pins mark those that have yet to sign up. More than 1,500 rural facilities participated.

Each improvement intervention has an online how-to guide.

"We tried to write them as recipe books," explains Duncan. "Here's how you talk to administration. Here's how you get a team together. Here's who should be on that team. It's not just what to do; it's how to do it. It helps people work it into their daily routine and hardwire it with staff."

Sharing success

IHI resources have been invaluable to rural hospitals participating in the campaign. The institute's web site provides a forum for networking with other hospitals and sharing the latest research, evidence-based practices and ideas for quality improvement.

Michele Kelly, director of quality improvement and community services at Buena Vista Regional Medical Center in Storm Lake, Iowa, says she uses the site almost every day.

"At a small hospital, we don't have a lot of deep resources, like education or research departments," she says. "We're grassroots people looking for the best way to give care to our patients. The IHI offers it right there – you don't have to search."

Kelly's hospital experienced success with the prevention of adverse drug events, and Buena Vista became a mentor hospital, advising others on how

What is harm?

The 5 Million Lives Campaign defines "medical harm" as unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization or results in death. Such injury is considered harm whether or not it is considered preventable, resulted from a medical error or occurred within a hospital.

to achieve similar accomplishments by taking more thorough, accurate medical histories.

"It's been a great opportunity to communicate with other providers all over the U.S. and even in Canada, Saudi Arabia, Australia," Kelly says. "About every week I get e-mails from people asking questions."

Claxton Hepburn Medical Center in Ogdensburg, N.Y., which began implementing the interventions at the start of the 100,000 Lives Campaign in 2004, also found the web site to be valuable, according to respiratory therapy and nurse ICU manager Jennifer Shaver.

By implementing IHI's guidelines, the 153-bed hospital hasn't had a case of ventilator-associated pneumonia in more than four years. Previously, one in three patients on ventilators got pneumonia. Of those, half died, and the rest were costly to treat.

"IHI demystified a lot of what is going on as far as evidence-based standards go," Shaver says. "Just the fact that we could communicate with hospitals in other states and ask them what they've been doing was a tremendous benefit."

Over the last four years, Claxton Hepburn has mentored other hospitals on how to prevent ventilator-associated pneumonia and provide a higher quality of care overall.

"We are fortunate to be able to offer that level of care," Shaver says. "It was encouraging to be able to tell people how and why it's possible."

Claxton Hepburn Medical Center in Ogdensburg, N.Y., hasn't had a case of ventilator-associated pneumonia in four years.

Suzi Bean, director of quality at Mountain View Hospital in Madras, Ore., agrees that sharing ideas between hospitals has been helpful, especially for rural facilities with limited resources.

"We're **grassroots people** looking for the best way to give care to our patients."
Michele Kelly, director of quality improvement and community services, Buena Vista Medical

"A few years ago you couldn't get your hands on other hospitals' ideas," Bean says. "There was a proprietary feeling. IHI shamelessly promotes sharing your ideas and allowing others to use them. That concept has promoted quality and safety more than anything."

Mountain View has been most successful with the rapid response intervention, which Bean initiated after starting at the 25-bed hospital in July 2006.

"I found a how-to kit on IHI's web site and implemented it in the way they suggested," she says. "We already had an informal system of taking care of adverse events, so we didn't expect formalizing it to make such a huge difference."

Since starting the intervention, the hospital has experienced a 50 percent reduction in its non-adjusted mortality rate. They have also contributed to the pool of resources available through IHI by becoming a mentor hospital.

Getting staff on board

The key to these hospitals' success with the 5 Million Lives interventions lies largely with the staff. All three hospitals devoted time to educate staff about the interventions and show them how to incorporate changes into their daily practice.

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"If you invest that time up front, you will have good results," Kelly says.

Bean agrees, noting that she got "incredible buy-in" from physicians and emergency room staff who were part of the rapid response teams.

"We did a house-wide education session where we trained everybody in the hospital about rapid response teams in particular," she says. "We told them about the campaign and projects we'd be working on."

Shaver says changing practices was difficult at first.

"It's hard to convince people that if a patient is not in shock, the head of the bed should be up," she says. "But the staff owned it and made it their own. Now it's just the way we practice."

Shaver has also gotten the Claxton Hepburn board involved in the campaign, and she says this has contributed to the hospital's prevention of ventilator-associated pneumonia.

"I was excited to share our success with the board," she says. "The hospital board knows who I am and what I'm doing. The CEO knows the staff by name, and he helped us celebrate our four-year anniversary (without a case of ventilator-associated pneumonia)."

And Kelly points out the benefits of active leadership on a state level.

"We have a very active node, the Iowa Health Care Collaborative," she says. "Our state has its own web site and mentors."

The work is not done

Though the campaign ended in December, IHI is looking at ways to reach its goal through quality-improvement work and prevention of medical harm.

"We have made tremendous strides, but we know the work is not done," Duncan says. "Our goal is to continue to provide resources for these 12 interventions, and we're looking at more interventions in the future. In 2009, something will be launched to continue the work of the campaign."

And they plan to expand the free online resources available to rural facilities, including webinars and conference calls. Participation in the campaign remains free, requiring only a one-page hospital profile.

"We're testing things to see how we can educate people virtually for free," Duncan says. "Folks are telling us they love that they can sit in their office for an hour and be online with other hospitals asking questions."

And Duncan encourages even more rural hospitals to participate.

"We want you to be a part of this program, because we learn from you," she says. "We want you to network with folks who look like you and offer you resources."

The 12 interventions of the 5 Million Lives Campaign

1. **Deploy rapid response teams** at the first sign of patient decline.
2. **Deliver reliable, evidence-based care for acute myocardial infarction** to prevent deaths from heart attack.
3. **Prevent adverse drug events** by implementing medication reconciliation.
4. **Prevent central line infections** by implementing a series of interdependent, scientifically-grounded steps.
5. **Prevent surgical site infections** by reliably delivering the correct perioperative antibiotics at the proper time.
6. **Prevent ventilator-associated pneumonia** by implementing a series of interdependent, scientifically-grounded steps.
7. **Prevent pressure ulcers** by reliably using science-based guidelines for their prevention.
8. **Reduce methicillin-resistant staphylococcus aureus (MRSA) infection** by reliably implementing scientifically-proven infection control practices.
9. **Prevent harm from high-alert medications** starting with a focus on anticoagulants, sedatives, narcotics and insulin.
10. **Reduce surgical complications** by reliably implementing all of the changes in care recommended by the Surgical Care Improvement Project.
11. **Deliver reliable, evidence-based care for congestive heart failure** to reduce readmissions.
12. **Get boards on board.** Define and spread the best-known leveraged processes for hospital boards of directors so they can become more effective in accelerating organizational progress toward safe care.

