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Rural Roads focuses on model rural health practices and programs, creative use of technology, rural health heroes and human interest stories. The goal of each story should be to motivate, educate or inspire those working to improve health care or living in rural America. *Rural Roads* adheres to standard *AP Style* guidelines. Advance notification of intent to submit an article is appreciated. E-mail editor@NRHArural.org. The NRHA reserves the right to edit all materials submitted for clarity, consistency and formatting to meet in-house style guidelines. Submission of an article does not guarantee publication. We further reserve the right to publish all letters received.

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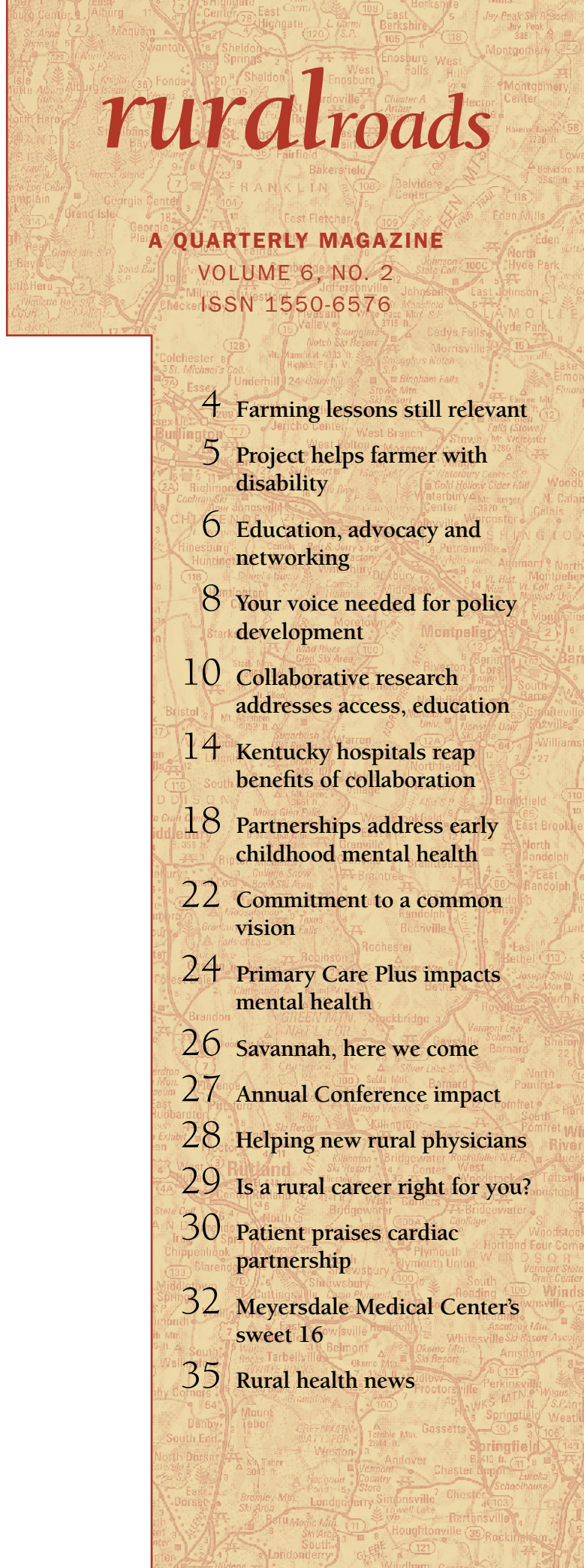
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ruralroads

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Farming lessons still relevant

BY PAUL DAVID MOORE, D.PH., NRHA PRESIDENT

Growing up on a farm, the hard work taught me many things, not the least of which is the value of an education. One significant lesson learned: there is no such thing as a harvest without plowing.

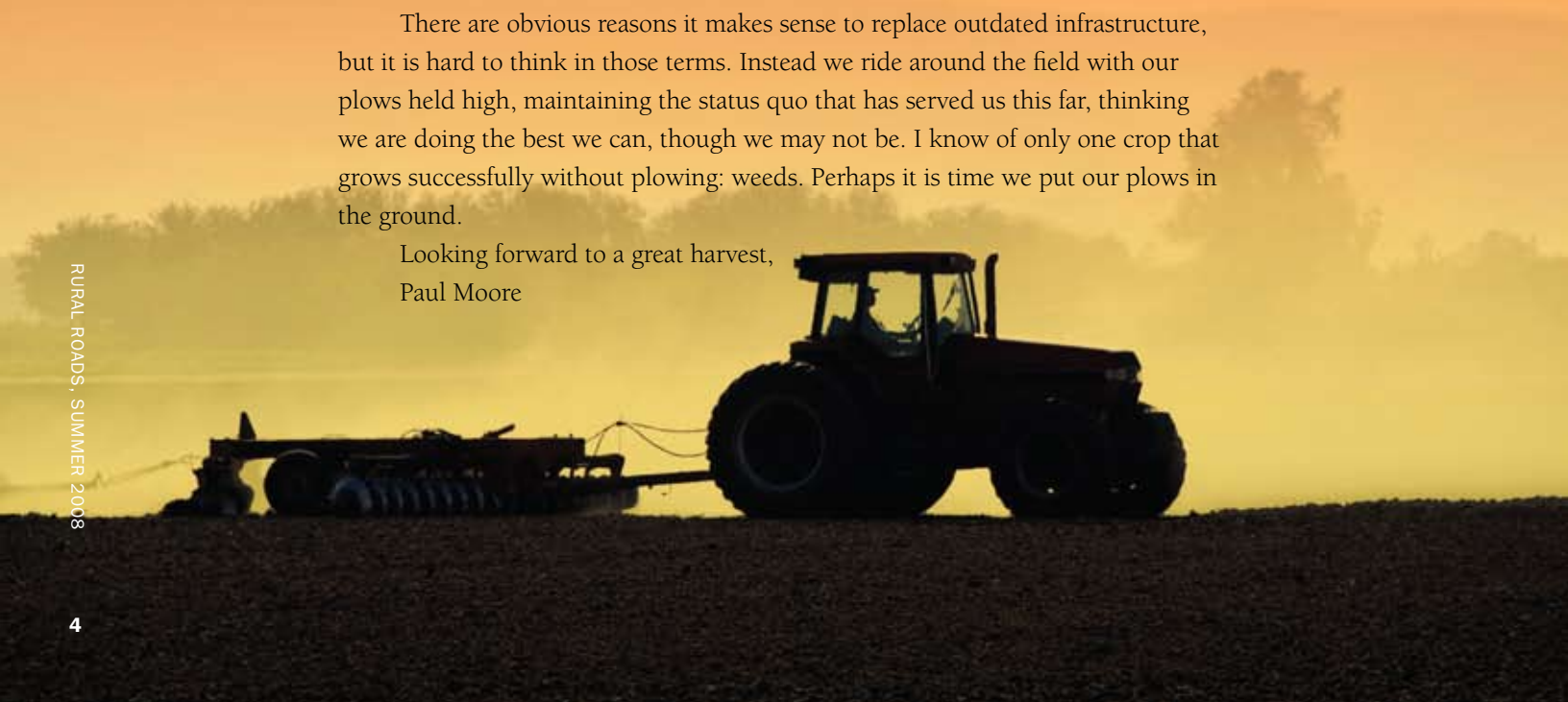
This undertaking is essential, even though it seems to produce nothing but dirt. Plowing is not exciting work. It expends resources in an effort that goes slowly, gets you dirty, and digs up things you didn't know were there. Since it's almost guaranteed to reveal unplanned obstacles, inherent in the process is the temptation to shallow up the plow to keep from getting stuck or to finish sooner. This method can bring less-than-desirable results, as I once learned after a toad-strangling rain when I had to re-plow an entire hillside. While plowing always works better when one goes with the contour of the land, it is one of the few activities I can think of that is more tolerable when the wind is in your face rather than at your back.

There are many dedicated individuals who have demonstrated both vision and endurance in doing the hard work of plowing to produce quality health care across rural America. Still, we must recognize that rural health care remains rich with fallow ground still waiting to be plowed.

There is the networking opportunity with "competitors" in neighboring towns that will serve our communities in mutually beneficial ways. There is the new stakeholder to engage that we are not sure should be entering the field. There is available technology proven to increase efficiency and patient safety, but we just can't let ourselves spend the money until it becomes a mandate.

There are obvious reasons it makes sense to replace outdated infrastructure, but it is hard to think in those terms. Instead we ride around the field with our plows held high, maintaining the status quo that has served us this far, thinking we are doing the best we can, though we may not be. I know of only one crop that grows successfully without plowing: weeds. Perhaps it is time we put our plows in the ground.

Looking forward to a great harvest,
Paul Moore



Project helps farmer with disability

BY NATIONAL AGRABILITY STAFF

Gary Wical, an Ohio farmer and Vietnam veteran, and his wife, Nelle Wical, have been raising corn, soybeans, wheat and hogs for more than 30 years on a rented farmstead.

In February 2007, Wical sustained a traumatic injury when his pant leg was caught in a PTO driveline, resulting in a bilateral above-the-knee amputation.

While Wical was in the hospital, his neighbor Gregg Sparks amassed a team of 40 friends and neighbors united in a single mission: get Wical back to farming. A committee formed, and fund-raising events were planned by neighbors, the fire department, a local fertilizer and seed company, county beef and pork producers and the Wicals' church. With a strong support system in place, Sparks and a small workgroup began researching where to find help for Wical.

In mid-March, Sparks contacted Mary Beck, rural rehabilitation specialist for the National AgrAbility Project (NAP). Speculating that lifts for farm vehicles and an all-terrain wheelchair might be useful accommodations for Wical, Beck connected Sparks with Mark Novak, NAP agricultural technologist and engineer, who provided Sparks with several resources.

