

rural roads

Spring 2010 National Rural Health Association



On a mission:

Pharmacists serve remote Alaska island

Wellness is contagious at rural hospitals

HPV programs promote prevention

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Community Matters



On May 19-21, we'll gather at NRHA's Annual Rural Health Conference in Savannah, Ga., where the theme is "community matters."

What are the community matters we should care about? I hope each of us would say the health of every citizen.

The local attitude toward community and economic development is also an issue. Housing and basic infrastructure may also be under discussion. Will there be enough EMTs to meet needs? Most of all what matters is who is leading the planning and implementation. Who crafts the vision?

Let's work for ways to advocate from a community vantage point for the health of our rural friends and neighbors. Join me in May to explore how we can use the power of our rural communities to advocate with and for them.

See you in Savannah.

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

Dennis Berens
2010 NRHA president

pit stop

5 things I picked up in this issue:

1. The tallest resident of Wilmington, Ill., stands two stories high. *page 35*
2. Even after 20 successful years in L.A., rural roots run deep enough to bring one Nebraska girl home. *page 28*
3. Half of sexually active men and women will become infected with HPV at some point. *page 20*
4. One professor created a physical therapy service learning program for high school athletes on an American Indian reservation. *page 26*
5. A 15-foot rock python hide hangs behind the cash register at Whale Tail Pharmacy in Alaska. *page 6*

ON A MISSION:

Pharmacists serve remote island

By Lindsey V. Corey



Prince of Wales Island, Alaska. Above: Bill Altland plays checkers with an island resident at Whale Tail Pharmacy. Right: Bill and Sarah Altland opened Prince of Wales Island's first pharmacy in 2001. Photos by Alison Quigley.



Bill and Sarah Altland are always on a mission, and often on the go.

From Arkansas to Zaire, the pharmacists have spent their 30-year marriage serving the underserved in remote areas.

Their focus was on helping others. There was always food on the table, but income was an afterthought.

A volunteer opportunity at a mission clinic brought them to rural Alaska a decade ago. For a year, Sarah served as an unpaid pharmacist in Glenallen, while Bill relieved pharmacists across Alaska.

“We’re both from small towns in Arkansas, and we knew we liked Alaska so I filled in at about 20 places around the state to make grocery money and to find a job,” he says. “I can’t describe it; I just had a good feeling about this place.”

Soon the couple was headed for an even more remote assignment on the country’s third largest island. Bill and Sarah shared the sole pharmacist position at an Alaskan Native clinic, one of two clinics on Prince of Wales (POW) Island.

A whale of a tale

Word spread on the island, population 3,600, that two pharmacists had moved in, and the Altlands were encouraged to open POW's first drug store.

"We didn't come here with the intent to run a business, just the vision of helping people," Sarah says. "But everyone was so supportive, enthusiastic and grateful. Even though it provides us with a livelihood, we see it as a mission in a way."

In 2001, the Altlands opened Whale Tail Pharmacy in Craig, the island's "hub," population 1,100.

"Even before we opened, both clinics were calling," recalls Bill. "So I

"We didn't move here with the intent to run a business, just the vision of helping people."
Sarah Altland, Whale Tail Pharmacy co-owner

feel like we really fill the need. It's a responsibility we've created in the community, but the need was there all along."

Tina Bell, a long-time local nurse, realized the need several years earlier and had researched the viability of starting an independent island pharmacy but shelved the idea when recruitment efforts failed.

"When the Whale Tail opened, the whole island was ecstatic," Bell remembers. "No more waiting for flown in or mailed prescriptions. Not to mention we have two wonderful people in our midst that have big hearts and try to accommodate every need."

At the clinic, Bell says, "I was the pharmacy," typing labels and requesting meds be flown in from what was the closest pharmacy in Ketchikan, Alaska.

"It was often touch and go because of the weather and caused quite a bit of nail biting when we had a really sick patient," she says.

From Craig, Ketchikan is a three-hour ferry ride followed by a 45-minute drive on a good day. In case of emergency and with clear skies, it's a 45-minute flight.

So Whale Tail, possibly America's most remote pharmacy, maintains a larger inventory than most pharmacies its size, according to Bill.

"We don't always get mail and drug orders regularly," Sarah says. "Sometimes we go four or five days without, and then we can get three or four orders at a time. It can be overwhelming, but people have a great attitude here. They're very understanding and willing to work with us."

Some Whale Tail customers drive four hours to the pharmacy, but ordering prescriptions online doesn't seem to be an option, Bill explains.

"Folks here rebel against that," he says. "The main problem is that mail comes by float plane and is often delayed because of inclement weather, and they'd miss doses if it's not received in timely manner. There can be 10 days between planes with mail. These folks also really seem to like having a relationship with a pharmacist."

Mom and pop apothecary

About the island Prince of Wales (POW) Island, Alaska

POW is the **third largest U.S. island**, following the Big Island of Hawaii and Kodiak Island, also in Alaska. It is **135 miles long and 45 miles across** at its widest point.

The POW archipelago includes the main island and hundreds of adjacent islands, more than **2,600 square miles**, with nearly **1,000 miles** of coastline.

3,600 people live on the island, but that goes up as much as **50 percent** in the summer when tourists arrive for salt and fresh water fishing.

About **one-third** of the island population is Alaska Natives, primarily from **two tribes**: Tlingit and Haida.

Most of the island is government-owned, including the Tongass National Forest, the largest national forest in America. Government jobs are most common, followed by logging and commercial fishing.

The Japanese current of the North Pacific Ocean controls POW's climate and generates **60-200 inches** of annual precipitation. The mean temperature range is from **35 degrees** in January to **58 degrees** in July. The longest day has **15 ½ hours** of daylight; the shortest has **7 hours**.

POW has more roads than the rest of the entire Southeast Alaska region, about **2,000 miles** counting the many miles of logging roads.

There are **11 communities** on the island; two can only be reached by boat.

POW has no hospitals. There are **two clinics**; the frontier extended stay clinic can keep people overnight. There are also several part-time satellite clinics.

There are **two banks** on the island, both in Craig, **population 1,100**.

The island boasts more than **600 caves**.

The Prince of Wales Island International Marathon is in its **11th year** and draws **300 runners**.

continues



Whale Tail Pharmacy, Prince of Wales Island, Alaska

The Altlands know most of their patients, and their patients know them. “I guess the downside is that in a small community, people know more about you than you ever realized,” Sarah says. “We get calls at home a lot saying they forgot to pick up their medication or their dog is really sick. We’re pretty easy and go get it for them. It’s a plus and a drawback. We give, and they give back in a way that doesn’t happen in metro areas.”

Bill says he often gets asked about medications on the ferry or in church. “I like answering my neighbors’ questions or just shooting the breeze about our kids, life or whatever,” he says. “People know each other and support each other, and we like that. Where we live is more important than income. We’ve spent a big part of our careers as volunteers and aren’t motivated by a higher salary but by quality of life, which is relative, I guess. “Living where we live is not for everybody. It’s hard to recruit. There’s no Wal-Mart or McDonald’s. It’s kind of like going back a few decades in time.”

Bill refers to Whale Tail as a “mom and pop apothecary.” He and Sarah split their time there, each working part time with Bill still providing some relief to independent pharmacists and Sarah handling the books.

“We learned over the years that we live together better than we work together,” he laughs.

Their second daughter, 20, instituted a ban on business talk at the dinner table, so the couple has weekly staff meetings and breakfast dates at the local café on Thursday mornings.

They’ve hired two full-time pharmacy technicians. Their oldest daughter,

now 25, filled in as a tech during college breaks.

Their youngest, 9, serves as “sanitation

engineer,” Sarah says. She cleans on Saturday mornings for allowance.