For more information or to access free resources to implement the interventions, visit the Institute for Healthcare Improvement at www.ihi.org.

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Men at work

Prostate cancer program emphasizes early detection

By Angela Lutz

Frankie Johnson visited workplaces to educate men about prostate cancer prevention.

Frankie Johnson knows how men feel about going to the doctor.

"As a man, I know how challenging it is for men to see the doctor and take care of themselves," says Johnson, director of public relations at Central Mississippi Residential Center in Newton, Miss. "We just don't do it."

Johnson also knows prostate cancer screening, one of the more frequently avoided tests, is also one of the most vital.

Research shows approximately one in six men will be diagnosed with prostate cancer in his lifetime, and the chance of developing prostate cancer increases as men age. Yearly screenings are recommended after age 50, but many men just don't go to the doctor.

So Johnson decided to go to the men.

In 2007, he was employed as a patient advocate and marketing director at Newton Regional Hospital, and he began visiting area businesses and industries to target men in the workplace and educate them about the importance of prostate cancer screening.

"I thought, I'll go to where they are," he says.

Johnson's presentations included statistics, warning signs and symptoms, how to cope with a diagnosis, how to access services and the importance of the prostate-specific antigen (PSA) blood test, which was offered by volunteers following the presentations.

Along with a digital rectal exam (DRE), annual PSA screening is the most reliable way to catch prostate cancer early, when it's most treatable.

Johnson understands the DRE can be "embarrassing and uncomfortable," and another goal of his presentations was to "eliminate the fear and shame" associated with this procedure.

"The DRE is the main thing that would hinder men from (getting screened)," he says. "I always say it's better to be uncomfortable for a few seconds and alive, versus comfortable and sick."

The response to the presentations was overwhelming, and most of the men stayed around for PSA screening.

"A lot of men were happy men's health issues were being addressed," he says. "A lot of them felt prostate cancer doesn't receive as much focus as women's health issues."

One grateful man even thanked Johnson for saving his life when the test after one of Johnson's presentations caught his prostate cancer early enough for treatment.

"He came to me out of the clear blue and said he had attended a session at his place of employment, had blood work done and ended up needing further treatment," says Johnson. "He is now a healthy man."

The presentations were a year-long project that reached more than 500 men. Though Johnson now works in the mental health field, he still advocates for the importance of prostate cancer screening, reminding men to take care of themselves so they can be there for their families.

"Do you have children, grandchildren? Do you want to be there for them, to see their graduation?" he asks. "Of course you do."

Should you get a prostate exam?

Prostate cancer affects nearly **230,000** men each year.

Prostate cancer kills approximately **29,000** men annually, following only heart disease and lung cancer.

After age **50**, doctors recommend a yearly prostate-specific antigen blood test combined with a digital rectal exam to detect prostate cancer early.

African-American men have the highest incidence and mortality rates for prostate cancer.

1 in **6** men will be diagnosed with prostate cancer during his lifetime.

Source: www.prostatecancerfoundation.org

Medical students become farmers for a day

By Mark Meurer

The cows looked a bit perplexed. Crowds didn't usually gather in the barn, but this day was different.

As students huddled around the farmer, he talked about the inherent dangers of working with 1,500-pound animals.

The event wasn't designed for future veterinarians. The No Harm on the Farm Tour was organized to teach medical students about health and safety risks associated with modern agriculture. It's hosted annually by the Rural Medical Education (RMED) program at the University of Illinois College of Medicine at Rockford.

The tour aimed to better educate future rural doctors about farm life and its risks.

"All RMED students are from rural communities, but most students are at least two generations removed from farm life," says Matthew Hunsaker, MD, RMED director. "Even rural medical students need training in agricultural health and safety."

The fall event was conducted at a 750-cow dairy farm. During the walking tour, students had the chance to interact with Doug Scheider, owner of Scheidairy Farms, and health care professionals interested in agricultural health. Students stopped at several learning stations where chemical exposure, manure pit gases, dust inhalation, hearing loss and safety equipment were discussed.

University of Illinois medical students witness a mock tractor accident rescue effort.

"The farm tour provides an excellent opportunity for the medical students to observe activities on a dairy farm that employs current technology and to hear the operator speak honestly and openly about the health and safety concerns facing him, his family and employees," explains Chip Petrea, PhD, University of Illinois extension specialist in farm safety.

After the walking tour, students witnessed a mock tractor roll-over accident with local firemen, EMTs, paramedics and a trauma helicopter on scene. The mock accident was conducted by Stateline Farm Rescue, a group coordinated by Mark Baker, a farmer and farm safety and rescue educator from northern Illinois.

Future rural doctors were able to see the decision-making processes and subsequent rescue procedures implemented by local emergency personnel.

"The farm tour allowed me to visualize and see first-hand the potential hazards on a farm," says Ryan Fitzgerald, second-year RMED student. "It demonstrated how medical care is affected by a well-coordinated rescue effort."

> "As a future rural physician, I can use this experience as a platform to gain **common ground** between myself and rural patients."
>
> Matt Mason, University of Illinois Rural Medical Education student

Matt Mason, also a second-year RMED student, valued the opportunity.

"The real world examples we witnessed through the farm tour gave me a true appreciation for not only the dangers of farming, but also the amount of community and professional support that goes into approaching and resolving farm-related emergencies," he says. "As a future rural physician, I can use this experience as a platform to gain common ground between myself and rural patients in the hopes of better understanding their health care needs."

Mark Meurer is the recruitment and public relations assistant director for the University of Illinois College of Medicine Rural Medical Education program.

Free guides aim to simplify medical decisions

By Seth Meyer

Everyone – clinicians, consumers and policymakers – shares an interest in making the best health care decisions possible. But simply finding quality, evidence-based clinical research among the morass of health information available can be difficult and time consuming.

The Agency for Healthcare Research and Quality (AHRQ) hopes to change that with its Effective Health Care Program. The program is unique in that it takes scientific evidence on a variety of health topics and translates it into short, easy-to-read health guides for consumers, clinicians and policymakers. The guides do not attempt to sway the user toward or away from one specific treatment; instead, they present all the evidence available in a simplified format and allow the user to make the decision that best suits their needs.