Beck also suggested Wical apply for services with the Ohio Vocational Rehabilitation (VR) agency as soon as possible. She said VR may be able to provide disability-related assistive technology to accommodate workplace barriers, and she described the Amputee Coalition's peer support program as well as the Ohio extension service for agriculture-related resources. Fortunately, Wical was already connected to the Department of Veterans Affairs (VA) system.

Wical's recovery and return to farming has not been easy. He missed part of spring planting in late April when a staph infection landed him back in the hospital and delayed getting his prosthesis. The local VA was helpful in acquiring the prosthetic when Wical was

ready. They also assisted him in applying for the VA's Millennium Bill Emergency Coverage for veterans who are treated in a private facility and do not have health insurance.

The committee of more than 80 friends, relatives and neighbors managed to raise \$73,000. Because VR was able to purchase the necessary farm accommodations, the committee gave the Wicals the money to use as needed.

Wical's resolve, the resources and network that make up AgrAbility and the caring and powerful family and community have allowed Wical to continue farming.



Nelle and Gary Wical with neighbor Gregg Sparks (front).



Education, advocacy and networking

BY ALAN MORGAN, NRHA CEO

It is a tough task to sum up the activities of the National Rural Health Association in three words. However, education, advocacy and networking seem to cover it.

NRHA has evolved over time to become the premier national educational source for rural health policy and practice. The organization hosts multiple national educational conferences throughout the year for its membership. These range in size and scope from the NRHA Annual Conference each May to our Rural Health Clinic and Critical Access Hospital Conferences every October.

All of these educational events have their own planning committees comprised of NRHA members. They all seek session proposals, which are reviewed and rated for educational merit by the respective planning committees. All of these conferences offer the relevant and appropriate continuing education credits for attendees.

Advocacy is the heart and soul of this organization. Over the past 30 years, NRHA has been the voice of rural health in our nation's capitol and provided input into the policy formation process for all rural-health-relevant federal legislation that has passed through Congress. NRHA membership consists not only of policy experts and rural health practitioners, but also the community members affected by national policy changes. Therefore, NRHA is the obvious place for lawmakers to start when discussing our nation's rural health care system. It is not surprising that NRHA members have already been called upon multiple times this year to testify before Federal Senate and House health committees.

Networking is what makes NRHA unique. If you have attended an NRHA conference in the past, you know this statement to be true. We are a welcoming bunch.

Rural does not mean "second tier." I've seen this firsthand in travels across the country while at NRHA, and we share best practices and success stories in our ongoing networking efforts.

This year, we are in the process of revitalizing our *Rural Roads* magazine. We are certainly not fixing something that is broken. Rather, we are ensuring this publication is the best magazine for our members. You deserve a magazine that leads, not follows. We will launch the new magazine in the fall, and we will maintain the tradition of producing an association magazine that highlights the best in rural health care.

The activities of education, advocacy and networking are without merit if the ultimate goal is not to achieve excellence in practice. I hope that you enjoy this summer issue of *Rural Roads*, which looks at collaborations in rural health care. Success and greatness occur often in rural health care, and it is our goal that your membership in NRHA can help you achieve both.



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Your voice needed for policy development

BY TIM FRY, NRHA GOVERNMENT AFFAIRS MANAGER

This summer, Congress will have considered and most likely passed legislation to halt a scheduled 10.6 percent payment cut to physicians and other rural providers. The Washington, D.C., NRHA staff has worked most of the year on this legislation to ensure rural providers will be able to remain in business. It will be a great accomplishment for our lobbying staff, but it was not staff who decided preventing the physician pay cut was important policy; it was you.

The NRHA is a membership-driven organization. This means all policies and positions of the association come directly from our members. Any member can propose, support and advocate policy proposals within the association and to the wider public, meaning you can directly influence the rural health landscape.

In the past, participating in policy creation meant writing a paper, attending a meeting and taking part in debate. Today, technology allows all members to participate more easily. The NRHA web site lists all policies under development, and by visiting the site, members are able to read the current versions of policies under review, write their own policy, edit policy positions or share thoughts online with other members. Go to www.RuralHealthWeb.org, and click on the “About the NRHA” link. Under “Boards and Committees,” visit the “Rural Health Congress” page on policy position development.

Once the online policies are complete, the NRHA Rural Health Congress, made up of members, decides whether to make them official NRHA policy positions. The congress meets face-to-face at association conferences three times each year to consider

new policy. Representatives are proportionally-elected members from each of the association’s nine constituency groups, as well as the State Association Council, State Office Council, issue groups and officers. The five most recent NRHA presidents also sit on the congress. This gives the congress a strong grassroots representation that reflects the concerns of the full NRHA membership.



The association has adopted many policy positions over the years; more than 70 positions are currently considered active. With so many important policy positions approved by the Rural Health Congress, the Government Affairs Committee, also made up of members, works with the NRHA staff to identify priority policies helping to focus the association's resources for maximum impact on Capitol Hill.

One way of doing this is the creation of the NRHA's annual legislative and regulatory agenda, which is a great way to get involved in rural health advocacy. Each year, the NRHA staff asks all members for suggestions to be included in the agenda. Suggestions range from ideas for new rural programs to Medicare payment methodology changes to descriptions of how current practice is impacted by

legislative and regulatory changes. If a suggestion for the agenda is totally new, the Rural Health Congress will work to develop the policy into a full statement. The agenda is distributed to NRHA members, policy makers and all members of Congress and their staff. It's also available on our site under the "Policy and Advocacy" link. The NRHA agenda is the main document policy makers on Capitol Hill use to determine how to improve health care in rural America.

Obviously, the reality of practicing medicine and efforts to change national policy are not tied to the NRHA agenda-setting timetable. Throughout any given year, issues arise that require immediate attention. These issues are often brought to the attention of NRHA staff by members, and some of these issues do not yet have a policy. To deal with this, NRHA has a rapid response

process in place where leaders of the association review the issue and make a decision to determine policy. This rapid review is then presented to the full Rural Health Congress at its next meeting, when it can become permanent policy of the association.

Most of the time, however, the association has already stated a position. NRHA staff works with this stated policy to determine the best way to proceed and meet the needs of members. This may mean direct lobbying of congressional staff, comment letters on regulatory changes or involving members in grassroots advocacy through our e-mail *Action Alerts*. This is when you should pick up the phone or write a short note to your congressional office to help improve the health of millions of rural Americans.

Everyone goes to you for answers. Where do you go?

National Rural Health Association

2008 Save The Date

EDUCATIONAL Calendar

Clinical and Quality Conference

July 15-17, 2008
San Diego, California

Rural Health Clinic Conference

October 14-15, 2008
Savannah, Georgia
Early bird rate deadline: September 20, 2008

Critical Access Hospital Conference

October 15-17, 2008
Savannah, Georgia
Early bird rate deadline: September 20, 2008

Minority and Multicultural Health Conference

December 11-12, 2008
Albuquerque, New Mexico
Early bird rate deadline: November 7, 2008

Collaborative rural research *addresses access and education*

in Idaho

BY DAVID SCHMITZ AND ED BAKER

Workforce and medical education have become front and center in many of today's health care conversations in Idaho.

The Idaho legislature recently directed the State Board of Education to commission a study focusing on student demand for medical education and the state's need for physicians. The findings showed access to physicians and medical education is extremely limited in Idaho, when contrasted with other comparable states as well as the nation as a whole.

"Understanding the dynamics that go into rural family physician recruitment and retention is critical to the primary care work force needs of rural America," says Ted Epperly, one of Idaho's leaders in medical education and Family Medicine Residency of Idaho program director and CEO.

With one of every three Idaho residents living in a rural area, the challenge of providing access is particularly applicable to the broad scope of services provided by family physicians.

The genesis of the work on recruitment and retention of family medicine physicians in Idaho grew from meetings with Mary Sheridan, Idaho Department of Health and Welfare Office of Rural Health and Primary Care supervisor. That office provided funding to begin the research.

"The results will help us identify resources needed in rural health care facilities and communities to assist them in their workforce efforts," Sheridan says.

Affiliations with the Family Medicine Residency of Idaho and the Center for Health Policy at Boise State University provided a framework to develop a research plan. However, this effort would require extensive collaboration with other groups, so the Idaho Academy of Family Physicians and the Idaho Hospital Association were recruited to participate in the research. They were excited to partner on an endeavor that was relevant to their missions and critical to the success of these organizations.

"When we were presented with this opportunity, we jumped on board because our very small rural member hospitals have a difficult time recruiting physicians due to lack of resources and not necessarily knowing what factors attract physicians to rural areas and keep them there," says Steven Millard, Idaho

“We jumped on board because our very small rural member hospitals have a difficult time recruiting physicians...”

Steven Millard, Idaho Hospital Association president

Hospital Association president. “Hopefully, through this collaborative research, they will receive the information necessary to allow them to focus in on the specific attributes their communities have to offer in order to match with physicians’ interests and needs.”

The Idaho Rural Family Physician Workforce Pilot Study, completed in 2007, surveyed both practicing physicians and administrators of rural hospitals to identify demographics, scope of practice, recruitment factors and satisfaction rates in several areas. This included pre-recruitment experience training in Idaho as well as use of technology and economic factors pertaining to rural practice.

The analysis produced dramatic and somewhat unexpected results. Ninety-two rural family medicine physicians (37 percent physician response rate) responded to our survey, and 94 percent of these

Idaho physicians were satisfied or very satisfied overall with their practices. They provided a wide scope of medical services to rural Idaho citizens, including obstetrics (52 percent), C-sections (37 percent), emergency room coverage (49 percent) and hospital care (89 percent). These physicians also reported a robust use of technology for clinical care and continuing education purposes. In addition, rural hospital administrations reported an overwhelming level of satisfaction with their family medicine staff as 18 of 19 respondents (94.6 percent) reported they were satisfied or very satisfied with their staff.