And their son, 16, and his best friend added to the apothecary’s ambiance with a 3-foot Star Wars death star made of Legos. Smaller Lego creations made by smaller people line the counter with artist credits. Children also regularly submit paintings for public display.

“Sometimes moms will ask if they can leave the kids in the play corner while they run an errand or something,” Bill says. “People stop in for coffee or checkers, and we encourage that.”

“When the Whale Tail opened, the whole island was ecstatic.”

Tina Bell, local nurse


After hours, the pharmacy hosts jam sessions with Bill on harmonica, Al-Anon meetings, book clubs, Bible studies and Socrates Café (a philosophical discussion group).

“You’ve got to make your fun on the island a lot of times,” he says. “Folks are creative and most folks know each other, so it’s an opportunity to get together and use the space for other things.”

The island population grows as much as 50 percent in the summer with tourists and commercial fishers, and new customers almost always remark on “our dead animal,” Sarah says, referring to a 15-foot rock python hide hung behind the cash register.

“In Alaska, when you go into somebody’s home, there’s usually a dead animal on the wall... moose, deer, sheep,” Sarah says. “We don’t hunt. But we do have this giant snakeskin tanned by a group of disabled young people while we were living in Zaire, now the Congo. That’s a popular attraction. Nothing fancy, but we like to put our personality into the business, even though it’s really about the community.”

Bell named the pharmacy even before the Altlands arrived on Prince of Wales Island.

“One day while fishing a huge humpback whale breached the water right in front of my boat and then slapped its tail down and just missed us,” she says. “After we calmed our nerves, we decided Whale Tail Pharmacy had a nice ring to it. We’re so lucky to have it and thankful to have the Altlands as part of our island family.” 

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Wellness is contagious

at rural Texas hospitals

By Lindsey V. Corey



Kathy Whelchel and Debra Wells were part of the “Future Little Women” wellness team at Golden Plains Community Hospital.

After 25 years, Kathy Whelchel is smoke-free.

And that’s freeing, she says.

“When you need nicotine, it’s all you think about,” she remembers. “I probably smoked 10 years before I even realized I couldn’t lay them down. It’s the most agonizing feeling, crippling really. So you can just imagine what a difference quitting has made.”

Whelchel smoked three packs a day, most of those cigarettes with coworkers in the parking lot of Golden Plains Community Hospital in Borger, Texas, where she works as medical staff secretary.

She’d quit once for about four months with the help of nicotine patches, but this time was different, Whelchel says. The critical access hospital in the Texas panhandle offered the LoneStart Wellness initiative to its 180 employees and provided financial incentives for improved health.

“I think the program worked because you have so much camaraderie with your

continues

coworkers,” she says. “They’re there to support and help and when you fail, to pick you up and carry you through the next day and vice versa. It’s just a good basic program. They don’t beat you down; they lift you up and make you aware.”

“If hospitals can’t set the standard in health care, we’re all in the wrong business.”

Dennis Jack, Golden Plains Community Hospital administrator

Whelchel, 59, says she’s grateful to administrators for offering the program in 2009 and again this spring. When she started with 88 hospital staff last time, Whelchel was motivated by fear after a cardiologist found blockages in her heart.

This time, her success is her motivation for weight loss.

“I conquered a huge problem I had for so long, and now I feel like I can do anything,” she says. “My attitude is so different now. I’m excited because I’ve gained so much confidence that I’ll beat this too.”

A growing population

There is one fast food restaurant for every 1,500 Americans.

It takes a 3,500 calorie deficit to lose one pound of weight.

Most Americans walk less than 300 yards a day. Walking the length of a football field burns the calories in one M&M.

In 1970, the average French fry serving size was 2.5 ounces. Today it’s 7.4 ounces.

The Honda Accord sold in the United States has front seats two inches wider than those in the same car sold in Europe and Japan in order to handle the extra girth of the American consumer.

For every two hours of TV watching, there is a 23 percent increase in obesity.

Between 1977 and 1997, soft drink consumption doubled in the United States. So did the number of obese Americans. One-third of teen boys drink at least three sodas a day.

During the last 10 years, the U.S. airline industry spent an extra \$27.5 million per year on fuel due to heavier passengers.

Since 1991, the number of Americans considered morbidly obese has increased more than 74 percent.

The Social Security Administration pays more than \$77 million per month to those who meet obesity requirements for disability.

5 percent of bariatric surgery patients reach and maintain their target weight.

60 percent of American adults want to lose at least 20 pounds.

Source: LoneStart Wellness

And while she’s at it, she’s hoping to help coworkers kick the smoking habit.

“Knowing that other people are looking at stopping because they saw I did it makes me feel pretty good,” Whelchel says. “I tell them if I can do it, I know they can. The extra support made all the difference to me.”

Viral wellness

That support is spreading in Borger, population 12,700.

After seeing Golden Plains participants boasted 4.65 percent total weight loss, Dennis Jack, hospital administrator, challenged the local school district to try the program.

Second-grade teacher Elizabeth Dickerson hadn’t felt well for awhile, but decided she was too busy to see a doctor while preparing for her classroom.

“Employees take their improved habits home, and suddenly we’re helping the next generation.”

Dennis Jack, Golden Plains Community Hospital administrator

“As educators, we spend many hours working for the welfare of others. We often neglect our needs, which could cause us to let health issues go unattended until we’re on the verge of disaster,” she says. “When I began the (LoneStart) health screening at the school, everything looked pretty good until my blood pressure reading. It was out of sight. I found myself in the E.R. for the remainder of the day. The day could have ended by having a heart attack or stroke, but instead I began taking care of my health.”

Dickerson, 58, completed the wellness challenge with about 250 other school district staff. Her blood pressure is now at an acceptable level.

“If hospitals can’t set the standard in health care, we’re all in the wrong business,” Jack says. “In my humble opinion, hospitals today are not health care, they’re ill care. I want this to be a place to help people get healthier. I want them to think about us for both. We need to work on community health, or we’ll lose the battle.”

Jack also offered LoneStart packets to local businesses at cost. About 1,000 more people signed up.

“It could have a major impact,” he says. “And it’s fairly



“The Golden Girls” team won Golden Plains Community Hospital’s 2009 wellness challenge with a total of 9.1 percent BMI reduction. Each team member won \$150, and Pam Trout, second from right, lowered her BMI 15.2 percent to win \$350. Left to right, Elaine Feese presents a check to Sherry Kramer, Judy Cassetty, Trout and Becky Peery.

simple stuff that you can carry with you for the rest of your life. Eat less, move more. Employees take their improved habits home, and suddenly we’re helping the next generation.”

Caring for caregivers

Golden Plains is one of 18 Texas Organization of Rural and Community Hospitals (TORCH) members to take advantage of discounts through LoneStart.

“It’s simple to sustain a wellness program. It’s really just picking a time to promote lifestyle changes.”

Dave Pearson, TORCH president and CEO

A 2005 survey of member hospitals indicated containing employee health care costs was their most pressing concern.

Golden Plains institutes a self-funded insurance

operation, so Jack says claims hit the hospital’s bottom line harder.

“Health care workers are about the lousiest group to insure,” says Jay Seifert, LoneStart Wellness cofounder. “When your mission is to care for someone else, you tend, for some screwy reason, to not take good care of yourself. People want to get healthy and are almost desperate for a chance

continues

Big spenders

Chronic illnesses account for **75 percent** of our national spending on health care.

80 percent of these illnesses are caused by preventable health behaviors: physical inactivity, poor nutrition and smoking.

-Robert Wood Johnson Foundation

More than **50 percent** of corporate profits go toward health care costs vs. **7 percent** 30 years ago.

-American Institute for Preventative Medicine

For every **\$1** companies spend on wellness programs, they save up to **\$6** on employee health benefits. That’s a **600 percent** return on investment.