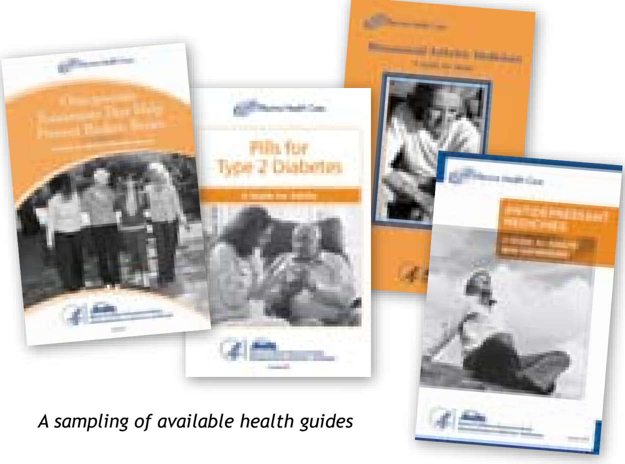
"These guides can help people with limited resources who face tough medical decisions."
Jean Slutsky, Effective Health Care Program director

"Given the unique challenges that both clinicians and patients in rural areas face, these guides can help people with limited resources who face tough medical decisions," says Jean Slutsky, Effective Health Care Program director.

The free health guides are available electronically, in print and as MP3 files and podcasts. All of the guides are either available in Spanish or will soon be.

"One of the program's goals is to provide quality health care decision aides to populations who have been neglected in the past," says Slutsky. "Our guides are written in basic plain-language, but they still provide the most up-to-date scientific evidence available on a given treatment."

Current guides compare treatments for prostate



A sampling of available health guides

cancer, pills for type 2 diabetes, antidepressant medicines, osteoarthritis medicines and rheumatoid arthritis medicines, among others. Many guides also detail the costs of treatments available.

The Effective Health Care Program was created through the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Its mission is to review and synthesize scientific evidence and translate and promote findings in a variety of consumer- and clinician-friendly formats.

The guides are funded by AHRQ, a part of the Department of Health and Human Services.

Seth Meyer is the communications specialist for Oregon Health and Science University John M. Eisenberg Center.

Guides for consumers include the following topics:

Treating prostate cancer

Pills for type 2 diabetes

Gastroesophageal reflux disease

Comparing two kinds of blood pressure pills: ACEIs and ARBs

Renal artery stenosis treatments

Antidepressant medicines

Choosing pain medicine for osteoarthritis

Osteoporosis treatments that help prevent broken bones

Rheumatoid arthritis medicines

Almost all of the above topics have a companion guide for clinicians that provides strength of evidence ratings.

Guides can be found at www.effectivehealthcare.ahrq.gov. Free print copies can be requested by calling 800-358-9295 or by e-mailing ahrqpubs@ahrq.hhs.gov.

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My professional metamorphosis: From lab rats to wild turkeys

By Patricia Moulton

Patricia Moulton and daughter Angela, 4

Small-town friendliness can be a bit unnerving for this city girl.

My rural health story begins at the end of my experimental psychology doctoral studies in 2002. After years of intense studying and rat research, and with a newly-minted PhD in hand, it turns out there are very few jobs for rat researchers in the rural state of North Dakota.

In desperation and with student loans hanging over my head, I replied to an ad looking for someone with research design skills to do a statewide study on workforce. That position was to report to Mary Wakefield, who had recently moved back to her native land – North Dakota – to direct the Center for Rural Health. Although during the interview it was discovered that I had no experience in rural health, health care policy or workforce. Dr. Wakefield took a chance and hired me anyway.

This was the beginning of a great and life-changing adventure. I began to learn about health care and the crucial role each provider plays in the health care system, especially in rural areas. I also learned how to present research results to policy makers who don't care about my P values and F ratios; they want me to paint a picture of the problem and to talk about how it might be fixed.

Earlier this year, my family relocated to Minot, N.D., (population 36,500) – the state's largest rural "city". This has opened up a new set of experiences, as I am not only doing research in rural health, but also experiencing rural living.

Small-town friendliness can be a bit unnerving for this city girl, when cashiers at the gas station ask me how I am doing and actually care what the answer is! I enjoy looking outside my window and seeing a flock of wild turkeys in the front yard. The flock travels throughout the neighborhood and stops by twice weekly.

Today, I don't look back and regret my professional metamorphosis. I am proud to be a rural health researcher and look forward to many more interesting rural experiences.

Patricia Moulton, Ph.D., is assistant professor at the Center for Rural Health at the University of North Dakota School of Medicine and Health Science and was a 2008 NRHA Rural Health Fellow. She has been a member of NRHA since 2004.

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.

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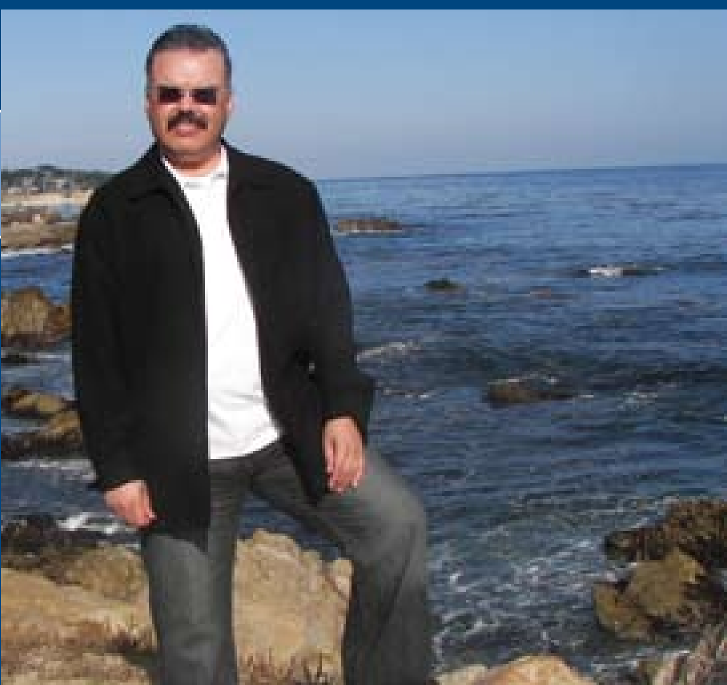

My business model: Empowering people is key

By Edward H. Lujano

Understanding a business and what it takes to provide quality health care go hand in hand.

I have worked for rural community health centers for more than 24 years as a CFO and for the last two and half years as a CEO. Fresno County is predominantly a rural, agricultural community. I grew up in this area, and I have roots here – my family, my wife. It's been a place we call home.