These findings were validated through qualitative interviews at more than 25 rural site visits throughout the state with the assistance of Neva

Santos, Idaho Academy of Family Physicians executive director.

“Visiting my members in their rural practices really helped me get to know their issues and each of them as physicians in an important way,” she says.

What began as a pilot study of rural Idaho family physicians expanded to a multi-year phased effort to better understand rural Idaho, its physicians and its communities with continuous funding by the Office of Rural Health and Primary Care. Phase two of this

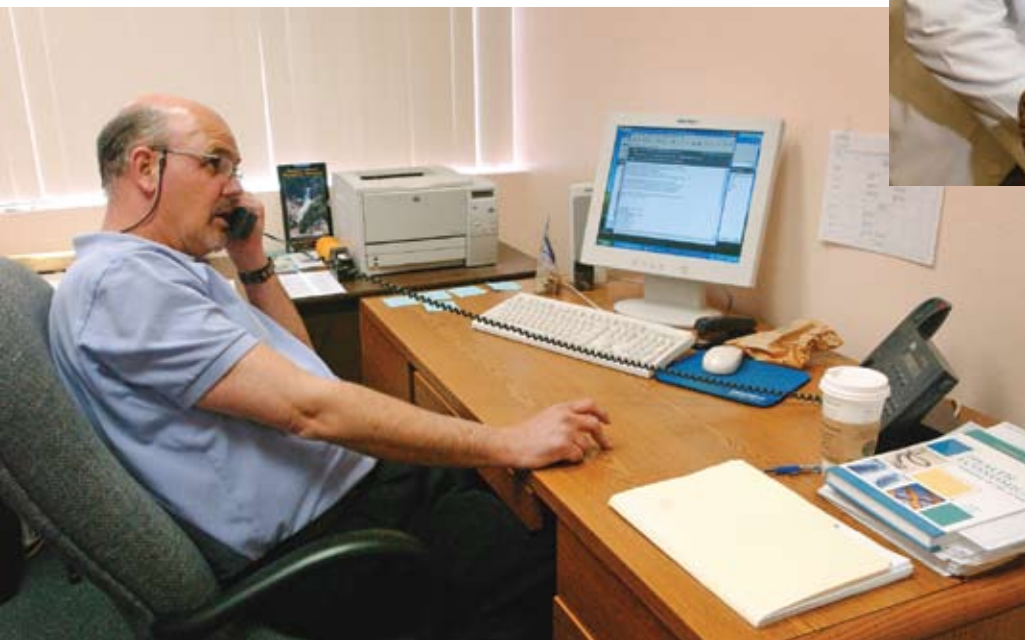
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Top: David Schmitz formerly practiced medicine in a rural community of Idaho and continues to see patients with his new responsibilities as associate director of Rural Family Medicine at the Family Medicine Residency of Idaho.

Left: Ed Baker discusses rural physician recruitment and retention issues with research partners across Idaho at the Center for Health Policy at Boise State University.

Photos courtesy of Boise State University.



collaborative effort, led by the Family Medicine Residency of Idaho and Boise State University, focuses on the community factors that most influence recruitment and retention of rural family physicians. Conducted as on-site interviews, it is hoped this information will help policy makers and recruiting entities have a broader sense of what it takes for a physician to select and stay in a rural Idaho practice.

This team of researchers and educators is also looking to better understand the characteristics of physicians who choose the lifestyle and profession of rural family medicine. The third year of this study will aim to identify factors that help to explain and perhaps predict the high satisfaction seen amongst these physicians who give so much to provide such a breadth of care across the many miles of this rural state.

“As we near the end of phase two, the project has exceeded my expectations,” Sheridan says. “The success of the project is attributed to the dedication of project staff and the collaborative partnerships, as well as the encouragement and support from Idaho critical access hospitals.”

As Idaho moves forward in supplying its citizens access to the services they need, upcoming policy decisions will shape the education and the provision of its medical provider workforce.

“This endeavor could become a Rosetta stone of understanding and unlocking the critical factors that not only draw but keep family physicians in some of the most under-served parts of America,” Epperly says.

David Schmitz, M.D., is associate director of Rural Family Medicine at the Family Medicine Residency of Idaho.

Ed Baker, Ph.D., is director of the Center for Health Policy at Boise State University.

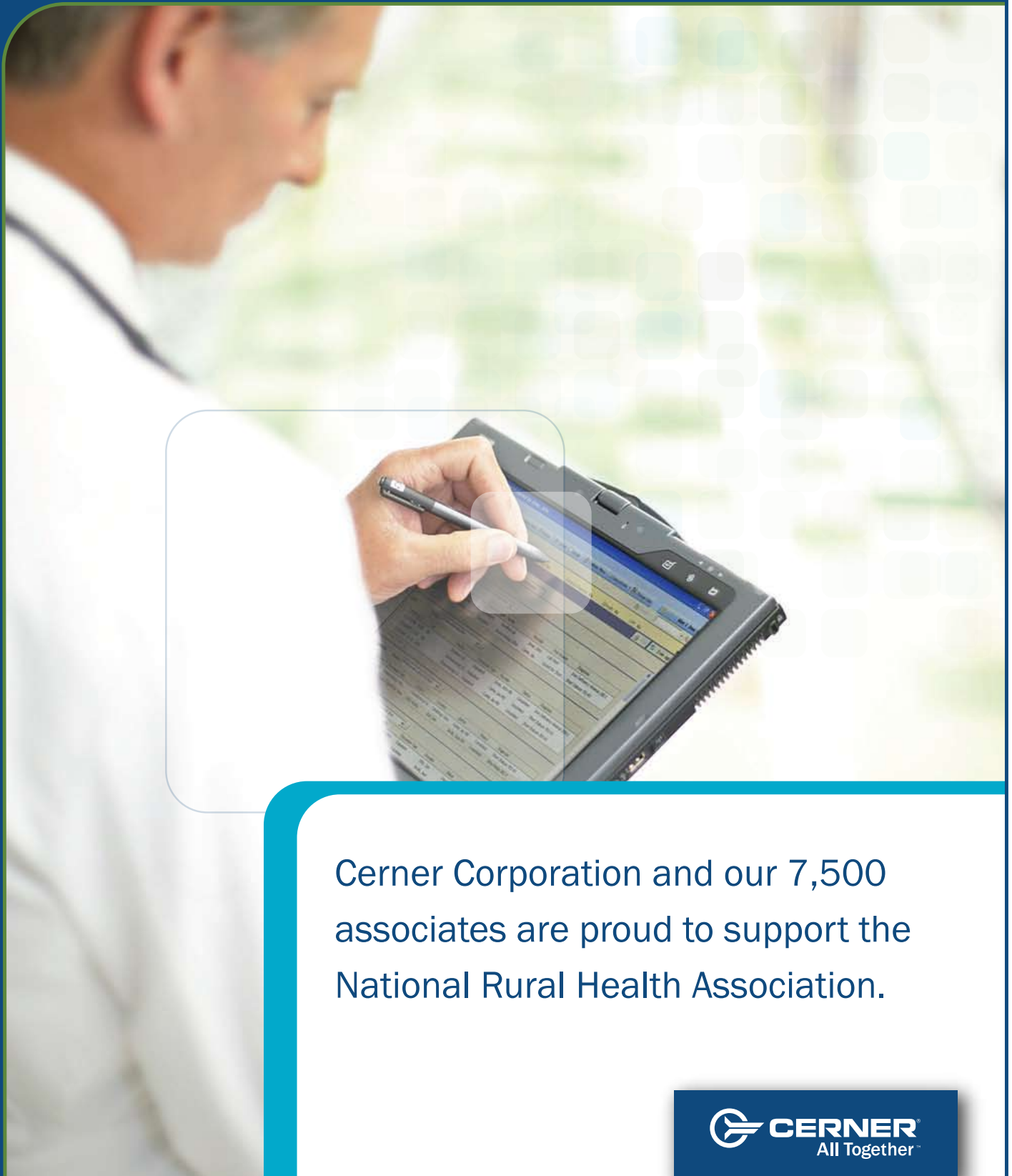
Share your story.

As you read this magazine, NRHA staff is already working on the revitalized Rural Roads for fall, which will share members' inspiration, insights and experiences. So we need to hear from you.

- ◆ Who most influenced your career choice?
- ◆ Tell us about your most memorable career moment.
- ◆ Have you shared your medical expertise in the war or on an overseas mission?
- ◆ Share your mantra.
- ◆ Do four-legged friends frequent your waiting room? Share your success stories with pets and healing.
- ◆ Are you proud of a collaboration in your community? Could it be replicated throughout rural America?
- ◆ Tell us about your effective breast cancer screening and prevention programs.
- ◆ Has your facility made any strides to go green?

Send responses to any or all of these questions to editor@NRHArural.org.

Improving healthcare delivery...all together



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South Central Kentucky hospitals *reap benefits of collaboration*

BY DAVID A. GROSS, UNIVERSITY OF KENTUCKY
CENTER FOR EXCELLENCE IN RURAL HEALTH

What has begun as a cost-saving experiment among a collection of Kentucky hospitals has grown into a formal rural health network that produces substantial benefits to regional health care providers.

It started modestly enough. Facing tight budgets and legislative changes early this decade, hospital administrators in south central Kentucky were feeling squeezed. They knew, among other things, that their rural facilities could not independently support many of the specialty services offered in nearby population centers.

“The small guys were getting lost in the shuffle,” says Jennifer Tweedy, then-director of respiratory therapy for Cumberland County Hospital, a critical-access provider near the Kentucky-Tennessee border.

To address the situation, the administrators did something they had not done before: They held a face-to-face meeting.

After a series of roundtables, and with assistance from the Kentucky Hospital Association and Kentucky Office of Rural Health, the administrators applied for and received a one-year, \$85,000 network development planning grant. At that time, they launched the South Central Kentucky Rural Healthcare Network. In 2006, the group received a three-year federal network development grant worth \$180,000 annually.