-National Business Group on Health and Research Triangle Institute

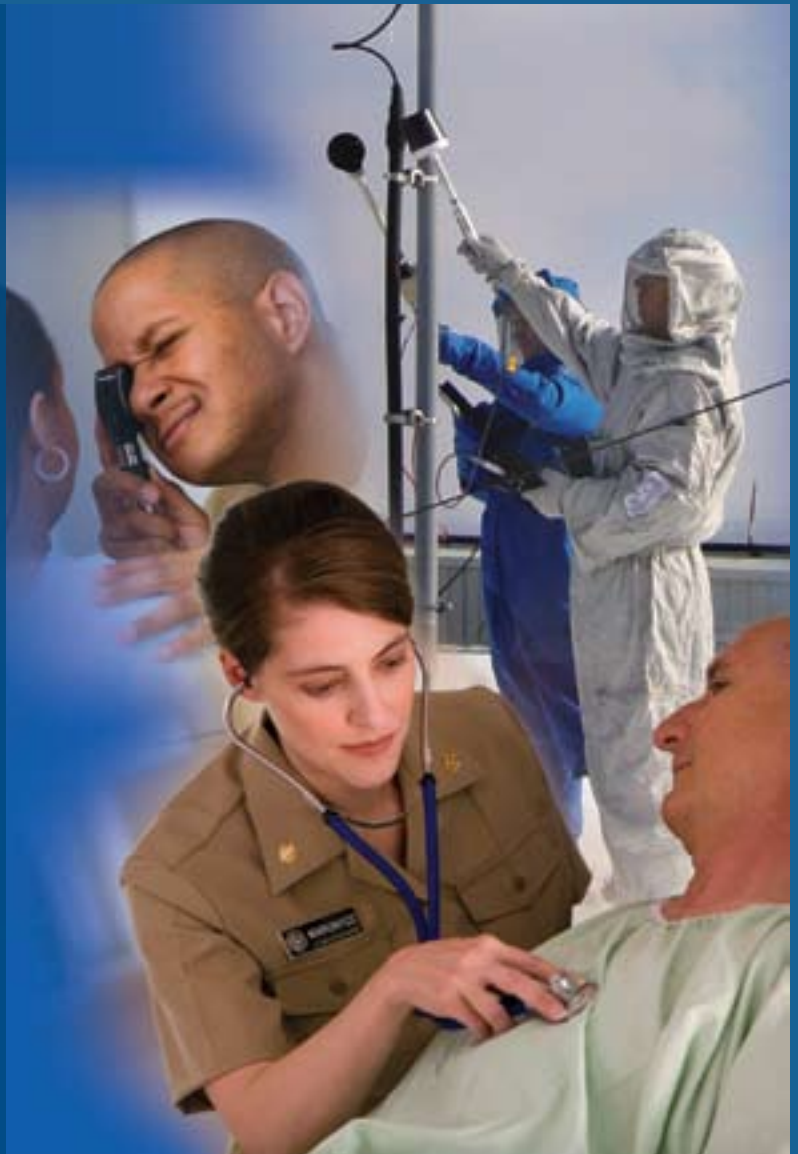
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continued

to prove to themselves that they can. They just often don't have the expectation in their heart that they can be successful because of their own personal history. It's not earth-shattering; a little initiative, a reasonable amount of common sense and very little money can go a long way toward reducing preventable chronic illness."

Each LoneStart participant is evaluated on five health indicators: body mass index, blood pressure, cholesterol, glucose and smoking. Jack chose to reward Golden Plains employees with \$100 for each of the five indicators they improved at the end of the 63-day challenge. (Non-smokers automatically earned \$100.) Three-person teams also competed for additional monetary prizes, and a total of \$19,000 in bonuses were paid in December.

"We invested a significant dollar contribution in this," Jack says. "But it actually was a savings."

For each of the past five years, the hospital's employee insurance costs rose 10 percent. After completing the first wellness challenge, Jack says the hospital paid less out of pocket and didn't increase costs or premiums, according to Jack.

continues

You are what you eat

The average American makes between **120 and 200** food decisions each day. Most are not triggered by hunger.

The average American eats about **1,800** pounds of food per year or about five pounds per day, including **152** pounds of sugar each year.

The average American also downs (annually):

64 pounds of beef	55 pounds of fats and oils
57 pounds of chicken (about 27 chickens)	300 cans of soda
50 pounds of pork	200 sticks of gum
14 pounds of turkey	80 quarts of ice cream
236 eggs	18 pounds of candy
200 sandwiches	5 pounds of potato chips
60 hot dogs	63 dozen donuts
	70 pounds of cookies and cakes

The average American eats fast food **72** times a year, drinks **9.5** pounds of coffee and eats about **35,000** cookies in their lifetime.

Source: LoneStart Wellness

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“Everyone was really jazzed we’ve started it again,” he says. “Is the money part of it? Sure, but I think the education and competition are drivers too. You see people standing by the elevator and getting nudged to take the stairs. It’s improved morale. People realize we do care about them. And as an employer, a healthy workforce is a more productive workforce.”

Whelchel, who’s been on Golden Plains staff since 1986, says she was always a hard worker “between smoke breaks.”

“It’s amazing how I can sit in my office all day and it not bother me,” she says. “My productivity has probably gone up 40 percent because I’m able to focus and get on a project and stay on it.”

Whelchel says she didn’t do it for the money; giving up cigarettes already saves her \$300 a month.

“What a life change,” she says.

Hospitals getting healthy


Dave Pearson, TORCH president and CEO, says LoneStart’s behavioral wellness model resonated with members on a budget. Not all hospitals provide monetary incentives and still see success, so Pearson says it’s affordable to small employers.

“It’s so perfectly in tune with what we’re all trying to accomplish,” he says. “Whether the hospital delivers babies or does surgeries or not, wellness is all-encompassing, so all of our members can participate and see a benefit with modest effort. It’s simple to sustain a wellness program. It’s really just picking a time to promote lifestyle changes. Our goal is to get more hospitals to provide this as an evergreen benefit for their employees and community.”

He says wellness programs are especially important in rural areas, where chronic disease rates are higher and on the rise.

“You often have an education system that doesn’t deliver health education anymore, so there’s a lack of information,” Pearson says. “And most jobs are sedentary now, not physical labor like they used to be. Add to that the fact that healthy food isn’t as available as it should be, and people don’t make good nutritional choices.”

Since 80 percent of chronic illnesses are caused by three preventable health behaviors, physical inactivity, poor nutrition and smoking, Pearson says he hopes more employers offer similar programs.

“In all the discussion about how to give everybody insurance, the biggest health care reform factor isn’t access to insurance,” he says. “The cost of health care is too much. The system is stressed taking care of people who have issues that were perhaps preventable. We want to get to the foundation and get people to take personal responsibility for their health, not just in Texas, not just in hospitals, everywhere.” 

Startling statistics

In the next hour, **120** Americans will die of heart disease. Cardiovascular disease is the leading cause of death and illness in U.S. adults, and the prevalence is disproportionately high in underserved populations.

In the next hour, there will be **170** cases of type 2 diabetes in this country, and it will claim **33** lives.

150 Americans will have an amputation today due to type 2 diabetes.

Type 2 diabetes has increased **1,000** percent in the last 30 years and is projected to double in the next 10 years.

Lung cancer is the **second-most** commonly diagnosed cancer in both men and women. And it is the most common cause of cancer death.

COPD, also known as emphysema and chronic bronchitis, is the **fourth** leading cause of death in the United States.

Two-thirds of all physician visits result in a drug prescription, and **50** percent of American adults now take prescription drugs.

Sources: American Lung Association Centers for Disease Control, and LoneStart Wellness

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workable plan evolved.

- **Pressing:** Their rural location required a connection to major emergency care; a heli-pad was designed and built for transfer to the closest trauma center.