I believe people move a business. If you look at your staff as assets and do what it takes to hold on to them, mentor them and show them that they make the organization move, success will follow.

At Castle Family Health Centers in Atwater, Calif., I saw an organization in need of nurturing and mentoring. This was my first job as a CEO. I motivated the staff by listening to them. I'm not a believer in coming in and making changes just because I see the need. You need to gain the staff's trust and confidence first. And you must collaborate in your changes with them.

My favorite word is empowerment. I shared with our staff that the culture can change for the better with a well thought-out plan and a strong team approach.

In our first year we began providing customer service training, developed an internal marketing plan to identify our strengths and weaknesses and worked on improving our facilities and overall appearance. By the end of the first year, we had a new look, exceeded the prior year's stats and began considering new services.

In the second year, we opened our Child and Adolescent Behavioral Health Center with a specialized psychiatrist. With his leadership and a complement of licensed clinical social workers, we have managed to reach new patients and add services our community needed.

This is the best job I've ever had, and I'm thoroughly enjoying the challenges and opportunities. The old saying, what you put into something is what you get out, is true for me. I drive 130 miles round trip to work, an hour each way. I am committed and dedicated, and I thank my staff for allowing me to live out my dreams and share my success with them.

Edward H. Lujano is the CEO for Bloss Memorial Health Care District and Castle Family Health Centers in Atwater, Calif. He has been a member of NRHA since 2006.

Advice from our experts

How have you responded to the challenges facing rural emergency medical services (EMS)?

For the past seven years, the South Carolina Office of Rural Health has sponsored an annual Rural EMS Leadership Conference.

The conference brings together about 30 squad captains, chiefs and EMS directors from across the state for two days of public health and management classes and lively group discussion.

I set the stage by explaining the differences between urban and rural EMS systems. This year, as in the past, I presented a group exercise comparing an anonymous urban EMS system with an anonymous rural EMS system. Attendees looked at differences in population, health statistics, geography, resources, budgets and infrastructure. They also compared performance and outcomes.

The conclusions weren't surprising; everyone agreed the urban system could out-perform the rural one, which was doomed by disparities that define the urban-rural EMS dichotomy.

But this year I pushed the group with one last question. "Is that okay?" I asked. "Is this acceptable?"

To my astonishment, as I looked around the room, heads were bobbing up and down. Just as I was becoming discouraged, an enlightened voice said "no."

My spirits lifted as I affirmed the correct answer.

"Don't rural citizens deserve equal access and care in an emergency?" I asked. "It is not acceptable that we typically can't perform at the same level as our urban counterparts."

For the next day and a half, our instructors and leaders exchanged lessons learned, examples and ideas for improvement.

More than 50 EMS providers in South Carolina banded together to create the South Carolina Rural EMS Coalition.

The attendees left the conference with ideas about how to better their own systems.

A few weeks later, some of us reassembled to create the South Carolina Rural EMS Coalition, a grassroots advocacy group. In just a few months, the coalition has grown to more than 50 members, and we have developed a mail and web-based communications network, worked with others groups on projects and even published position papers.

For more information on the coalition, visit www.screms.org.

William F. Minikiewicz is director of Calhoun County Emergency Services and executive director of the South Carolina Rural EMS Coalition. He also serves as volunteer EMS specialist with the South Carolina Office of Rural Health and has enjoyed a 36-year career in EMS.

Our organization is doing its best to stay afloat during this challenging economic time. Are there still opportunities to bring in new funding?

Yes, but it's becoming even more competitive. Charitable giving was estimated at $306 billion in 2007, an increase of 3.9 percent despite concerns over the economy, according to *Giving USA*. This year, however, is certainly different.

A study conducted by the Council of Foundations found that almost one third of foundations increased their contributions in 2008 to help families, provide human services or support economic development due to the state of the economy. Of those surveyed, 37 percent of foundations indicated they intended to increase funds available in 2009.

Grant makers will have to carefully issue their funding resources, as they too are feeling a financial restraint. So grant writers will have to make a poignant case for funding requests. There are several guides and resources for taking advantage of funding opportunities and writing a compelling, case-appropriate proposal.

Some key points to remember:

- Make a habit of searching for grant announcements every day. New opportunities are announced all the time by the federal government, state agencies and foundations.
- Always read instructions thoroughly prior to writing your grant.
- Use key data to make a meaningful case as to why your organization should be awarded. This may be common sense, but data overrides anecdotal information and helps drive the point home.
- Emphasize the organization's technical capacity for implementing the intended proposal making the case as to why the funder should invest in your organization. If you received the money today, then your technical expertise/capacity should highlight how your organization could implement the proposal right away.
- Make sure your final proposal adheres to the guidelines and is organized, error-free and professionally presented.

For more tips and resources visit:

- Federal opportunities: grants.gov
- Rural Assistance Center: raconline.org
- Chronicle of Philanthropy: philanthropy.com
- The Grantsmanship Center: tgci.com
- The Foundation Center: fdncenter.org
- Charity Channel: charitychannel.com
- Guidestar: guidestar.org
- Free Management Library: managementhelp.org
- American Association of Grant Professionals: grantprofessionals.org

Amy Elizondo, NRHA program services vice president

How can I protect my eyes while working at a computer?

If you are one of the nearly 75 million Americans who spend many hours a day in front of a computer working, playing computer games or reading the daily news, you may also be experiencing eye strain. More than 50 percent of computer users report eye strain, eye fatigue, dry eyes, burning eyes, light sensitivity, blurred vision and headaches, as well as pain in the shoulder, neck or back.

But there are ways to alleviate computer eye strain. Take frequent vision breaks. This can be as simple as remembering to look at a distant object 20 feet or more away every 20 minutes to relax your eye muscles. It also helps to alternate your computer work with non-computer tasks to give your eyes a rest.

With increased concentration also comes a decrease in the normal blink rate. So blink regularly and more often to rewet your eyes. Use artificial tears to lubricate your eyes. An antiglare screen and glare coating on your lenses will ease strain too.

Use a document holder so you do not have to turn your head back and forth or constantly refocus your eyes. Adjust text size as needed for ease in reading. The monitor distance should allow you to read the screen without leaning your head, neck or trunk forward or backward.

If you continue to have uncomfortable vision or headaches while using the computer, visit an eye doctor.

Norma Bowyer, OD
Bowyer of Morgantown, W.Va., has been an NRHA member since 2002.