“Smaller hospitals don’t have the affiliations that larger hospitals do,” explains Vicky McFall, chief executive officer of the 49-bed Monroe County Medical Center. “This was a collaborative mechanism to allow smaller hospitals, by putting our beds together, to get the advantages of a larger group.”

The network marks its fifth anniversary in July. It is one of three active network development grantees in Kentucky and one of 77 nationwide, according to Sherilyn Pruitt, network grants coordinator for the Federal Office of Rural Health Policy.

Network development grants are designed to improve access to care by bolstering rural health care providers. According to the Health Resources and Services Administration’s web site, the grants “further ongoing collaborative relationships...

Jennifer Tweedy, executive director of the South Central Kentucky Rural Healthcare Network, stands outside Clinton County Hospital with Randel A. Flowers, the 42-bed facility’s CEO.
Photo by David A. Gross



“We got a better system than we would have been able to afford separately.”

Erik Garland, Cumberland County Hospital's information technology director

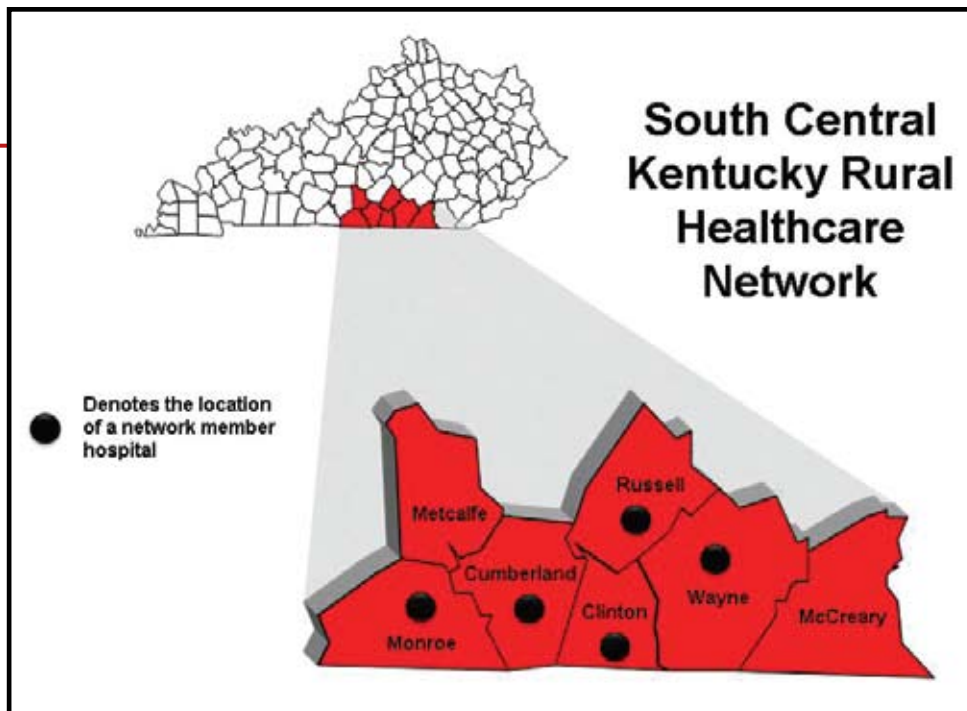
that focus on integrating clinical, information, administrative and financial systems across members.”

To be eligible for these grants, networks must include at least three separately owned health care providers or other entities that provide or support the delivery of health care services. The Kentucky example is referred to as a “horizontal network” because all of its members are similar providers; a “vertical network” might also include clinics, health departments or ambulance services.

In addition to the Cumberland County and Monroe County hospitals, the South Central Kentucky network includes the 42-bed Clinton County Hospital and two critical-access providers: Russell County and Wayne County hospitals. The five facilities combined serve nearly 92,000 rural residents in seven contiguous counties.

Tweedy, a former Cumberland County Hospital employee, is now the network's executive director, and an information technology specialist was hired last spring.

Since incorporating as a nonprofit organization, the network has



The South Central Kentucky Rural Healthcare Network's service area encompasses seven counties and approximately 92,000 residents along the Kentucky-Tennessee border. *Graphic by Tena R. Smith and David A. Gross*

provided health information technology assessments for the member hospitals, hosted health literacy awareness seminars for area health care professionals and conducted behavioral health surveys of an 11-county area. It also is assisting member hospitals in the development of electronic health records.

“This is the kind of network we like to see develop,” says Larry Allen, director of the Kentucky Office of Rural Health. “These hospitals have strengthened rural health care in their communities by reducing fragmentation and duplication of services.”

‘Knowing your neighbor’

The hospital administrators say their facilities have never had a particularly competitive relationship. For instance, Randel A. Flowers, Clinton County Hospital CEO, says his facility does not even have a budget for advertising.

“Sure I'd like to draw some patients from the adjoining counties,

but we're not going to compete over them,” he says. “If you have a good facility, it will draw patients.”

Still, officials say they are now much more likely to contact their counterparts at another network hospital.

“I never would have thought to call for advice or to share information,” says Erik Garland, Cumberland County Hospital's information technology director. “We've progressed from being civil to polite.”

Tweedy put it this way: “It's just a matter of knowing your neighbor. There are so many things to work toward; you don't want competition to be a stumbling block.”

More for the money

When all five hospitals participate, the network is the equivalent of a 166-bed facility. Therefore, a primary benefit has been reduced costs due to group purchasing and shared equipment. For example, the Cumberland County and Monroe

continued on next page



Vicky McFall is chief executive officer of the 49-bed Monroe County Medical Center, the largest member of the South Central Kentucky Rural Health-care Network. Photo by David A. Gross

County hospitals jointly purchased a dictation system and share a server, which resulted in savings of nearly \$50,000.

“We got a better system than we would have been able to afford separately,” Garland says.

During a recent 12-month period, the network provided savings of more than \$140,000 to member hospitals, Tweedy says, with most of that amount coming from information technology software, hardware and consulting services. The network also provided much-needed technical support to Clinton County Hospital during its recent 55,000-square-foot expansion project.

Future considerations

In a region with an undersupply of health care providers, particularly specialists, the administrators say physician recruitment is an issue ripe for further collaboration. Three network hospitals currently share a radiologist, and Clinton and Russell counties are cooperatively pursuing a urologist.

Clinton County also recently hired a gynecologist — the only one in a 60-mile radius. Flowers says the physician’s services potentially could be shared with the other network hospitals.

In spite of its successes, the network’s federal funding expires next April, leaving Tweedy to search for grant opportunities. Other sustainability alternatives include annual dues for member hospitals and service lines for specific types of assistance provided to individual members.

“I’d really like to see it continue,” Flowers says.

David A. Gross is the University of Kentucky Center for Excellence in Rural Health’s director of research, marketing and community engagement.

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Partnerships address *early childhood mental health issues* in Appalachian children

BY LYNN M. HARTER

Karen Montgomery-Reagan, a pediatrician with University Medical Associates and the Ohio University College of Osteopathic Medicine (OUCOM), was concerned about Sarah. She had repeated kindergarten twice and was still experiencing academic and social difficulty in the first grade.

Her parents were at a loss for what to do. Montgomery-Reagan referred them to Sue Meeks, a registered nurse and well child and behavioral health specialist with the Community Health Services program of OUCOM. During Meeks' intake interview with the parents, they discussed some of Sarah's difficulties at school. She was generally inattentive in class and had difficulty forming relationships and communicating with adults and peers. As a result, Sarah usually could not complete tasks and was falling increasingly behind developmental standards.

As Meeks talked with the couple, it became clear that at an early age Sarah had witnessed physical violence and drug abuse. Although they fought for two years for custodial rights of Sarah, she remained in the care of her biological mother for the first three years of her life. During that time, the mother was physically abused in the presence of Sarah. By the time Children's Services removed Sarah from her mother's care, she was malnourished, depressed, anxious and unable to bond.

"Witnessing this sort of violence generally has the same sort of impact as abuse itself," Meeks told the parents. "It is possible that Sarah is experiencing a form of post-traumatic stress disorder. What is important for you to understand is that Sarah's responses are quite normal responses to very abnormal and traumatic circumstances."

With tears in her eyes, the mother lamented, "Sarah doesn't seem to trust anybody; she thinks everybody lies to her. We know something is very wrong, but we don't know where to start."

Meeks reassured them that she would help. As a family navigator, her job is to be a primary point of contact for the family and ensure Sarah can access the medical resources she needs. During the intake interview, she asked the couple

about Sarah's basic health and developmental history including speech, language and hearing abilities, sleeping and eating patterns, toilet training, chronic illnesses, motor coordination, school and social history and current behaviors.

"I don't believe that we can just focus on Sarah," Meeks said. "We must also address family history and factors that may relate to Sarah's difficulties."

After identifying health care providers who previously had worked with Sarah, Meeks went to work connecting her parents with other professionals, including an early childhood mental health

specialist at Tri-County Mental Health Services and a speech, language and hearing specialist at Ohio University.

"It is critical for Sarah to have a thorough mental health evaluation because many of the same behaviors are associated with anxiety, ADD and post-traumatic stress disorder. A thorough evaluation will help ensure a correct diagnosis," Meeks said.

She also provided the family with information about their legal rights to an evaluation of Sarah at school. After signing a form allowing Meeks to share Sarah's medical history with other providers, her father sighed, "For the first time in a long time, we have hope. Thank you."

Montgomery-Reagan and Meeks are members of the board of directors of the Interprofessional Partners for Appalachian Children (IPAC). IPAC is a rural health network composed of university, community and consumer partnerships aimed at strengthening southeastern Ohio's health care delivery system to meet the needs of Sarah and children like her.