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Veterans' mental health care hits closer to home

By Angela Lutz

Telemedicine is all about coming closer.

For rural veterans who are geographically isolated and physically or financially unable to travel long distances, moving care to community-based outpatient clinics (CBOCs) by using telemedicine to connect to main Veterans Administration (VA) facilities has been invaluable to improving access.

"We're trying to go to them rather than make them come to us," says Dean Robinson, MD, chief of mental health services based at the Shreveport, La., VA Medical Center, who has been using telemedicine to provide mental health care to rural veterans for seven years. "I have vets who have driven three and a half hours to get to clinics. If we can lower the burden, they'll be more likely to fully participate."

Telemedicine is also about overcoming challenges.

In 2001 the VA mandated that CBOCs be equipped to provide mental health services, and Kathy Henderson, MD, mental health product line manager for the South Central VA Health Care Network, which extends from the panhandle of Florida to the panhandle of Oklahoma, knew telemedicine was the only viable solution.

"We had always provided mental health services at our large facilities, but only a few clinics actually had mental health providers," she says. "It's very hard to find a full complement of mental health professionals out in rural America. Because we are a rural network, the only way we'd be able to get mental health services to very rural areas was to use telemedicine."

Improving access

Over the last decade, telemedicine solutions have expanded to allow veterans to seek treatment closer to home for everything from wound care to dermatology and spinal cord injuries to eye exams. The 21 Veterans Integrated Service Networks across the country offer telemedicine options at most of their 700-plus CBOCs.



By utilizing real-time videoconferencing equipment to link main Veterans Administration facilities to community-based outpatient clinics, psychiatrists cut down on costs and travel for rural veterans needing mental health care.

Available technologies fall into one of three categories: general (or real-time) telehealth, which utilizes videoconferencing equipment to connect patients directly to doctors; home telehealth, which allows veterans to respond to prompts and monitoring questions from home; and store-and-forward telehealth, in which digital images, sounds and video are collected and forwarded to another site for clinical evaluation and diagnosis.

"Because we are a rural network, the only way we'd be able to get mental health services to very rural areas was to use telemedicine."

Kathy Henderson, South Central VA Health Care Network mental health product line manager

"For example, in Bismarck, N.D., they might not have a dermatologist, but we have plenty in Minneapolis," explains Peter Kaboli, director of the VA Office of Rural Health Midwest Rural Health Resource Center in Iowa City, Iowa. "We can send those images to Minneapolis and get the diagnosis without sending the patient there."

Tele-mental health services have also grown, and in the first four months of 2010, Henderson says tele-mental health providers from VA facilities have seen more than 2,000 patients at CBOCs. The availability of this care has been tremendously beneficial to veterans.

"Patients with mental health problems won't travel as far to receive mental health services as patients with physical problems," Henderson says.

“For a lot of patients, it’s very hard to come to facilities – they live four to five hours away, whereas a clinic might only be an hour away. It improves access for veterans who not only need to be assessed for mental health conditions but also to be treated.”

And according to Robinson, improved access to care during treatment causes veterans to increase the frequency of their visits, which lowers costs by decreasing relapse and the need for hospitalization.

Telemedicine has also proven cost-effective by making the most of human resources.

“We’re trying to go to them rather than make them come to us.”

Dean Robinson, Veterans Administration psychiatrist

“You can deliver the same services from a facility instead of seeing a patient face-to-face,” Henderson says. “It’s much cheaper than hiring a professional to be at the clinic.”

Overall, veterans’ reactions to receiving evaluations via general telehealth have been positive, and some have even said they prefer videoconferencing to speaking with a live psychiatrist. Even older veterans who are less tech-savvy and were initially skeptical have gotten comfortable with the technology after using it a few times.

“If you can make the technology as glitch-free as possible and provide what they need, they’re very accepting of it,” Kaboli says.

And for veterans who can’t or won’t adjust to the technology, in-person sessions with psychiatrists are still available at VA facilities.

“Over the last six to seven years, only a couple of people have said it’s not for them,” Robinson says. “It’s voluntary, and patients can get face-to-face therapy if they want. But the vast majority have been grateful they don’t have to travel as far.”

The availability of mental health services at primary care clinics has also helped veterans overcome the stigma still associated with treatment in many rural areas.

“The expectation that they may be looked at as ‘crazy’ can be hard for them,” Robinson says. “You don’t get that same environment at the CBOCs. That kind of subtle change in setting really does increase the comfort level a lot for some people.”

Meeting expectations

As accepting as patients have been of telemedicine, there has been more of a learning curve for some rural providers. Even after getting over the barrier of learning to use the equipment, many psychiatrists have questioned the quality of the outcomes.

“They’ve had some concerns about whether it would be as useful or

produce the same favorable outcomes as face-to-face visits,” Henderson says. “Research shows it does, but they’ve felt a little uncomfortable with certain patients, especially if they’re suicidal or actively psychotic.”


As research continues to show telemedicine is as effective as face-to-face therapy, however, health care providers have grown more confident.

“It’s still a new thing, so we have to ensure providers they’re offering quality care,” Robinson says. “The barriers are pretty insignificant in comparison to the benefits.”

Robinson is excited about future options, and he’s studying the effectiveness of using telemedicine to treat post-traumatic stress disorder, which requires treatment once a week for a minimum of two months. He also hopes to eventually treat bipolar disorder, substance abuse, and other conditions with high rates of relapse, and he is confident that the technology can grow with the health care expectations of the new generation of veterans.

“[Recent] vets are younger and have different expectations regarding access to health care,” he explains. “They’re going to drive a lot of change in the VA. They’re fond of electronic communications with rapid response times, such as text messages and e-mail.”

And as internet connectivity and video technology continue to improve and lower in cost, Robinson sees home telehealth services expanding and becoming more prevalent.

“It’s not too far-fetched to imagine that we may have a secure Skype connection with people at home while they’re in the comfort of their own living room,” he says. “The technology has improved so dramatically that I see the future VA as something that intermingles with video, texts and e-mail at vets’ own homes.” 

Connecting to care

Learn more about the telemedicine programs in this article and discover additional ways rural health professionals are using technology to connect veterans and other rural residents to care at NRHA’s 33rd Annual Rural Health Conference May 19-21 in Savannah, Ga.

Visit www.RuralHealthWeb.org/annual.

Promoting prevention: HPV programs increase awareness

By Angela Lutz

Especially when it comes to their health, women want the facts.

And when it comes to the Gardasil vaccine, which became available in 2006 and prevents the two high-risk types of human papillomavirus (HPV) that cause 70 percent of cervical cancer cases, many women still have questions: what is HPV? What is the best age to vaccinate? What options do parents have?

To help separate facts from myths, Dolores Scott, health ministry program director to the State Baptist Young Woman's Auxiliary (YWA) of the Woman's Baptist Education and Missionary Convention of South Carolina, has been working to educate rural and minority communities about the vaccine and the connection between HPV and cervical cancer.

"The vaccine brought the risk to their attention and to the face of the community," she says. "They learned African-American women were one and a half times more likely to be diagnosed with cervical cancer than their counterparts."

"It's hard to think the things you do today will affect you years down the road. Getting people to understand that is so important."
Baretta Casey, University of Kentucky Center for Excellence in Rural Health director

According to the Centers for Disease Control, 20 million Americans are currently infected with HPV, making it the most common sexually transmitted infection. There are more than 40 types of the virus, and approximately half of sexually active men and women will become infected at some point,



University of Kentucky researchers educated rural Appalachian women on the Gardasil vaccine, which prevents high-risk types of HPV that cause 70 percent of cervical cancer cases.

though most will remain asymptomatic.

"The majority of infections will regress or clear over time," explains Jessica Bellinger, PhD, South Carolina Rural Health Research Center (SCRHRC) post-doctoral fellow. "But certain high-risk types stay in the body longer. Most cervical cancers are due to these persistent HPV infections."