Need advice?

Send your questions to editor@NRHArural.org.

journeys

My best day on the job...

Diem Nguyen's best day was her busiest.

Diem Nguyen

I can honestly say that one of the best days I had at work was actually one of the busiest.

It was a Monday, and who can say that any Monday can be a good day, right? I mean, who wants to work coming off any weekend?

I was in the clinic helping with translations when I noticed we had more patients coming in than normal. Our Vietnamese patients were coming in one after another. Most wanted their flu shots, while others wanted to see the doctor.

That day alone, we had 42 patients in the clinic. What you must realize is this was a new clinic that the community, with the help of Tulane University Medical School, opened just two months earlier.

After Hurricane Katrina, the clinic has been such a godsend for us. After three years, some community members are now able to see a physician.

It was such a gratifying day, knowing that so many people were using the clinic that we worked so hard to open, and I had a moment during that day thinking, "I'm so glad we did this for our community."

People were getting health services that they otherwise would not have. All the hard work we had done was finally paying off, big-time. At the end of the day, I knew I'd done a good job and that others do appreciate our efforts.

Diem Nguyen works for Tulane University Clinic as an interpreter and for Mary Queen of Viet Nam Community Development Corporation in New Orleans, La., on a health care access project. She received a scholarship to attend the NRHA Rural Minority and Multicultural Health Conference in December.

Dave Pearson loves being a rural health ambassador.

As the director of a statewide rural hospital association, our day-to-day activities generally consist of responding to the requests our members and constituents make on a wide variety of issues.

TORCH President Dave Pearson, Congressman Ruben Hinojosa, James Robinson, a retired rural hospital administrator, and Lance Keilers, a member of the NRHA Rural Health Congress.

The best days are when we as an organization of rural hospitals can make a lasting impression that helps to secure access to health care for rural communities for the long-term. We do this by vigorously pursuing the advocacy needs identified by our members.

We are constantly pursuing changes to legislation and regulations at the state and federal levels. Ensuring proper reimbursement and maintaining a well-trained and highly qualified health care workforce have effectively become our top priorities.

We often meet with elected officials, policymakers and other stakeholders in an effort to explain the complexities of health care funding and the need

to enhance the rural impact of our educational system, health professions training programs and physician residency programs.

With the entire country in an economic slowdown, there is a natural tendency to invest less money in programs that support rural providers. To prevent this from happening, we plan to travel to Washington, D.C., with some of our members again very soon.

The best days for me always happen to be those spent walking the halls of Congress alongside our hard-working rural hospital CEOs. Nothing is more satisfying than scheduling 20 appointments and realizing you also helped to create 20 separate a-ha moments among the leaders and staff of your Congressional delegation.

Every time those days come to an end, I get an overwhelming sense of satisfaction knowing we had our say, and we played a meaningful part in the process.

I always enjoy a day on the Hill. Any day spent as an ambassador for rural health is by far my best day on the job.

Dave Pearson is president and CEO for the Texas Organization of Rural and Community Hospitals (TORCH). TORCH has been an NRHA member since 1992.

Petrus Tjandra deployed new technology.

Working in rural areas was not part of my vision when I was in college, not to mention I was used to living in metropolitan cities such as Los Angeles. But then I joined National Health Services, Inc. (NHSI) in 1995.

NHSI is a federally qualified health center providing primary care services for 12 communities in mostly rural areas throughout Kern County, Calif. During the 13 years I have worked for NHSI, my main area of responsibility has been information technology and communication. As the director of general services for the last three years, I am also responsible for outreach and health promotions, plant management and fund development.

I enjoy every part of working at NHSI. There are always challenges and opportunities. My best day on the job is every day, but the best of the best was when we deployed our first site for electronic medical records (EMR) in October 2007. NHSI is one of the few rural health centers in California, if not nationwide, that has deployed EMR. The path for our EMR has been cultivated since 1996, when I became the lead person to combine our patients' multiple accounts into one. Eleven years of waiting has finally paid off, although there is still more to accomplish.

Petrus Tjandra

Looking back, I would not change a thing. I love the dairy and farmers' fields, quiet rural roads, the communities and definitely our health centers that serve our rural communities' health care needs.

Petrus Tjandra is director of general services at National Health Services, Inc. He has been an NRHA member since 2006.

Tim Fry's research paid off.

I had one of my best days working on rural health issues in D.C. during a meeting on the Centers for Medicare and Medicaid Services (CMS) proposed rule on rural health clinic (RHC) and federally qualified health center (FQHC) conditions of participation in the Medicare program.

This meeting was the culmination of a long process. I had prepared for the anticipated proposal by reading thousands of pages on RHC and FQHC programs, including past regulations, reports, statutory or passed legislation and the programs' history to gauge what CMS would be seeking to address in a new rule.

continues

Tell us about your biggest challenge at work.

Send your comments to editor@NRHArural.org for consideration in the next issue of *Rural Roads*.

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Tim Fry

On the day the rule was released, the government affairs team prepared a brief summary of the proposed rule for NRHA members. We offered a series of conference calls on the proposed policy changes in the rule and an in-depth regulatory guide on these changes. We also prepared a detailed letter against changes in the rule our membership did not support.

We always do in-depth research for proposed regulations to build an argument for rural health. In this case, we found a flaw in one of CMS' central justifications for the proposed changes: their claim they needed to fix a newly-discovered issue. Our hours of research found copy from 1996 proving CMS (then called the Health Care Financing Administration) knew about the issue.

During this contentious August meeting, as CMS said they were just discovering the issue, I responded by reading their language from 1996. The room went silent. And for the first time during the meeting, there was real reception to listening to the overall message represented through the NRHA.

The months of research had paid off, and we could influence the agency's final decision.

Tim Fry is NRHA's government affairs manager.

The purpose of a proposed rule is to allow the public, including the NRHA, time to provide comments and concerns on policy changes before implementation.

The NRHA submitted a comment letter to CMS in August on behalf of rural RHCs and FQHCs. CMS is required to take into account all public comments before issuing a final rule. At press time, CMS had not issued a final rule.

Landon leads in 2009

Beth Landon and her daughter Marisa at a park outside of Anchorage, Alaska.

Reaching for our common goals

By Beth Landon, 2009 NRHA president

While in the Peace Corps in remote Thailand I learned allocation schemes and funding formulas created by well-intended urbanites just don't work in rural.