After the initial referral from Montgomery-Reagan, Meeks developed a comprehensive care plan for Sarah that included her family and the expertise of a pediatrician, early childhood mental health specialist, physical therapist, educators and a speech, language and hearing specialist. As an IPAC frontline provider, Meeks will continue to serve as the family's primary point of contact as professionals work interdependently to address the complex challenges facing Sarah.

The federal Health Resources and Services Administration's Office of Rural Health Policy awarded a three-year, \$540,000 grant to Ohio University to support the IPAC network. IPAC serves children and



Top left: Sherry Shamblin answers questions from staff members at a Head Start program in Athens, Ohio.

Top right: Grace Matheny, receptionist, background left; Melissa Martin, registered medical assistant, center; and Billie Owens, L.P.N., at right; listen to a child screening presentation by Sue Meeks, R.N., far left.

Bottom: Beth Helber, left; Jody Hart, center; Jennifer Cain, second from right; and Sherry Shamblin, far right, discuss issues with children at a Head program in Athens, Ohio.

Photographs by Lawrence Hamel-Lambert

continued on next page

“Every single one of us is passionate about what we do. And you just can’t fail when you have that much passion sitting around one table.”

Sue Meeks, RN and Community Health Services program well child and behavioral health specialist

their families in Athens, Meigs, Hocking and Vinton counties in Ohio. The population of these counties approaches 127,000 people, including 7,021 children under age 5. Like the broader region of Appalachia, these counties are characterized by higher levels of unemployment and poverty and lower levels of education in comparison to national baselines. All four of the counties are federally designated as medically underserved areas. Residents generally have less access to mental health care due to few material resources, experience geographic isolation from mainstream medical infrastructures, and face uneven distribution of health care providers across rural and urban settings.

Rural health networks like IPAC offer an alternative way to organize mental health care resources for traditionally underserved populations. IPAC includes 13 community agencies

in addition to several Ohio University departments and clinics that provide professional training and services. By integrating their clinical expertise and resources, IPAC affiliates offer coordinated and comprehensive services that address early childhood mental health issues and concerns.

Over the next three years, IPAC members will develop more fully a family care navigator program including intake mechanisms and protocols, facilitate interdisciplinary mental health assessments and comprehensive care plans for children, develop an infrastructure for scheduling and billing of support providers employed by different agencies, and expand training of childcare and health care providers to screen children regularly for social and developmental risk.

IPAC members are integrating mental health care assessments and services into settings where young children already are, including primary care offices, preschools and childcare centers. Sherry Shamblin, an early childhood mental health specialist employed by Tri-County Mental Health and Counseling Services and IPAC board member, underscored the importance of bringing mental health specialists

into environments already inhabited by children.

“There are not a lot of people who have expertise in serving young children in any kind of specialized service like mental health, particularly in southeastern Ohio,” she says. “But by bringing mental health care specialists into childcare centers and having them provide consultation or training to teachers, then you are shoring up services to address mental health concerns and you are developing the capacity of other frontline providers like teachers. The impact is huge compared to just keeping a mental health care provider in a clinic.”

Teachers at the Hocking-Athens-Perry Community Action Head Start Program, one of many programs served by Shamblin, couldn’t agree more.



“It is just incredible to have Sherry come in and observe our teaching in the classroom and give us pointers about things we could do when we are talking to the children and ways to manage different things,” says Beth Helber, a teacher at the Athens Head Start site. “I’ve talked with other people in centers in the region and they don’t have access to a mental health specialist and really feel like they need one. So I feel extremely lucky. This resource is just critical to what we do.”

Athens Head Start teachers provided numerous examples of successful interventions facilitated by Shamblin. Consider the following story told by Jennifer Cain: “Recently, we had a little boy who just couldn’t concentrate, and he would fight and kick. He wasn’t even able to really be part of the classroom for very long. And Sherry came in and we did some screening evaluations. We worked with his parents, and talked about different options and finally referred him to a doctor. He is on medication now and made the transition to kindergarten better than he would have otherwise.”

The diverse partners and initiatives of IPAC are united by their emphasis on early childhood mental health care interventions.

“Whenever we get afraid or threatened or worried, the physical response from early childhood traumas comes right back. So, catching those things early is



critically important,” says Meeks. “Straightening out kids’ responses early will prevent the sort of ingrained and automatic responses that become so habitual over the years. It’s no different than other medical fields. If you have cancer and you catch it early, you have a better chance of successful treatment. If you have diabetes and you have early intervention, you are probably going to have a better outcome. It’s the same with mental health. You lose time if you don’t catch it early. Kids often learn to read or speak at certain times, and once that time is gone, it becomes much harder for it to be that easy for the child again.”

Scarce resources and services related to early childhood mental health led rural community agencies and university partners in southeastern Ohio to create IPAC.

“By forming the network, we have become a more powerful and collective voice that has allowed us to access funding and to integrate services so families can have more streamlined and successful services,” Shamblin says. “What we found

prior to IPAC is that people were really in their own silos doing their own thing, and we had families who went here, then went there, then went here, then went there over a period years and still really never knew what was going on with their child. So the network approach has already made a difference.”

Meeks credits IPAC’s success in part to the passion and commitment of its affiliated partners.

“I think what is special about IPAC is that we all have similar passions. It may not be coming from the same place, and the passion may not be aimed at the same thing, but we’ve been successful because we all care deeply about mental health issues,” she says. “Every single one of us is passionate about what we do. And you just can’t fail when you have that much passion sitting around one table.”

The Ohio Department of Health acknowledged the success of IPAC by awarding the network the annual Distinguished Rural Health Program Award in 2007.



Commitment to a common vision: *a rural hospital's path to long-term success*

BY RAYMOND T. HINO, CEO OF MENDOCINO COAST DISTRICT HOSPITAL,
AND MICHAEL PHILPS, PRESIDENT OF MJ PHILPS AND ASSOCIATES LLC

Mendocino Coast District Hospital (MCDH) was built 37 years ago in Fort Bragg, a rural North Coast California community, after the passage of a bond measure to support construction of a 54-bed, 42,000-square-foot hospital at a cost of \$2.5 million. The scenic area is known for its rugged coastline, quaint neighboring Mendocino village and easy access to Redwood forests and wine country.

Over the years the hospital downsized to 49 beds, remaining a viable provider of a full array of services, including active surgery and obstetric programs, an emergency room and a four-bed ICU. During the past six years, however, the Mendocino coast economic environment declined dramatically. In 2002, after more than 100 years of operation, Fort Bragg's largest employer, the Georgia-Pacific lumber mill, closed. Historically, this coastal area served as a mainstay for commercial fishing. In recent years, however, the fishing industry has declined as well.

As the economic fortunes of this coastal community declined, so did the financial success of MCDH. The hospital is located two to three hours from urban areas, insulating it from major medical center competition. The only access to this area is via winding, two-lane country roads. With a declining local population and deteriorating economy, the hospital began to suffer major financial losses.

MCDH is a publicly-owned district hospital, allowing the entire community to discuss how this small hospital, which is so vital to the area, could survive. One potential solution included instituting a new parcel tax for property owners, but the tax failed to get the necessary majority approval of 66 percent of voters. Other options included developing "boutique" services that could be offered in a vacation setting or affiliating with a large hospital system. Inquiries were sent to all major systems serving northern California, but they were reluctant to align with a small hospital in an economically declining area.

In early 2006 concerns about the hospital peaked. Financial woes were mounting, with losses exceeding \$100,000 per month. Fiscal year 2006 ended with an audited loss of over \$5 million. In June of 2006, shortly before the arrival

of Raymond T. Hino as CEO, MCDH's board made a decision to apply for critical access hospital (CAH) designation. That October, MCDH became California's 25th critical access hospital.

An opportunity for involving the local citizens in the hospital's recovery emerged in early 2007, as the hospital board and management decided to embark on a formal strategic planning process. The planning effort was made possible through a FLEX grant from the California Office of Rural Health with the support of Health Program manager Michele Yopez and California Hospital Association Vice President for Rural Health and Governance Peggy Wheeler. This financial support enabled MCDH to bring MJ Philps and Associates on board. The collaboration between the state and MCDH was essential to secure this funding. The hospital had spent hundreds of thousands of dollars on

consultants in the past and wanted to show the community they could do a professional strategic planning process without expending funds from the hospital budget. This was key to getting community support.

Michael and Kathleen Philps of MJ Philps interviewed representatives of each of the hospital's stakeholder groups, which included staying late and arriving early to meet with night shift staff. The purpose of these meetings was to demonstrate to the community and staff that the movement toward recovery would be inclusive and transparent. Philps representatives also met with the hospital's planning committee and facilitated a management team strategic planning session.

During the March 2007 retreat, the Philps team led a group of more than 60 citizens, including hospital board, management, employees, volunteers and interested community members, in a discussion of the

real issues preventing MCDH from achieving financial and operational success. The end result was a strategic plan that included eight key goals. Not surprisingly, the most important of the goals was reconnecting with the community. Other goals included financial performance, physical plant renovation, new programs and services and staff recruitment and retention.

MCDH has achieved remarkable success since conversion to CAH designation and its emphasis on community inclusion and transparency. For fiscal year 2007, the hospital announced a positive bottom line exceeding \$1 million and including an operating gain of \$613,000. This was the hospital's first operating gain in 10 years. The hospital is continuing to do well; however, there are still many challenges ahead. Perhaps the largest challenge is California's current budgetary woes, which could likely lead to a 10 percent across-the-board cut in the state's Medicaid (MediCal) program.

This year MCDH will be evaluating how community attitudes have changed toward the hospital, as well as the community's acceptance of new change strategies and aggressive measures needed to maintain a healthy financial condition and the positive forward momentum achieved over the past two years.

For more information, contact Hino at 707-961-4630 or rhino@mc dh.net.



Primary Care Plus *impacts mental health in rural Indiana*

BY KATHY L. COOK

n Indiana's Fayette and Rush counties, it is difficult to get mental health and medical services due to the lack of availability of providers and the small population numbers.