Though HPV is common, cervical cancer in the United States has become fairly rare. Since the pap test became widely available in the mid-20th century, cervical cancer mortality has decreased by 75 percent, and for women between the ages of 21 to 70 a pap test every two to three years is a reliable tool for detection and prevention.

But as women's levels of education and income decrease, so does the likelihood that they will get regular pap tests. According to a study in the December 2009 issue of *The Journal of the South Carolina Medical Association*, women living in poverty with less than a high school education are nearly 25 percent less likely to have gotten a pap test in the last three years than their more affluent, college-educated counterparts.

And according to Bellinger, rural residence and insurance status also contribute to differences in care. An SCRHRC study examining racial, ethnic and geographical disparities in preventive services found rural women were less likely to have received pap tests than urban women. And while the screening rate among insured rural women is close to the Healthy People 2010 goal of 90 percent, uninsured rural women still have lower rates of approximately 73 percent.

“When you look closer, certain groups are still dying of cervical cancer at higher rates,” Bellinger says. “[Prevention efforts] should lead to equitable reductions in mortality among all women, but we didn’t see that drop in rural and minority populations.”

Spreading the word

To ensure disparities don’t continue to widen, health care and community leaders such as Bellinger and Scott are reaching out to communities across South Carolina, which ranks 14th in cervical cancer mortality.

To determine rural women’s knowledge of HPV, a research team led by Heather Brandt, PhD, from the University of South Carolina Arnold School of Public Health conducted a statewide telephone survey. Nearly 77 percent of the 1,000 respondents were accepting of an HPV vaccine for themselves or their daughters, but less than half had high knowledge about the virus and its connection to cervical cancer.

“Many women didn’t know HPV was sexually transmitted,” Bellinger says. “The vaccine is recommended for girls 11 to 12 because it is preventive, not therapeutic. The earlier you get it, the more protection you have against high-risk types of HPV.”

After gauging communities’ needs, Bellinger, Scott and the State Baptist YWA, and the South Carolina Cancer Disparities Community Network began working with area leaders to spread the word about prevention.

In 2007 the partners held a summit, “A Call to Action: Preventing Cervical Cancer among African-American Women,” where they taught 190 men, women and teenagers about prevention. Then, based on strategies identified by communities, they began

conducting local educational activities explaining the connection between HPV and cervical cancer and how both can be prevented, including where vaccines and screenings are available.

“We made presentations to women and parents in the community,” Scott says. “It’s all about making sure individuals have the information they need.”

“[Prevention efforts] should lead to equitable reduction in mortality among all women, but we didn’t see that drop in rural and minority populations.”

Jessica Bellinger, South Carolina Rural Health Research Center post-doctoral fellow

To have an even greater influence, the partners also reached out to affiliated churches within the Baptist Educational and Missionary Convention, which is comprised of 1,500 churches in South Carolina and is the largest African-American Baptist group in the state.

“We held forums for ministers, who are the gateway of entry into the congregation,” Scott says. “The members go to the pastors about different things, and we wanted to make sure they were educated on cervical cancer themselves. We also held educational sessions for all members and community residents.”

Utilizing the National Witness Project, which was developed by the University of Arkansas to educate women about breast cancer, they educated congregants on HPV and cervical cancer as well as breast cancer. And

using the simple, inexpensive option of church bulletin inserts, they have reached more than 7,000 people in January alone.

“Our goal was to make sure people had enough information to make a decision based on education and not based on myths,” Scott says. “Our goal was not to help them make a decision but to provide them with the information to make a decision that was best for them.”

An informed decision

In Hazard, Ky., Baretta Casey, MD, University of Kentucky Center

Added insight

Meet the women and men behind the programs in this article and discover other innovative ways rural health care leaders are using research and community outreach to prevent HPV and cervical cancer at NRHA’s 33rd Annual Rural Health Conference May 19-21 in Savannah, Ga.

Go to www.RuralHealthWeb.org/annual.

continued



Jessica Bellinger, PhD, South Carolina Rural Health Research Center post-doctoral fellow, left, and Deidre Odom, State Baptist Young Woman's Auxiliary president, held a workshop educating rural minority women on HPV and cervical cancer prevention at Mt. Pisgah Baptist Church last fall.

for Excellence in Rural Health director, is also working to eliminate disparities by helping rural Appalachian women overcome the barriers that prevent them from receiving the HPV vaccine.

“I’ve been a family physician for over 20 years, and I saw a tremendous amount of cervical cancer among women in rural Kentucky,” Casey explains. “I wanted to do everything we could to prevent a cancer we actually have a prevention for.”

To assess reasons for low HPV vaccine uptake, Casey and researchers from the University of Kentucky recruited 400 women from an area community college and clinics to receive the vaccine.

Researchers discovered many women haven’t been vaccinated for the same reasons other health care disparities exist – access, transportation and cost – but also because the vaccine is administered in a series of three shots, which increases travel and time off work and decreases the likelihood that a woman will return for all three doses. Especially in rural Kentucky, Casey also struggled with the barrier of cultural beliefs.

“Many young and even adult women who are married look to others for consensus or acceptance of receiving the vaccine,” she says. “There’s stigma surrounding it – if we vaccinate children, are we giving them the presumption that it’s okay to have sex? Do parents want their young girls – and soon boys – to receive the vaccine?”

To clear up misconceptions, the University of Kentucky research team educated the community by distributing informational handouts at the local Wal-Mart, family resource centers and schools, hosting get-togethers and forums, and writing articles for publications.

“[Many community members] didn’t realize there was a myriad of viruses out there,” Casey says. “They didn’t realize the vaccine was to prevent contracting the disease, and giving them that knowledge helped them make a good, informed decision.”

HPV is more common than you think.

- There are more than **40** varieties of human papillomavirus (HPV).
- Approximately **20 million** Americans are currently infected with HPV, making it the most common sexually transmitted infection.
- **50 percent** of sexually-active men and women will contract HPV at some point.
- In **90 percent** of cases, the body’s immune system will clear HPV within **two years**.
- Each year, approximately **12,000** American women get cervical cancer. Most of these cases are caused by persistent HPV infections.
- Because cervical cancer shows no symptoms until it’s advanced, women need to get screened regularly.


To learn more, visit www.cdc.gov/hpv.

Even after overcoming the barrier of education, the issues of access and cost remain. One step toward overcoming these obstacles was the passage of the Breast and Cervical Cancer Prevention and Treatment Act in 2000, which has helped establish free cervical cancer screening for eligible uninsured and low-income women, such as through the Best Chance Network in South Carolina.

But according to Bellinger, more public health policies addressing prevention and disparities need to be enacted to reach women living in poverty and geographic isolation.

“Awareness, education, getting women screened and following up as recommended are really important, as is addressing issues of availability of the vaccine,” Bellinger says. “We also need policies in place to address the disparities.”

Casey agrees, noting the importance of a health care system that promotes prevention.

“We need to make sure we understand the cultural beliefs and communicate with communities and groups to work together to come up with solutions accessible to all,” she says. “We also need a health care system that will focus on prevention. It’s hard to think the things you do today will affect you years down the road. Getting people to understand that is so important.” 



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Policymakers gain firsthand knowledge of rural Midwestern hospitals

By Lindsey Corey

Like it or not, Marty Fattig's staff works under federal regulations every day at the 20-bed hospital in Auburn, Neb.

"Policymakers out East essentially control our destiny," says the Nemaha County Hospital CEO. "So we believe it's very important to educate them on what rural is really about. They may think rural is 200 beds, but there's a big difference."

"Policymakers out east essentially control our destiny."

Marty Fattig, Nemaha County Hospital CEO

To increase understanding and foster communication, the Nebraska and Kansas hospital associations coordinated a rural health preceptor opportunity in November.