Funding for the mosquito-transmitted disease offices with which I worked was allocated on an annual cycle or by volume of people tested and treated. After my second trip to the "field" that involved horrid roads and hours of hiking in the dark, I suggested to Bangkok officials that perhaps their funding formulas should include other factors: miles driven on unpaved roads, average hours hiked to reach remote hill-tribe villagers, or volume of blood-sucking leeches removed from employee legs while hiking by cheap flashlight. I got a chuckle and sweetened coffee.

I relearned the lesson while living in northern Idaho and again in eastern Washington. For the past decade, I have served in the Alaska Center for Rural Health, Alaska's AHEC; it's the same story, amplified by an order of magnitude. My job has afforded me the opportunity to conduct program evaluations, health needs assessments and other applied research in and for frontier Alaska communities, regions and health organizations. And my time as chair of the NRHA Frontier Constituency Group brought similar stories from other frontier states. The challenges are similar to rural states, but more dramatic.

If higher volume equates with greater reimbursement, how can our country's least populated areas sustain access to care? Unfortunately, the most remote areas must also provide the broadest range of services, from outpatient to 24/7 emergency and prevention to in-patient care until weather allows transport. The fragility of infrastructure in these areas further compounds the dilemma.

Our current health care system perpetuates the "golden arches" mentality that serving more is somehow better or more worthy. My life history has led me to understand the importance of changing this attitude.

It is a pleasure to work with you through NRHA, an organization that embodies our common goals and provides an avenue through which to express our hope and the hope of those residing in rural America for quality, affordable health care.

How you gonna keep him on the pharm?

A couple years ago, we had a serious talk at the Moore house about family income versus opportunity, and we decided in favor of the latter. We hired a pharmacy manager and extra pharmacists, and thus began my journey of serving as your president.

We made the right choice.

These past years have been nothing short of amazing, and NRHA has seen unparalleled growth in membership and participation. Our influence has grown as we have been called on to testify before Congress more often than ever on a broad spectrum of rural health issues.

On a professional level, I have witnessed strong support for continued access to rural pharmacies, medication safety in small rural hospitals and collaboration with other national associations, as evidenced by the first national rural pharmacy conference.

Thanks for the privilege. There remains much for us to do, so I'll be seeing you.

Paul

Paul Moore
2008 NRHA president

Side trip

Jon and Karla Weng on vacation with their sons Mark, 5, and Luke, 3.

Five things you should know about NRHA member Karla Weng

- She is a NHRA Rural Health Fellow.

  Through this yearlong leadership training program, Weng has gained a better understanding of how to use NHRA resources.

  "It has been great learning about the different issues and concerns from such a variety of people – both in role and geography – from practitioners to researchers and Appalachia to Arizona."

- Weng is a program manager for Stratis Health.

  Since 2000, she has managed numerous grants and contracts for this health care nonprofit organization that leads collaboration and innovation in quality and safety. For the past three years, Weng was a liaison with the QIO leaders at Centers for Medicare and Medicaid Services and provided support to QIOs working with rural hospitals. She is now co-leading Minnesota Rural Palliative Care Initiative and continuing to provide support for nine Minnesota health plans that collaboratively implement performance improvement projects.

- She's got rural roots.

  Weng is a rural girl. She grew up in North Dakota, South Dakota and Montana in small towns with 500 to 5,000 people.

  She now lives in Faribault, Minn., (population 22,000) about an hour from the Twin Cities. Weng and her husband moved to Faribault in part because they wanted to raise their family in a smaller-town environment.

- Weng enjoys cooking.

  Cooking is about connecting with family for Weng, such as a baking project with her two young boys doing the pouring and stirring. Recently, she has been doing a lot of canning, including recreating family favorites like her grandmother's cinnamon cucumber rings and rhubarb jam. Weng also "put up" apple butter, dill pickles, diced tomatoes, spaghetti sauce, salsa and pickled banana peppers.

- The most rewarding part of Weng's job is the changes she sees.

  Weng began her work at Stratis Health by providing quality improvement technical assistance to northwestern Minnesota hospitals and clinics. At that time, there were only three critical access hospitals (CAHs) in the state. Minnesota now has 79 CAHs. And there have been big changes in the attention paid to quality efforts by rural providers.

  "When I started this work nearly nine years ago, few rural hospitals had processes in place to look at quality indicators on a monthly or quarterly basis," Weng remembers.

  Now nearly all Minnesota CAHs are collecting data on pneumonia, heart failure and other indicators important to their communities.

  "One of the things that is so rewarding about working with rural providers is that they can make significant gains quickly," Weng says. "They don't have the large bureaucracies or multiple committees some of their urban counterparts work in. They can decide something needs to be done and act on it the very next day."

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

Members on the move

H.D. Cannington is a hospital clinical integrator helping open Basra Children's Hospital in Iraq. Cannington left his position as CEO of Morgan Memorial Hospital in Madison, Ga., in November for the opportunity.

Basra Children's Hospital, which will primarily provide oncology services, is scheduled to be complete in early 2009, and Cannington will be assisting with organizational management, recruiting personnel, training, policies and procedures, budgeting, procuring equipment and performance improvement.

"It is reported that 15 percent of the children born in Iraq never see their 6th birthday," Cannington says. "The Iraqis very much want to improve their health care, especially for the kids. They have many resources but need assistance with the organization. I thank God I have this opportunity."

He had attended the Iraqi New Health System Conference in July with fellow NRHA volunteers Wayne Myers and Paul Moore.

Cannington has been an NRHA member since 2001.

H.D. Cannington (left) meets with officials in Iraq in July.

Several National Rural Health Association members gathered in October to celebrate the marriage of Marcia Brand and Mark Outhier. Pictured here and representing 10 years of leadership of the Office of Rural Health Policy and are Wayne Myers, MD, (1998 to 2000), Marcia Brand (2000 to 2008), and Tom Morris, who assumed the position in July.

Paul Moore, RPh, was awarded the 2008 National Community Pharmacists Association (NCPA) Spirit of Independence Award. The award is given to individuals or organizations that have gone above and beyond the norm in their support of independent community pharmacy.

Moore, who served as NRHA's 2008 president, owns Roy's Discount Pharmacy in rural Wilburton, Okla., and the Pharmacy & Consulting Management Company, which provides remote pharmacist services to improve medication safety and utilization in small, rural hospitals.

"Paul Moore is a champion for ensuring Americans in rural communities have access to high-quality and affordable health care," says Stephen L. Giroux, RPh, NCPA president. "Moore sees on a daily basis the challenges his patients face, and he uses that knowledge in his steadfast advocacy."