Both counties are designated as health professional shortage areas, and only two providers there take Medicaid. In response to this need, a Health Resources and Services Administration rural outreach grant was awarded for a collaboration of three organizations that came together to implement mental health services in two existing rural health clinics. The organizations were Dunn Mental Health Center, Family Health Services-Rural Health Clinic and Affiliated Service Providers of Indiana (ASPIN), a former HRSA grant recipient that has provided technical assistance.

The goal of the project was to improve the health and wellness of people living in the rural communities of Fayette, Franklin and Rush in Indiana, especially the low income and elderly, by focusing on decreasing barriers, providing prevention and early intervention education, increasing treatment effectiveness and replicating the program in other areas of the state.

Primary Care Plus is in year two of the grant and has seen success in many areas. The main barrier that has been impacted is offering mental health services in a health care setting to reduce stigma associated with treatment. Even though the local mental health center provides services in the area, patients were reluctant to utilize them because they would be classified as seriously mentally ill. Barriers are also being reduced by offering transportation and child care for individuals to seek mental health counseling and conducting outreach education and communication programs to spread the word to the community. Advertisements were placed in the local paper, schools and groceries stores.

The program offers several benefits to providers and patients. Treatment effectiveness has improved due to the receptiveness of the medical physicians and the availability of therapists. This availability enables close interaction with psychiatrists and advance practice nurses, who can assist the primary care physician with patients who are high users of service. Transitioning these patients to mental



health professionals allows more open appointment times for other patients. Other benefits include sharing of administrative and operations expertise, board members serving on both provider organizations boards, overwhelming community support and positive patient feedback.

One barrier was that the elderly population was not accessing the program because of age-specific belief systems or because they had a wide range of wellness issues that already demanded much time in primary care visits and expense with medications, transportation, etc. Therefore, many elderly who were referred by their primary care physicians did not choose to come to the program. When interviewed, primary care providers speculated that the elderly population sought faith-based services before mental health services. Also suspected was the cost of the transportation and pharmacology related to their medical issues prevented them from seeking mental health services even when referred.

Determining the barriers allowed Primary Care Plus to work toward marketing to the elderly population in ways that began to break those barriers.

Determining the barriers allowed Primary Care Plus to work toward marketing to the elderly population in ways that began to break those barriers. One of several marketing efforts focused on primary care providers was a community breakfast, which offered means for referrals to the program and information on removing the stigma attached to mental health care. Flyers and informational posters were placed in primary care offices, churches, bingo areas and other venues frequented by the elderly population. A community educational event hosted by the Family Health Services group allowed participants to learn how the health center was integrating primary health care and mental health. If applicable, calls were also made to determine the reason for no-shows. The top three reasons were travel expenses, home crises and affordability.

Primary Care Plus' third year will focus on replication and dissemination of the program model. This will be accomplished in several ways. A manual will be developed to include samples of the administrative pieces developed to make this project a reality. It will be available for purchase on CD for any mental health or health care provider. Also, several Indiana mental health centers will be targeted to receive the information through a statewide training program.

Kathy Cook has been instrumental in the development of Affiliated Service Providers of Indiana (ASPIN), a provider sponsored network consisting of nine community mental health centers and four addiction providers serving 32 of the 46 rural designated counties in Indiana. Cook is serving her second year on the Indiana Rural Health Association board of directors and has participated in the strategic planning efforts of the Indiana Office of Rural Affairs.

Join us for Rural Health Clinic and Critical Access Hospital conferences

Plan now to attend the Rural Health Clinic Conference Oct. 14 and 15 and Critical Access Hospital Conference Oct. 15 through 17 in Savannah, Ga. Each conference is the best of its kind and was designed exclusively for the needs and concerns of administrators, leadership and staff.

The Rural Health Clinic Conference will feature two days of integrated billing and cost reporting strategies for rural health clinics. From the basics of billing and cost reporting to advanced techniques that maximize reimbursement and keep clinics financially viable, the RHC conference will offer valuable insights, new strategies and a question and answer opportunity with renowned financial consultants.

The Critical Access Hospital Conference will feature two sessions with Brian Lee, one of the country's leading experts in the field of world-class patient satisfaction and employee retention. As the CEO and founder of Custom Learning Systems Group, Lee and his team have helped hundreds of hospitals and health care organizations achieve service excellence through the Accountability Protocol, which directly links accountability and patient satisfaction and explains how to improve accountability, control and communication systems.

The conference will also include a session comparing and contrasting facility renovation and replacement. Part of the information in this session is based on the findings of the Stroudwater and Red Capital Group Rural Hospital Replacement Facility Study, which is available on the NRHA web site and reveals how replacement facilities impact the operations and bottom lines of critical access hospitals. In response to member suggestions, conference attendees will also have the chance to attend a full session on either renovation or replacement based on their individual needs.

Other session highlights include making long-term care feasible and outsourcing the revenue cycle, as well as the latest on health information technology funding.

"The best benefit of the conferences is you can interact with your peers and you know the agenda will be relevant to the challenges we face," says David Sniff, president of Midwest Consultants for Rural Health Inc.

To register, visit the NRHA web site at www.RuralHealthWeb.org.

Experience Savannah

Turn your trip to the conferences into a vacation, as Savannah, Ga., offers plenty to do and see.

Take a unique dolphin-watching cruise along Savannah's historic riverfront and watch Atlantic bottlenose dolphins play around Tybee Beach. Also see notable landmarks, forts and lighthouses, such as the 200-year-old Tybee Island lighthouse.

Spend an afternoon lounging and listening to live music on Tybee Island, which has a three-mile beach, and explore the nightlife at 17 Hundred 90 Inn, a restaurant and tavern in a restored mansion from the 1790s. Be sure to pay attention to the scenery — Savannah is home to many monuments and fountains, and Spanish moss adorns the branches of the trees.

For more on what to do around the conferences, visit www.savcvb.com.

Volunteers work to rebuild homes

Nearly 50 NRHA members volunteered to help rebuild homes devastated by Hurricane Katrina during the Annual Conference in May.

Volunteers from as far away as Australia worked on three houses in St. Bernard Parish, a community adjacent to New Orleans' Lower Ninth Ward where 100 percent of residences and businesses flooded.

"I'm grateful for the assistance the volunteers provided to rebuilding St. Bernard Parish and for their contribution to restoring hope to three families who lost everything," says Stacy Fontenot, Louisiana Rural Health Association executive director, who coordinated the effort with the St. Bernard Project, a local nonprofit organization dedicated to rebuilding homes damaged as a result of the August 2005 hurricane.

Two teams used wire brushes to break up and kill mold on bare studs and then treated the wood to prevent further mold damage in two houses. Another group installed insulation and drywall to a home that had already been treated to prevent mold.



"It's wonderful that the NRHA Annual Conference could return to New Orleans because tourism has to come back to sustain the economy so residents can return home," NRHA CEO Alan Morgan says. "And I'm really proud that our members were willing to get their hands dirty and give back even further by helping in these homes."



Annual Conference welcomes 900 to Louisiana

The 2008 NRHA Annual Conference attracted 900 rural health professionals and students to New Orleans' lively, historic French Quarter from May 7-10.

The conference featured more than 95 sessions, which covered topics from mission-centered marketing to oral health care to government affairs, and the expertise of many speakers, including a keynote address from U.S. Surgeon Gen. Steven Galson.

When members weren't in educational meetings, they enjoyed a local jazz band, hurricane bar and a yoga class.

The 2009 NRHA Annual Conference will be May 5-8 in Miami Beach, Fla.



Helping new physicians succeed in rural settings

BY GEORGE CONOMIKES

Many hospitals try to support physicians who are new in solo practice, but the new rural physician is known for making major costly mistakes. If there are too many mistakes it can lead to the physician leaving the community and opting for a job elsewhere. If that happens, the community and the hospital lose.

Here are a few guidelines to minimize errors.

Space requirements

New physicians look at the cost of space as a major overhead expense. To save, they often decide to have only two exam rooms. This may be adequate for the

first few months in practice; however, to have healthy practices, studies show primary care physicians should be able to see 25 or more patients per day. To meet this goal, a third exam room to maximize productivity is a must. The daily cost of a fully-furnished exam room is no more than \$40 to \$55, including rent and depreciation of equipment, furniture and fixtures. This can be gained in less than a brief visit. With only two exam rooms the physician is often waiting for an exam room to be prepared, and the downtime translates to lost revenue.

Staffing

To save money many new physicians hire untrained individuals, but there is no substitute for an employee with significant medical office experience. The first hire should be someone with multiple skills. Many new physicians have succeeded early by starting out with one knowledgeable person.

In the beginning, the new physician can handle the exam rooms, and the first employee can work the front desk and answer the phone.

The second employee, a registered nurse, can come on when the physician starts to get busy. The licensed professional can provide most patient education, some management of chronic patients and answers to most patient phone inquiries. A skilled nurse allows the physician to maximize their skills. Ideally, the nurse is the data collector; the physician is the analyst and problem solver.

Competent employees are costly, but they should be looked at as revenue producers, not cost centers. Facilities and staff are guideposts that can make or hurt a new practice.

George Conomikes is president of Conomikes Associates, medical practice management consultants.



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IS A RURAL CAREER RIGHT FOR YOU?

BY SABRINA SCHLEICHER

Making the move to a rural area is a big step that involves many lifestyle changes. Here are some suggestions from professionals who have made such moves.