"After Centers for Medicare and Medicaid Services (CMS) issues a new regulation, we question 'what were they thinking,' or say 'they don't understand,'" says Kevin Conway, Nebraska Hospital Association health information vice president. "These statements foster the impression that policymakers have lost touch with the providers and develop rules in a vacuum."

Fifteen federal employees from CMS and Health Resources and Services Administration gathered in Omaha, Neb., to hear from a panel including a University of Nebraska Medical Center public health professor and a Kansas physician. They were then divided among eight critical access hospitals in Nebraska and Kansas for day-long tours.

Conway says more hospitals volunteered, but there weren't enough participants. Nemaha County Hospital was selected for its advances in health information technology, according to Conway.

"Just because you're rural doesn't mean you're

operating a 1900 hospital. We happen to be pretty techno savvy and very proud of it," Fattig says. "But we also wanted to show them the challenges we face and how some of their regulations really don't apply."

Policymakers who visited Auburn, population 3,350, also took part in a community meeting and toured the public health department, a physician clinic, pharmacies and the local nursing home.

"They got the whole ball of wax," Fattig says. "We don't own the nursing home but wanted them to see the continuum of care."

Preceptors visiting Wamego, Kan., population 4,300, met with staff at Wamego City Hospital and community leaders, who opened the Oz Museum after hours for them.

Nebraska hospitals hosted a similar program in 2004. Chad Austin, Kansas Hospital Association government relations vice president, says sunflower state hospitals welcomed the opportunity to participate.

"Regulations coming out of D.C. have a significant impact on rural communities, so it was great for these regulators to learn firsthand about the benefits our hospitals provide and the challenges rural providers face," he says. "Many of the attendees had not experienced a rural environment, so we really opened their eyes."

Robert Epps, CMS Medicare Operations acting branch manager and region VII rural health coordinator, helped recruit CMS staff for the experience and allocated travel funds.

"It's important to get our folks who are involved in policy or programmatic interpretations out into the real world."

Robert Epps, CMS Medicare Operations acting branch manager and region VII rural health coordinator


"It's important to get our folks who are involved in policy or programmatic interpretations out into the real world," Epps says. "They deal with these areas on a daily basis but have only a faintest notion of what goes on in a critical access hospital. They recognize that this is good background for the work they do."

National Rural Health Association and American Hospital Association representatives spoke at the debriefing back in Omaha following hospital visits. They discussed effects of policy changes

regarding designation of rural areas, physician supervision and limited service providers.

“It was nice to be able to provide a greater perspective about rural health,” Austin says. “I think we at least established relationships to become a resource to these people as they look at how rules will impact providers and patients throughout the state as well as the country.”

Fattig recommends the event be replicated even though the visit didn’t bring about immediate improvements for his southeast Nebraska hospital.

“You can work with delegation, but when you start trying to work with bureaucrats, that’s a whole different challenge,” he says. “But education is always good, and the more we try to improve communication through education, the better.” 

Counting CAHs

- CMS federal region VII (Iowa, Kansas, Missouri and Nebraska) has about **21 percent** of the nation’s critical access hospitals (CAHs).
- Kansas has **83 CAHs**, more than any other state, followed by Iowa with **82 CAHs**. Nebraska has **65**.
- The fall event marked the **third time** CMS and the Nebraska Hospital Association collaborated on rural preceptor programs for public officials involved in rural health. Previous events involved CAHs around Lincoln and Scotts Bluff, Neb.

Share your story.

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

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Contact Lindsey Corey at editor@NRHArural.org.
Editorial suggestions must not be advertisements.

Beginnings & Passages



Although balancing responsibilities is at times a challenge, it is also gratifying, as each day I am doing something I love.

Influential experience

By Patrick Cross

As a child growing up in the suburbs, becoming a rural health care practitioner and advocate never crossed my mind. My decisions to attend college at Truman State University and then further my professional education at Creighton University (CU) gave me invaluable skills and reshaped my thinking as to the type of population I wanted to serve.

The most influential experience that fostered this transformation was when I completed a three-month affiliation on two rural, underserved American Indian reservations in northeastern Nebraska.

My experience eventually assisted me in securing a position with CU in which I provided clinical and community physical therapy services to members of the tribes, offered students inter-professional training and service-learning experiences in rural areas, and worked as part of a team that wrote grants and produced scholarships related to student training. A few years later, one of the tribes independently hired me as director of rehabilitation services, and not long after, I became director of the Four Hills of Life Wellness Center. This allowed me to respond to the needs of this underserved, rural population through programming and grant attainment.

One of the activities I am most proud of is the initiation of acute sports physical therapy/first-responder services for the community's high school athletes. This initiative provides a service that was previously unavailable to this community and has given more than 100 physical therapy students the opportunity to participate in service learning that includes hands-on mentorship in the provision of culturally-competent assessment and treatment of acute athletic injuries.

Today I continue to maintain a clinical affiliation with the tribe but have also accepted a new challenge as assistant professor of physical therapy and director of the transitional doctor of physical therapy program at the University of South Dakota.

Although balancing responsibilities is at times a challenge, it is also gratifying, as each day I am doing something I love – providing clinical services in a rural setting and opening the eyes of students to the world of rural health through teaching/mentoring in academic, clinical and community settings.

Patrick Cross is assistant professor of physical therapy and director of the transitional doctor of physical therapy program at the University of South Dakota, physical therapist and director of rehabilitation for the Umonhon Tribe of Nebraska, and an NRHA Rural Health Fellow. He joined NRHA in 2008.

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

Innovative rookies and seasoned professionals share their experiences.

My scope and place of practice have, over decades, prepared me for this.



Meaningful work

By Randall Longenecker

For the past 28 years, I've had the wonderful opportunity to live in rural Logan County, Ohio, raise a family, care for patients from cradle to grave, and establish a rural residency in family medicine.

Practicing and teaching medicine in this community has been very meaningful work.

On one memorable morning it snowed – a lot! So when I received a call from the midwife who attends Amish women in home birth saying one of her patients was in labor with twins and she couldn't get to her home to assist, I knew it was going to be another challenging and exciting day.

I had done an ultrasound the week before at the request of the midwife and knew that the first baby was vertex, the second breech.

Three hours later, after at least one failed attempt by the father to find a willing driver with a plow, the couple arrived. Our anesthesiologist was already in-house waiting for several operative cases to begin, pending the arrival of our orthopedic surgeon who lives 45 minutes away. Our obstetrician, who had been alerted and backs me up for Cesarean delivery, was still at home waiting to be plowed out.

Fortunately the woman's labor was not particularly active, and I waited the hour until my obstetrical backup arrived. I then deftly facilitated the birth of a healthy boy and girl.

My scope and place of practice have, over decades, prepared me for just this moment. I have gained the trust of the midwife and Amish community, as well as that of my nurse and physician peers.

I've learned to think ahead, to make use of the resources I have at hand, and to foster generative relationships with patients, families, specialty colleagues and nursing staff that make the highest quality of medical care possible in even the most rural environments. In fact, one could argue it's easier here than in an urban setting, where my family physician colleagues have restricted their scope of practice, inter-professional relationships are often territorial rather than collaborative, and such cases just don't happen.

Randall Longenecker, MD, is rural program director and assistant dean for rural medical education at Ohio State University College of Medicine in Bellefontaine. He joined NRHA in 2000.



Janelle Ali-Dinar and her husband Abbas

Five things you should know about NRHA member Janelle Ali-Dinar

1. She challenges tradition and encourages others to compete.

Especially since returning to the rural Midwest, Ali-Dinar, PhD, is led by two mantras: “Here and now, and if not now, when?” and “We are in the middle of something and not in the middle of nowhere.”