Moore is also a member of the Oklahoma Rural Health Association's board of directors and of the U.S. Health Resources and Services Administration.

Moore has been an NRHA member since 2000.

Send your career updates to editor@NRHArural.org.

New NRHA members

Ted Althoff
Kelly Arduino
Joe Ashcraft
Joyce Beck
Lora Bell
Belinda Bennett
Mark Bolton
Doris Brown
Ed Brown
Lawrence Brown
Susan Campbell
Heather Carr
Chad Carrington
Julie Carter
Vanessa Carvan
Laurie Casias
Kevin Chako
Teresa Cherry
Sheila Chilson
Jeri Christensen
Stephen Clapp
Brad Clark
Heather Clark
Mary Pat Cowan
Roxana Cruz
John Danis
Heather Davis
James Davis
Rebecca Drummond
Ken Duncan
Cynthia DuPree
John Everett
Carla Ezell
Sherri Fisher
Stacey Flynt
Anthea Francis
Rebecca Funke
Amanda Gallivan
Chris Garcia
Vicky Gay
John Graham
Beverly Grayman-Rich
Eric Hagan
Penny Hatmaker
Michelle Hogan
William Iveson
Diane Jones
Leslie Kannus
Daniel Kelly
Kay Kiechel
Lisa Kilburn
Trip Kinmon
Patricia Knapp
Kurt Kruger
Buffy Lacy
Clara Layman
Jay Leatherman
Irene Liddle
Kimberly Little
David Lovell
Christine Lowman
Allison Lunde
Robert Marinich
Philip Marsden
Nancy Marticke
Roger Masse
Dean Mattern
Bill May
Robert McBurney
Jim McCoy
David McMullin
Robert Milvet
Moira Morrison
Don Mulenthaler
James Nester
Diane Newman

continues on page 40

2009 NRHA leadership selected

NRHA members elected the following leadership team in November.

Officers:

Dennis Berens, president-elect

Sandra Durick, treasurer

Constituency Group chairs for 2009-10:

Clinical: Ray Christensen

Diverse Underserved Populations: Marita Novicky

Frontier: Kristin Juliar

Hospitals: Lance Keilers

Rural Health Clinics: Tommy Barnhart

Rural Health Congress representatives:

Hospitals: Rhett Carver Partin, Mark Chustz, Michael Hagen, Thomas Henton, Roger Masse, David Pearson, Elizabeth Schnettler, Erick Shell, Susan Starling

Research and education: W.M. Woods

Statewide health resources: Kristina Sparks

NRHA names new class of Rural Health Fellows

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

The 2009 NRHA fellows are

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

Katherine Brewer, University of Pittsburgh Medical Center administrative fellow and practice manager

Barbara Cliff, Cheboygan Memorial Hospital president and CEO

Amy Ham, California Telemedicine and eHealth Center program specialist

Loretta Heuer, University of North Dakota College of Nursing department chair and professor

Fiorella Horna-Guerra, Office of Rural Health and Community Care program consultant

Trent Howard, DeBusk College of Osteopathic Medicine second-year student

Terri Hurst, Colorado Rural Health Center policy analyst

Carole Pratt, American Dental Association dentist

Andrea Radford, North Carolina Rural Health Research & Policy Analysis Center research fellow

Laurissa Stigen, Central Minnesota Area Health Education Center executive director

Alan West, Veterans Affairs Medical Center health scientist

News briefs

Gingrich to speak at NRHA Annual Conference

Newt Gingrich will be the keynote speaker at the 32nd NRHA Annual Rural Health Conference May 5 through 8 in Miami Beach, Fla.

Former House Speaker Gingrich is the founder of the Center for Health Transformation, a collaboration of public and private sector leaders dedicated to building a 21st century intelligent health system that saves lives and saves money. Since leaving Congress in 1999, he has devoted much of his time to transforming health care into a system that delivers more choices of greater quality at lower cost.

He has served as a member of the national advisory board for the Agency for Healthcare Quality and Research, the Library of Medicine board of regents and the Juvenile Diabetes Research Foundation board of directors. Gingrich co-chairs the Alzheimer's Study Group and the National Commission for Quality Long-Term Care with former Sen. Bob Kerrey.

Newt Gingrich will give the keynote address at NRHA's 32nd Annual Rural Health Conference.

The conference will also feature more than 50 practical, educational sessions on topics including veterans' health, grant writing, cancer prevention and treatment, dental care, primary eye care and medical school programs, as well as poster and research paper presentations and the opportunity to enjoy the recently renovated Fontainebleau Resort at a special rate.

More information is available at www.RuralHealthWeb.org/annual.

Rural Minnesota communities to build palliative care programs

Ten rural Minnesota communities were selected to participate in Stratis Health's Minnesota Rural Palliative Care Initiative to establish or strengthen palliative care programs in their communities. Community teams led by Stratis Health in partnership with Transitions and Life Choices will work together to accomplish the initiatives.

Seven out of 10 Americans who die each year die of a chronic disease. Palliative care is an approach to managing chronic disease and other serious and advanced illness that centers on relieving suffering and improving quality of life for patients and their families. It differs from hospice in that palliative care is appropriate at any point in a serious illness and can be provided at the same time as curative treatment.

"Health care needs are changing. Chronic diseases are now the leading cause of death and disability in Minnesota. Our health care services need to evolve to provide appropriate care," says Jennifer Lundblad, PhD, Stratis Health president and CEO. "Palliative care is new to many health care providers. By fostering palliative care in rural communities we hope to decrease the number of patients having to leave their home community to receive this patient-centered care."

Visit www.stratishealth.org/palcare for information, including a list of participating organizations.

Wisconsin project first in the country to receive FCC Pilot Program funding

The Rural Wisconsin Health Cooperative Information Technology Network (ITN), based in Sauk City, has become the first FCC Rural Healthcare Pilot Program network to receive a funding commitment letter. The FCC Pilot Program, a first-of-its-kind federal health care network initiative, will be distributing up to $400 million over three years.

The Wisconsin project provides high-speed, redundant broadband connectivity initially to four critical access hospitals, two physician clinics and two collaborative data centers that are participating in a cooperative hospital information system and electronic health record (EHR) initiative.

"By collaborating on health IT," says Louis Wenzlow, ITN's chief information officer, "the participating facilities are able to work together to implement EHR systems, share their server and datacenter costs, and benefit from the expertise of a pooled support staff. Ultimately, the communications infrastructure supported by the FCC Pilot Program is what makes our shared datacenter model possible."