- Talk to other professionals who have moved from an urban to a rural area.
- Learn about the area from several people of varying backgrounds.
- Talk to those within your profession who are already living in the area. Ask about ethical issues, laws pertaining to your profession and licensure requirements. Begin putting professional support in place before you move.
- Consider your interests and the interests of your family. Does the community offer activities compatible with your interests? If not, are there other interests you can develop?
- If you are married, involve your spouse in decision-making. Bring your spouse to visit the community prior to accepting your job.
- Keep in mind that being a professional in a rural area often means you are a generalist first and a specialist second.
- Consider your ability to be flexible and adaptable. Things move slower in a rural community. For example, some communities do not have overnight mail delivery. Extreme weather conditions may shut down the community for days at a time. Are you able to be flexible with your work in such circumstances?
- Consider your ability to be self-directed in furthering your knowledge in your field. It is more difficult to access training from a rural area. Are you willing to travel out of state to acquire your preferred training? Are you willing and able to pay for these expenses if your employer does not?
- Don't be shy. Take the lead in seeking out your colleagues.
- Handle yourself with grace and tact. As one professional advised:
“Don't come in like gangbusters, ready to make your mark and show the locals how it should be done. The community has seen many like you come and go. They will wait to see if you have the courage and seriousness to stay. While they are friendly, they will have a little bit of a wait-and-see attitude. Be patient, polite, receptive and genuinely interested. Rural towns have their own wisdom. You'll be much more part of the whole community than you would be in a large city. As a result, everything you do will be more public. People can be very forgiving, but you have only one chance to make a first impression.”
- Become involved in the community. Get a subscription to the local newspaper. Attend events, and don't avoid community activities for fear of having a dual relationship. Seek out colleagues in your own profession for mentoring and professional support.

Above all, don't take such a move lightly. Your professional presence has a profound impact on the community. The experience will change your career for the better if the move to a rural community is the right fit for you.

Dr. Sabrina Schleicher is a business coach and licensed psychologist in Riverton, Wyo.

Patient *praises* CARDIAC PARTNERSHIP

BY KYP GRABER-SHILLAM, LINCOLN HOSPITAL PUBLIC RELATIONS

Betty Marsh, 63, remembers her first heart attack well.

“It was two years ago, and it felt like indigestion in the front of the chest,” she says. “I didn’t recognize it as a heart attack at first.”

Ex-husband Larry Marsh knew something was wrong and drove Betty from rural Harrington, Wash., to an emergency room at a major hospital in Spokane, one hour away.

Once Betty arrived in Spokane, the long process of diagnosis began.

“I spent probably 10 minutes in the ER waiting room; they took me right back. But it was a long time, hours before they found out I was having a heart attack and a couple of hours for the heart cath team to get together to do the procedure.”

In the spring of 2007, Betty felt similar symptoms. This time, Larry called for an ambulance and Betty was driven the 15 miles to Lincoln Hospital in Davenport where the Level One Cardiac Care Partnership between Lincoln and Sacred Heart Medical Center had just been put into place.

“In a cardiac emergency, time is a deadly foe. For patients who live in rural areas, possibly hours from a cath lab, the clock is already against them,” says Dr. Ralph Monteagudo, Lincoln Hospital chief of staff. “In the past, rural physicians with a cardiac patient needing transport and treatment at a larger hospital were faced with a quagmire of paperwork and phone calls to find a hospital and a cardiologist, then check with insurance and comply with government red tape.

“Outcomes were not good,” he adds. “We’ve said a resounding, ‘no,’ to that system. We’ve gone doctor to doctor saying we’re going to get this done and save lives. No more struggling to transport patients because of red tape.”

Modeling Level One Cardiac Care after a groundbreaking program in the state of Minnesota, stringent timelines for all partners were put in place to speed the process for better patient care.

Larry noticed the difference right away. That’s because even before Betty entered the building, Lincoln Hospital’s cardiac team was preparing the ER. The goal was aspirin therapy and a diagnostic EKG within 10 minutes of arrival.

“In a cardiac emergency, time is a deadly foe.”

Dr. Ralph Monteagudo, Lincoln Hospital chief of staff



“This quality program is making an immense difference to cardiac patients.”

Dr. Michael Ring, medical director of Sacred Heart’s cardiac services

When the EKG suggested a blockage, Dr. Rolf Panke picked up the phone to continue the chain of lifesaving events. First, Sacred Heart’s cardiac catheter team was called into action. Then, Betty was immediately airlifted to Sacred Heart by partner Northwest MedStar. She was taken directly to the cath lab where the team was waiting. No paperwork. No red tape.

“She went over the top of me in the helicopter as I was leaving Davenport,” says Larry. “Dr. Panke told me I couldn’t get to Sacred Heart before she was done in the cath lab. When I did get there, I called the cath lab and talked to the doctor who did the procedure. He said it was done, and she’d come through it just fine.”

The time from door to door? Ninety-three minutes from Betty’s arrival at Lincoln Hospital to having her artery opened and a stent inserted. The protocol worked.

“This quality program is making an immense difference to cardiac patients” says Dr. Michael Ring, medical director of Sacred Heart’s cardiac services. “It allows us to deliver the most effective care to heart attack victims throughout our region, not just those who show up in our ER.”

Larry agrees.

“This program is going to save lives, no question about it” he says. “They told me her heart damage was

very minimal, and we all know it’s because they got in there sooner and opened it up and made things work again.”

The partnership was a success, and Betty sings the praises of both her hometown hospital and the metropolitan medical center responsible for such an innovative, lifesaving program.

“From now on, we’re going to call an ambulance and stop at Lincoln Hospital first to get stabilized” Betty says. “Then, if it is a heart attack, they know what’s going on and they can communicate with the cardiologists at Sacred Heart so the cath lab team will know what to expect when we get there.”



Meyersdale Medical Center's *sweet 16*

BY MARK MEEKINS AND KAREN T. BRUCHAK, RN, MSN

With a single-slice computed tomography (CT) scanner, Meyersdale Medical Center routinely had to refer patients from its community to be imaged in different cities. The single-slice CT scanner was not meeting the needs of the community, and staff members at the 20-bed critical access hospital were concerned newer CT technology was financially impractical.

Now an affordable 16-slice CT scanner is allowing Meyersdale to improve access to higher-end technology for its community and consequently the diagnostic quality of the imaging services provided.

Since installing the scanner, there has been an increase in patient volume, and Meyersdale has expanded its imaging services.

Geographic challenges

Meyersdale Community Hospital was established in 1952 and joined with Conemaugh's Memorial Medical Center in Johnstown, Pa., forming the Conemaugh Health System in 1994 and changing its name to Meyersdale Medical Center.

With a single-slice CT scanner, Meyersdale could only perform routine exams of the head, neck, abdomen and pelvis. More complex procedures, like CT angiography or pulmonary embolism chest exams, were referred to other towns. With no imaging centers in the Meyersdale area, patients were forced to travel 20 to 40 miles.

The scanning that could be performed with Meyersdale's single-slice CT scanner was limited in image quality and speed.

"Single-slice CT scanners are virtually obsolete now, and it was becoming more and more disheartening for us to have to send patients miles away for the scans that they needed," says Mary Libengood, Meyersdale Medical Center president. "Our biggest goal is to serve the people who live here with the best medical care possible, and our limited CT scanning ability was definitely hampering that mission."

Further, once a patient was referred to another facility, they rarely returned to Meyersdale Medical Center. Those individuals typically decided to have all their health care needs addressed at a facility offering more comprehensive options.

Quality vs. cost

The purchasing process was daunting at first, and Meyersdale staff expected that they would need to strain the budget for high-end technology or settle for a low-end model.

It turned out that a 16-slice CT could meet all of the medical center's imaging needs. Meyersdale was able to lease the system for a price that was a manageable amount more than the payments for the single-slice scanner.

Another benefit of the 16-slice CT was its small footprint, which

allowed Meyersdale to use the existing CT room without making any major modifications. The system was installed in January, and the process took four days, including de-installation of the old scanner and quality assurance checks.

Technology benefits

The 16-slice CT is now enabling Meyersdale to perform, on average, 20 more scans per month for a total of about 230 scans each month. In addition to the 9.5 percent increase in CT imaging volume, the 16-slice scanner has allowed Meyersdale to enhance the types of scans it was already performing. It also now allows the staff to perform coronary CT angiography (CTA) exams. The first time Meyersdale staff performed a leg runoff CTA was exciting,



Heather Smith, chief financial officer, and Mark Meekins, director of radiology, with the 16-slice CT.

because they were able to perform the necessary imaging study for a patient who would have otherwise been referred to a facility in a different town.

The new scanner has also allowed the Meyersdale staff to speed up the pace at which they acquire images and the clarity of those images. With a single-slice scanner, pulmonary embolism chest scans had a limited acquisition speed and a slow gantry rotation time. That led to thick image slices, and those images were not reconstructed and rendered on a 3-D post-processing workstation. With the 16-slice scanner, Meyersdale is generating quality images that are reconstructed and rendered to suit the radiologist's preference.

Another benefit of the new scanner is the weight limit of 440 pounds, which gives Meyersdale the ability to scan larger patients. These days, Meyersdale turns away few patients. This is a tremendous benefit considering numerous studies have reported that rural



As a 20-bed critical access hospital in rural southwestern Pennsylvania, Meyersdale Medical Center serves a regional population of 7,500. Meyersdale's radiology team is proud to expand the service offerings and improve the level of care provided to their community.

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By upgrading to a 16-slice CT scanner, more complex procedures, like CT angiography and pulmonary embolism chest exams are now performed at Meyersdale.

“In the eyes of the people in this community, having this technology and the expanded capabilities that go with it is truly larger than life.”

Mary Libengood, Meyersdale Medical Center president

communities have higher rates of obesity. In fact, a much larger facility in the Meyersdale service area now refers heavier patients to Meyersdale Medical Center for CT scans.

Referral and reimbursement benefits

Still in the early phase of deployment, Meyersdale Medical Center has already experienced an increase in referral patterns due to the new scanner. As word continues to spread throughout the referral base, and as Meyersdale continues to educate physicians about the enhanced CT scanning capabilities, the referral volume is expected to increase.