“Urban or rural, I like to think outside the box, to examine the vast possibilities of greatness and to be ready for change. That only comes from sharing, tapping into people’s strengths, being engaged and being open. The byproduct and benefit of that work is that together we can champion the hurdles of adversity to create win-win situations.”

2. She is vice president of research and capital development for the Mary Lanning Hospital/HealthCare Foundation in Hastings, Neb.

After spending nearly 20 years in Los Angeles working with Fortune 500 and international companies in senior executive management, Ali-Dinar never thought her urban and global business experience would be instrumental in developing a career in health care “back home.” But in 2006 her father was diagnosed with colon cancer, and she and her husband decided to purchase the family farm and assist her parents.

She found herself “catapulted into a career in health care.” Working at a hospital with a service area of 80 counties in Nebraska and north and northwestern Kansas, Ali-Dinar “develops programs for underserved communities, builds internal hospital programs to support medical specialties, establishes partnership collaborations for community outreach projects and serves on leadership committees for hospital governance and employee engagement.”

3. She is the daughter of fifth generation farmers and ranchers.

“I grew up on a farm in Nebraska. I remember family and community concerns regarding health care insurance affordability, dental care, access to rural ambulance services and specialty medical services. Alarmingly, 20 years later, while much progress has been made in many areas, we are still trying to resolve many of the issues, only now the dynamics and vulnerabilities have been compounded and entire populations are truly at risk.”

4. Traveling to ancient cities is her passion.

Ali-Dinar and her husband, Abbas, who has a doctorate degree in psychology, have visited ancient cities around the world, including Jerusalem, Israel, where they were married. They view their home in Nebraska as their “sanctuary for cooking authentic foods and entertaining family and friends.”

5. She serves on the board of directors of the Nebraska Rural Health Association and is a 2010 NRHA Rural Health Fellow.

“Nebraska Rural Health Association leadership and board engagement is allowing us to assertively tackle issues relating to patient safety, direct patient care, medical reimbursement, the rural ambulance network and physician recruitment and retention.

“And being a fellow is a once-in-a-lifetime opportunity for me to help chart the policy course and strategic plan for rural Americans. It is an opportunity to work with and learn from six other amazingly talented professionals as well as others who have graduated in the program. It is the time to sharpen my active listening, networking and leadership skills and work to advocate for positive impact and sustainable change.”

If you would like to be featured in *Rural Roads*, e-mail editor@NRHArural.org.

Nurse Educator Improves Quality, Decreases Turnover at New Mexico Hospital

Former administrator goes back to school, encourages staff to do the same.

By Lisa Long

A 99-bed acute care facility in Alamogordo, N.M., needed a transformation in order to meet criteria as outlined by Centers for Medicare and Medicaid Services. Nursing leadership needed to be recharged, so a new CNO came on board with a critical mission: raise expectations and increase accountability.

To do this, the CNO hired a new Master's-prepared management team that included a new Director of Critical Care Services and Education, Kelly Ramey, RN, MSA, MSN, CCRN, CEN. A big part of Kelly's job involved encouraging nurses to seek higher education and assist in the transformation.

But there was just one problem.

While Kelly had more than 13 years of experience in healthcare administration, she wanted more experience in nursing leadership and education. So she decided to go back for a second Master's degree – this time through an online Master's of Nursing (MSN) in Education program.

SATISFYING, NOT SCARY

"The biggest part of my job as a nurse educator is persuading nurses to see that education isn't scary," Kelly said. "In fact, I've seen proof that nurses who have earned advanced degrees can cite research or Joint Commission findings and really hold their own in meetings and with physicians."

The push for education has resulted in increased patient and physician satisfaction. Education has significantly improved quality indicators.

Naturally, there was some resistance to going back to school. But Kelly stayed true to her cause.

"Once associate degree-level nurses start going back to school, they take their blinders off," Kelly explained. "Advanced degree studies get nurses thinking about standards of practice – that it's not hooey. They do their own research, read literature and see proof that there is validity to the new changes at our hospital."

In fact, nurses have started nursing-journal clubs, and they've helped re-write policies based on standards they've studied. Many are now even driving some of the changes, especially toward total patient care.



QUALITY IMPROVES, TURNOVER DECREASES BY 29%

"Our push for education has resulted in increased patient satisfaction, increased physician satisfaction, and significant improvement in our quality indicators," Kelly said. Also, due in part to her efforts, nursing turnover has been reduced by 29 percent.

HOW THE EDUCATOR GOT EDUCATED

Kelly highly encourages accredited online nursing degree programs with the staff.

"In my MSN program at American Sentinel University, I collaborated with students living all over the country, bringing their unique experiences to the online classroom. The discussions were incredibly rich and diverse, and the networking opportunities incredible."

In fact, when the CNO said that a first-line leadership role wasn't working out, Kelly was able to cite current literature and research, thanks to a paper she wrote on the changing dynamic in nursing leadership. Her research dovetailed right into how the CNO wanted to develop this role.

"I was able to bring my class research into every day practice," Kelly said. "Online learning is real stuff, not fluff. The learning is constant, contemporary and applicable to practice."



Members on the move

Former NRHA president joins HRSA staff



Paul Moore

Paul Moore, DPh, began working with Health Resources and Services Administration (HRSA) as a senior policy advisor in March.

HRSA Administrator Mary Wakefield announced his hiring at NRHA's Rural Health Policy Institute in Washington, D.C., in January.

Moore, NRHA's 2008 president, works on clinical and regulatory issues within the Office of Rural Health Policy.

His experience as a pharmacist and former critical access hospital administrator will help him review and advise on Medicare regulations, patient safety and medication management issues.

Moore says he's bringing his "view from the trenches" to the office.

"I plan to maintain ownership of both my rural community pharmacy and my company which provides remote pharmacist services to small rural hospitals across our nation. I am blessed to have talented and dedicated people working with me who have agreed to take on the day-to-day management of the business while I focus my energies at the federal level."

Moore has been an NRHA member since 2000.

Laddie Williams, board of trustees chairman at Calhoun-Liberty Hospital in Blountstown, Fla., was named a 2010 Trustee of the Year by *Modern Healthcare* magazine. Ronald Gilliard, CEO of Calhoun-Liberty, has been an NRHA member since 2005.

Maggie Elehwany, JD, NRHA government affairs and policy vice president, was invited to the White House to witness President Obama signing the health reform bill on March 23.

Elehwany has 17 years of federal legislative experience and fought for

primary care workforce improvements, increases in Medicare and Medicaid payments to rural providers and patient protections for rural Americans to be included in the historic legislation.

To register for her Health Reform Workshop May 18, visit www.RuralHealthWeb.org/annual

News briefs

Group adopts mission to improve overall community health

NRHA's Community Health Status constituency group, formerly Community Grassroots, redefined and reinvigorated its purpose through the adoption of a new name and mission statement at NRHA's Rural Health Policy Institute in January.

CG members and chair Michael Meit decided the group would refocus its efforts to target individuals interested in community-wide health policy and interventions and population-level health activities aimed at contributing to tangible improvements in a community's overall health status.

To join the Community Health Status constituency group, e-mail membership@nrharural.org.

NRHA honors congressional rural health champions

NRHA is pleased to announce the winners of the 2010 Legislative Awards, which recognize outstanding leadership on rural health issues by U.S. congressional members and staff. This year's recipients are:

- Sen. Max Baucus, D-Mont.
- Rep. Earl Pomeroy, D-N.D.
- Rep. Greg Walden, R-Ore.
- Erik Komendant, House Blue Dog Caucus
- Hayden Rhudy, Health Education, Labor and Pensions Committee
- Lifetime Achievement Award: the late Sen. Edward Kennedy, D-Mass.

Award winners were honored during NRHA's 21st Annual Rural Health Policy Institute in Washington, D.C.

Send your career updates to editor@NRHArural.org.