Indiana Communities Institute created

Indiana Lt. Gov. Becky Skillman recently announced the launch of the Indiana Communities Institute with Ball State University. The institute will provide programs and services statewide.

The state's Office of Community and Rural Affairs

continues

continued

is providing a nearly $600,000 grant for two years to fund the institute, which will focus on leadership development, community, economic building and programs and services critical to Indiana's rural communities.

CMS offers e-prescribing incentive

The Centers for Medicare and Medicaid Services (CMS) implemented a new incentive for physicians to trade in their prescription pads for electronic prescribing.

The initiative aims to improve efficiency and safety when ordering medication.

"E-prescribing can greatly reduce the number of medication errors that jeopardize the health and safety of Medicare patients and waste precious health care dollars treating conditions that never should have happened," says CMS acting administrator Kerry Weems. "E-prescribing lets providers know – up front – their patients' medication history and the risk of dangerous interactions."

Medicare beneficiaries may also save, as e-prescribing facilitates communication between prescribers and pharmacies on generic alternatives.

Physicians and other health care professionals who adopt and use qualified electronic prescribing systems to transmit prescriptions to pharmacies may earn an incentive payment of 2 percent of their total Medicare allowed charges during 2009. This incentive is in addition to a 2 percent incentive payment for 2009 for physicians who successfully report measures under the Physician Quality Reporting Initiative. Both incentive payments are in addition to the 1.1 percent fee schedule update required by the Medicare Improvements for Patients and Providers Act of 2008. So successful reporting could grant a 5.1 percent pay boost for doctors.

Visit www.cms.hhs.gov/eprescribing for more information.

Minority and Multicultural Health Conference draws 200

Omar Sahak, California State Rural Health Association communications coordinator, reads to a child at Cuidando Los Ninos during NRHA's Minority and Multicultural Conference.

NRHA's Rural Minority and Multicultural Health Conference attracted 200 people to Albuquerque, N.M., in December.

The event showcased promising health and economic development models that have been effective in rural communities.

In addition to the educational conference designed for those who bring quality health care services to the underserved and often under-represented portion of the rural population, 50 participants enjoyed the New Mexico Experience, a pre-conference humanitarian opportunity to visit the Cuidando Los Ninos early childhood education center and clinic for homeless children and explore American Indian traditions at the Indian Pueblo Cultural Center.

The 2009 Rural Minority and Multicultural Health Conference will be Dec. 9 through 11 in Memphis, Tenn.

New NRHA members

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Janice Norris
Atina Northrup
Lisa Odom
Gregory Olson
Richard Osmus
Paul Parker
Gerald Phillips
Maximilian Prieto Ruiz
Todd Reichard
Mark Reynolds
Rosemarie Reynolds
Jeff Rimel
Cheri Rinehart
Bruce Roberts
Semmes Ross
Cris Saylor
Ron Sconyers
Laura Sever
Jarrod Shapiro
Toby Shelby
Kendra Siler-Marsiglio
Charles Steele
Gary Steinbach
Monica Stephenson
Tina Sullivan
Cheryl Taylor
Teresa Taylor
Mark Theine
Grace Tousignant
Andrew Traynor
Don Twining
Paul Utemark
Terry Varner
Todd Varney
Kevin Wahr
Johnny Walker
Angela Warr
Maria Wellisch
Kim Werdebaugh
John Wilson
Sherald Wood
Susan Wortman
Ann York

5 facts about President Obama

1 President Barack Obama has been a first black president before. He was elected president of the prestigious Harvard Law Review in 1990. And when Obama was elected to the U.S. Senate in 2004, he was only the third black U.S. senator.

2 In school, Obama was known as "Barry O'Bomber" for his basketball prowess. He is expected to build a basketball court at the White House.

3 During the presidential campaign, the Obama-Biden team responded to NRHA's questionnaire and promised to work to ensure a more equitable Medicare and Medicaid reimbursement structure, as rural providers often are paid less than their urban counterparts.

4 Despite comments during the primary that some believed disparaged rural Americans, Obama campaigned hard for rural voters and earned 45 percent of the rural and small-town vote, up from the 37 percent that Democratic candidate Al Gore received in 2000.

5 Obama's biggest challenge is likely to be restarting the U.S. economy, which will pose massive challenges to paying for health care plans as the nation will be running a debt of nearly a trillion dollars.

shifting gears

Turn off the lights.

Artificial lighting accounts for 44 percent of electricity use in office buildings.

Conserve power — and money — by flipping off the lights when leaving any room for 15 minutes or more, and utilize natural light when possible.

Photo by Seth Browarnik, Red Eye

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Featuring keynote speaker Newt Gingrich and more than 50 concurrent educational sessions on topics vital to health care in rural America, including veterans' health, grant writing, cancer prevention and treatment, dental and eye care and medical school programs, this year's conference is one you won't want to miss.

The conference will be at the newly-renovated Fontainebleau Resort in the heart of Miami Beach, Fla.

Check out five reasons the resort is one-of-a-kind.

1. Guests can relax by one of six oceanfront pools surrounded by private cabanas. Dining and entertainment options include 11 restaurants and nightclubs, a health spa and personal watercraft rentals. A complimentary shuttle takes guests to major shopping destinations.
2. The resort recently underwent a $1 billion renovation over two years, taking special care to preserve many of the original design elements including the famous "staircase to nowhere."
3. The Fontainebleau has appeared in several movies, including *Scarface*, *Bodyguard* and the James Bond film *Goldfinger*.
4. This famous hotel rises above 1,000 feet of private Atlantic Ocean beach and is just three miles from South Beach.
5. Get all of this luxury, relaxation and entertainment at the NRHA discounted rate of $189 a night. Rooms at the resort usually cost more than $400 a night.

For more on the Annual Conference or to register, visit www.RuralHealthWeb.org/annual.

{ hospital challenge no. 166 }

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

Rural Pharmacy Conference
Sept. 9-11
Kansas City, Mo.
Early registration discount deadline: Aug. 11

Rural Health Clinic Conference
Oct. 6-7
Portland, Ore.
Early registration discount deadline: Sept. 14

Critical Access Hospital Conference
Oct. 7-9
Portland, Ore.
Early registration discount deadline: Sept. 14

Minority and Multicultural Health Conference
Dec. 9-11
Memphis, Tenn.
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Jan. 25-27, 2010
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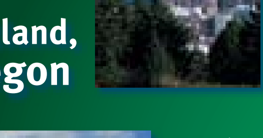

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