With a broader range of CT offerings coupled with enhanced image post-processing capabilities, Meyersdale performs an average of 10 scans per day, with their break-even point estimated at eight to nine scans per day. The current procedure mix is 80 percent routine procedures and 20 percent sophisticated and invasive studies. The plan is to increase the mix to 70 to 30 or

60 to 40, which would further increase the revenue stream.

Of course, no CT scanner will be productive if it is offline for frequent service and repairs. Meyersdale is a rural hospital that lacks an on-site service engineer, but so far there have been no issues with service and calls to the helpdesk have led to prompt resolutions.

The 16-slice CT allowed the Meyersdale staff to expand the service offerings and improve the level of care delivered to the community. Recently, a major academic medical center in western Pennsylvania called Meyersdale to refer a patient. The patient had traveled from Meyersdale to see a

specialist, who wanted the patient to have a CTA scan. By having the scan completed at Meyersdale, the patient could have the study done without having to travel again.

“In the eyes of the people in this community, having this technology and the expanded capabilities that go with it is truly larger than life,” says Libengood. “It’s very exciting to be able to serve them right here in our community.”

Mark Meekins is director of radiology at Meyersdale Medical Center in Meyersdale, Pa.

Karen T. Bruchak is national director for community hospitals, Customer Solutions Group, Siemens Medical Solutions USA, Inc.



The new scanner allows Mark Meekins, director of radiology, to gain higher diagnostic confidence due to the speed of image acquisition and the clarity of those images.

NRHA past presidents named to Veterans Rural Health Advisory Committee

NRHA past presidents Bruce Behringer and Hilda R. Heady were named to the Department of Veterans Affairs' new Veterans Rural Health Advisory Committee, which will advise Secretary of Veterans Affairs James B. Peake. Behringer and Heady are two of 13 committee members selected by Peake.

"We are delighted that Bruce and Hilda were chosen for this important role," says NRHA CEO Alan Morgan. "The NRHA first asked Congress to create this commission within the VA in 2005, and we now look forward to seeing the recommendations of this talented team."

Behringer, executive director of East Tennessee State University's Office of Rural and Community Health and Community Partnerships and assistant vice president of the Division of Health Sciences, served as the 1992 NRHA president and remains active in the organization.

Heady, associate vice president for Rural Health at West Virginia University and executive and state program director of the West Virginia Rural Health Education Partnerships/Area Health Educations Centers, served as the 2005 NRHA president and first testified before Congress on rural veterans' issues in 2001 and was the lead author on the NRHA policy paper on the topic.

Hawaii legislature recognizes Ka'u Rural Health Community Association's Pilot Nurse Shortage Program

Ka'u Rural Health Community Association, Inc. (KRHCAI) launched its inaugural Pilot Nurse Shortage Program in January with 17 adult students from the Ka'u District.

KRHCAI collaborated with health care institutions from across Hawaii to train students in a curriculum provided and taught by Hawaii Health Care Institute instructor Berdena Flesher, RN. Each student was required to complete 114 lab hours and 24 clinical hours. In addition to this experience, students were also enrolled in the Medical Reserve Corp. and American Red Cross disaster preparedness training and participated in the KRHCAI Wellness/Health Literacy Program.

At the graduation celebration in March, Hawaii House representative Bob Herkes presented Jessanie Marques, KRHCAI executive director, with certificates signed by state senate and house members congratulating KRHCAI on the establishment of its Pilot Nurse Shortage Program and efforts to alleviate the nursing shortage.

Centers for Medicare and Medicaid Services national Medicare education campaign

Medicare is paying 75 percent or more of prescription drug costs for Americans with limited incomes and resources.

One woman with Medicare was struggling to pay for her prescriptions even with a drug plan and her \$800 Social Security benefit. A counselor at the local State Health Insurance Information Program talked to her about how to apply for additional benefits. Once she heard that the value of her house, as long as she lived in it, would not be used to determine if she was eligible, she applied and qualified.

Qualifying for benefits will help pay monthly premiums, annual deductibles and prescription co-payments. Many people qualify and don't know. To find out if you qualify, apply online at www.socialsecurity.gov, call Social Security at 1-800-772-1213 or visit a Social Security office for assistance. To learn more about the Medicare prescription drug plans and how to join, call 1-800-MEDICARE (TTY 1-877-486-2048) or visit www.medicare.gov.

This information prepared by the U.S. Department of Health and Human Services.

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Medicare prescription drug coverage and VA benefits

By Tammy Twait, pharmacist, Centers for Medicare and Medicaid Services

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003, also called Medicare Part D. This landmark legislation provides seniors and individuals with disabilities a prescription drug benefit, more choices and better benefits under Medicare.

As of January, there were approximately 44.2 million Medicare beneficiaries eligible for Medicare Part D. Of this 44.2 million, 1.59 million have creditable prescription coverage through participation in the Veterans Affairs prescription pharmacy benefit. Because VA prescription coverage is creditable coverage, veterans who choose not to enroll in Medicare Part D when they are first eligible will not have a late enrollment penalty. Veterans enrolled in the VA health care system may choose to enroll in Medicare Part D in addition to their VA benefits.

Eligibility criteria are different for VA medical benefits and Medicare. Medicare prescription drug coverage is available to all people with Medicare, while VA prescription drug coverage is available to all veterans who are

eligible for and enroll in VA health care coverage, which is separate from Medicare. By law, VA does not bill Medicare. Medicare Part D provides extra help paying for out-of-pocket prescription drug costs to Medicare-eligible persons with limited income and resources. For VA purposes, limited income is based on VA's pension amount. Limited-income veterans will have no drug co-payments if they have Medicare Part D. A veteran's decision to participate in Medicare Part D will not change his or her VA prescription drug coverage.

Finally, there are some circumstances veterans may wish to consider when deciding to enroll in a Medicare Part D prescription drug plan. If they live far away from a VA facility or live in or move to a nursing home, they may benefit from Medicare prescription drug coverage. It is important to remember that veterans with both Medicare Part D and VA benefits cannot have a single prescription covered by both programs. A prescription will not go to VA for additional payment if a Medicare Part D plan fills and makes payment for that same prescription.

Poor birth outcomes in rural United States

The WWAMI Rural Health Research Center at the University of Washington has new research showing that while progress has been made, rural/urban gaps in birth outcomes remain high. Those outcomes include rates of low birth weight, poor outcomes and inadequate prenatal care and were compared from 1985-1997 using data from the Linked Birth-Death Data Set.

Overall, the study found that rural residents and residents living below poverty level have independent risk factors for inadequate care and some adverse birth outcomes, especially post-neonatal mortality.

Rural Health Trifecta planned in Texas

Partnering the Office of Rural Community Affairs (of the Texas State Office of Rural Health), Texas Rural Health Association and Texas Hospital Association, the Rural Health Trifecta: Collaborating to Make a Difference will be Aug. 5 through 7 at the Hyatt Regency Austin. The meeting is also co-sponsored by the Texas Organization of Rural and Community Hospitals.

The Rural Health Trifecta will provide one event for rural hospitals, health professionals and critical access hospitals. Visit TRHA's web site at www.texashospital-online.org/trifecta for more information and to register.

Indiana Rural Health Association awarded grant to expand network

The Indiana Rural Health Association (IRHA) recently received an \$180,000 grant that will be used to expand the Indiana Statewide Rural Health Network (InSRHN), a formal network comprised of rural health organizations and providers in Indiana.

The InSRHN also received a recommendation for the same award over the second and third years of the project from the Department of Health and Human Services Health Resources and Services Administration. The federal grant will fund 90 percent of the network's operating costs over the three-year project.

“The IRHA staff and InSRHN board of directors have worked hard during the planning phase of this project with great anticipation of receiving this grant award,” says IRHA executive director Don Kelso. “We see an unprecedented opportunity for Indiana to move into the 21st century in regard to information technology and connectivity.”

Connecting to health care in rural Illinois

The Illinois Rural Health Net (IRHN) is the creation of a coalition of universities and rural health care providers that collaborated to receive a \$21 million grant from the Federal Communications Commission. The FCC awarded \$417 million to 42 states and three territories for improvement to rural health care through Internet connectivity.

The IRHN will provide a fiber optic, point-to-point and wireless communications network connecting hospitals and clinics from Galena in northern Illinois to Metropolis at the southern tip. IRHN will be launched through Northern Illinois University in DeKalb and 11 other hospitals and universities.

“Rural health care is significantly impacted by the lack of transportation resources and an inability to access specialty care,” says Harry Wolin, CEO of Mason District Hospital. “This infrastructure will not only provide improved access to specialists, but it will also permit the full utilization of electronic health records.”



Eastern Washington Diabetes Network awarded grant

With a Washington State Department of Health grant of almost \$10,000, the Eastern Washington Diabetes Network (EWDN) hopes to increase awareness of diabetes prevention strategies and education and strengthen the internal network of health care providers, researchers and educators.

“We are hoping that we can make a bigger impact,” says Jennifer Polello, EWDN leader and health education manager for the Inland Northwest Health Services O.C. Olson Diabetes Education Center.

The growing EWDN is comprised of more than 90 individuals from a variety of local and regional organizations who have teamed up to pool their resources, enabling patients across the region to get the best diabetes care and education. This is especially important in the rural communities.

“Our rural partners are getting hit harder by diabetes,” Polello says. “EDWN started off as a Spokane-based network, and we quickly realized that we had a problem in our rural communities. Now they know what resources are available.”

CDC has free information to help educate parents about childhood development.



Developmental Milestones Fact Sheets



Waiting Room Poster



Disability Fact Sheets

Autism can often be recognized at 18 months or younger. The Centers for Disease Control and Prevention (CDC) has prepared materials to help health care professionals inform and educate parents about childhood development, including the early warning signs of autism and other developmental disabilities.

Visit www.cdc.gov/actearly to download materials or request a FREE kit.



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