New report ranks health factors and outcomes by county

A report released in February by the Robert Wood Johnson Foundation and the University of Wisconsin ranking health factors and outcomes in each of the nation's more than 3,000 counties shows where people live plays a role in their overall health. Comparing counties within each state, the report reveals that the least healthy counties are disproportionately poor and rural.

To determine a county's ranking, researchers measured health factors including:

- behaviors such as tobacco and alcohol use, diet and exercise and unsafe sex;
- access to quality health care;
- education, employment and income, family and social support and community safety;
- and environmental quality.

Researchers also measured health outcomes including birth weight, morbidity and mortality, providing a clearer view of how someone's geographical location can influence his or her quality of life and mental and physical health.

Interestingly but perhaps not surprisingly, the least healthy counties had less access not only to health care but also to large supermarkets with consistent availability of fresh, low-cost fruits and vegetables. Instead these often economically-disadvantaged communities had a higher density of fast food restaurants and liquor stores per capita than their healthier counterparts, contributing to problems such as obesity and alcoholism.

The report urges all members of a community, from health care professionals to employers to government officials, to work together to improve overall health by assessing needs and resources and implementing policies and strategies that work.

Visit www.countyhealthrankings.org to see how your county fared, and find resources to overcome health barriers.

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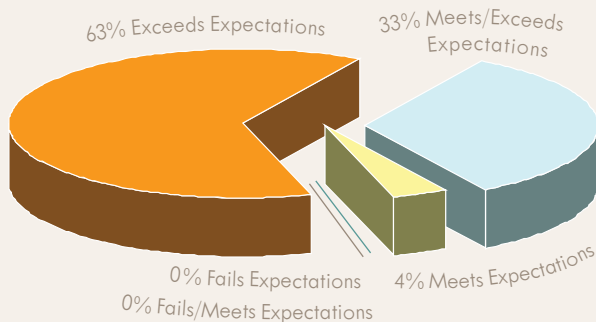
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— Jeffrey, ASC Manager

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— Christine, MD

"Jeff's an attentive, prepared and professional technician. He makes my job easier."

— Mark, OR Manager

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more information.

McKesson Corporation, currently ranked 18th on the Fortune 500, is a health care services and information technology company dedicated to helping its customers deliver high-quality health care by reducing costs, streamlining processes and improving the quality and safety of patient care.

McKesson is the longest-operating company in health care today, celebrating its 175th anniversary this year. Over the course of its history, McKesson has grown by providing pharmaceutical and medical-surgical supply management across the spectrum of care; health care information technology for hospitals, physicians, homecare and payors; hospital and retail pharmacy automation; and services for manufacturers and payors designed to improve outcomes for patients.

For more information, please visit www.mckesson.com.



Chilton Medical Center improves workflow and report turnaround in diagnostic imaging

Chilton Medical Center in Clanton, Ala., specializes in personalized care that is difficult to find in a large metropolitan hospital. Operated by Sunlink Health Systems, Chilton and Sunlink turned to Quick Study Radiology (QSR) to improve enterprise workflow for diagnostic imaging and reporting.

"Chilton has made tremendous strides in the last several years to advance its hospital systems and electronic health records," says Shanon Hamilton, Chilton radiology director. "We needed a partner in diagnostic imaging who could keep up with those advancements and continue to improve integration and workflow."

QSR, a long-time partner with Chilton, upgraded the diagnostic imaging technology from an outdated picture archive and communications system to its mainstream enterprise system, Philips iSite. Additionally, by working



with Chilton, QSR was able to leverage their existing system capabilities and provide an integrated reporting process with a modern voice recognition solution, implementing a more efficient workflow between radiology, referring physicians and the entire hospital enterprise.

"We are thankful to have QSR as our partner as we continue to work through the changes enabled by the new technology as well as invest in new advancements," says Jerome Orth, Sunlink Health Systems CIO. "QSR's focus on community care is a good fit for our dedication to efficient medical care to residents of rural populations."

To learn more about Quick Study Radiology, call 877-684-2777.



Sightpath Medical: national leaders in cataract, YAG, SLT and Lasik outsourcing

As the leading mobile ophthalmic services provider, Sightpath Medical provides ASCs, hospitals and clinics with state-of-the-art technology for cataract, YAG, SLT and refractive procedures. Sightpath's low, capped cost-per-procedure model without maintenance fees makes outsourcing to Sightpath a viable option for both small- and large-volume facilities.

Sightpath's ophthalmology-specialized, NBSTSA certified surgical technicians can scrub in to assist with cataract surgery. YAG and SLT technicians assist with procedures and patient flow according to client needs. Manufacturer-certified engineers and technicians support every refractive case.

Because Sightpath provides all the equipment, supplies and IOLs for cataract procedures, the facility avoids all upfront and ongoing capital purchases, upgrades and maintenance fees. Not owing on equipment



reduces risk while maintaining flexibility of choice.

“By partnering with Sightpath and benefitting from their knowledgeable staff, state-of-the-art technology and excellent service, we doubled our volume of ophthalmic cases in our rural multispecialty surgery center in less than a year,” said Dean K. Ward, administrator of Sutter North Surgery Center in Yuba City, Calif. “I would recommend Sightpath to anyone interested in a turnkey operation that will result in excellent quality of care and a profitable operation.”

Facilities interested in implementing or expanding ophthalmic services can contact Sightpath Medical at info@sightpathmedical.com or 800-728-9615. Visit us at www.sightpathmedical.com.



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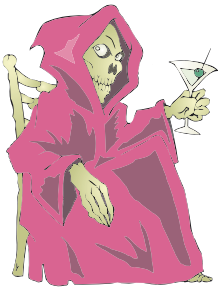
Spirits and spirits



Photo by Andrew Haley, Marlborough, CT.

Savannah, Ga., has a reputation as one of America's **spookiest cities**. While in town for NRHA's Rural Medical Educators and Annual Rural Health conferences May 18-21, make time to check out these local haunts.

1 **There's always a party going on at the Mercer House.** Former owner Jim Williams was famous for hosting lavish and lively parties, and 20 years after his death witnesses still claim to have seen ghostly gatherings inside the centuries-old mansion. The house gained further notoriety as the murder scene in the book and film versions of *Midnight in the Garden of Good and Evil*. www.mercerhouse.com



2 **You can drink your spirits, too.** Giggle and gasp at stories of specters and local folklore on one of Cobblestone Tours' candlelight pub crawls. Guides in full period costume will show you how to enjoy both types of Savannah's spirits. www.ghostsavannah.com

3 **You can never overstay your welcome.** Some guests of the 17Hundred90 Inn, have stayed "for a lifetime and beyond." Built in the year of Georgia's first democratic elections, the inn has a full-service restaurant and lounge and is said to be haunted by a 19th century ghost restlessly awaiting her beloved's return from sea. www.17hundred90.com

Visit www.RuralHealthWeb.org/annual to register. We look forward to seeing you in Savannah.



Off the beaten path

Muffler men

The tallest resident of Wilmington, Ill., has a lot going for him. He might be the most popular guy in the town of **5,000**, and when travelers on historic **Route 66** stop at the Launching Pad Drive-In for classic thick burgers and malt shakes, they often snap his photo while he effortlessly cradles a rocket ship in his arms.

He is the **Gemini Giant**, one of hundreds of fiberglass "muffler men" manufactured from **1963 to 1975**.

Standing from **18 to 23 feet tall**, the muffler men originally greeted customers at gas station chains. The Gemini Giant is one of the few that remains.

Tell us what puts your town on the map.
E-mail editor@NRHArural.org.

shifting gears

Get the whole office involved in **going green** by arranging **car pools**.

Use **nontoxic cleaning products** in your facility. Keeping plants around the office will also help **absorb inside pollution**.

Photo by Barbara Greenbaum, Hillsboro, OR.





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