

SPRING 2017

PENNSYLVANIA RURAL HEALTH

A Quarter Century of Progress, Challenge & Impact

CELEBRATING TWENTY-FIVE YEARS OF
THE STATE OFFICES OF RURAL HEALTH

PENNSYLVANIA OFFICE OF RURAL HEALTH

Presents 2016 State Rural
Health Awards

THE MEASURE OF QUALITY for Pennsylvania's Rural Health Providers

THE POWER OF THERAPEUTIC HORSEBACK RIDING: One County's Remarkable Program

message *from the* director



Welcome to the spring edition of *Pennsylvania Rural Health*. This issue marks not only the first quarter of 2017 but the First 100 Days of President Trump's administration. Since 1933, when President Franklin D. Roosevelt used his first three months in office to lay the foundations of the New Deal, the First 100 Days of any presidency have been seen as a unique moment—the new president's

first, and perhaps best, chance to reshape the nation according to his own agenda and vision.

There has been a great deal of reporting on and discussion about the voice that rural America had in the 2016 Presidential election. According to data from CNN, NBC News, and the *New York Times*, between 2008 and 2016, the percentage of rural residents who voted Republican in the election increased by 27 percent, to 62 percent, while the percentage of urbanites who voted Republican over the same time period decreased by 29 percent. In large urban areas, a bit more than 55 percent of voters cast their ballot for the Democratic candidate and slightly more than 70 percent of voters in very rural areas chose the Republican candidate.

Rural voters are a small but powerful group. Based on 2015 numbers, 14 percent of the country, or about 42 million people, live in small towns and frontier areas that cover 72 percent of the nation's land mass. Pennsylvania is considered to be one of the most rural states in the nation: 3.5 million residents, or 27 percent of our state's population, lives in rural areas and forty-eight of our sixty-seven counties are predominantly rural.

Given the demographics that powered the election, this well may be "rural's moment," the time when rural issues—among them, jobs, housing, education, transportation, technology, and health care—are elevated on the list of priorities in Washington. If it is our time, rural advocates need to prepare to be champions.

It can be hard to be rural. The economic, cultural, social, geographic, and demographic characteristics of rural communities are sufficiently different from those of urban communities to require special consideration. Rural areas are characterized by sparse populations and geographic barriers and those who live there are generally older, have higher rates of chronic health conditions, a higher reliance on Medicare and Medicaid, and are poorer than their urban counterparts. Fewer health care providers practice in rural areas and the health systems that serve these regions often struggle to remain financially viable.

And yet there are so many reasons why rural America matters. Here are just a few.

Rural communities are wonderful places to live and work. Great things are happening there. Rural leaders have the vision to drive change. Diverse economic, cultural, and recreational opportunities abound. Rural America is an economic engine that shapes the United States. Farms, ranches, mining, oil, gas, and clean energy from rural America provide a wealth of products and services. Millions visit rural and frontier areas to enjoy America's natural resources.

Rural health care providers deliver high-quality, innovative care. These providers build personal relationships with patients and families. Hospitals are the economic foundation of rural communities where high-quality care is provided and connections to urban tertiary care centers is facilitated by technology. Wait times for emergency care are 56 minutes faster in rural hospital emergency departments than in urban hospitals. Community health workers, community paramedics, and oral and behavioral health professionals have been incubated in rural America as a model for health systems across the county.

Collaboration is crucial to address the barriers that remain. State Offices of Rural Health, rural providers, and other stakeholders continue to foster partnerships that improve the health status of the communities they serve. Rural Health Clinics, Critical Access Hospitals, and Federally Qualified Health Centers may be the only source of primary care in a community and are vulnerable to changes in Medicare or Medicaid payments. Rural workforce education and training programs are needed to help recruit and retain well-qualified medical providers.

Two weeks after the election, the National Organization of State Offices of Rural Health and its partners recognized National Rural Health Week and those of us closer to home celebrated Rural Health Week in Pennsylvania. We honored leaders throughout rural Pennsylvania and have highlighted those events in this issue of the magazine. These leaders have found local solutions to address local needs but in each community, I heard about the need for continued federal and state support for those efforts to continue. We need to be clear and we need to remain vigilant. Rural matters. Let your voice be heard.

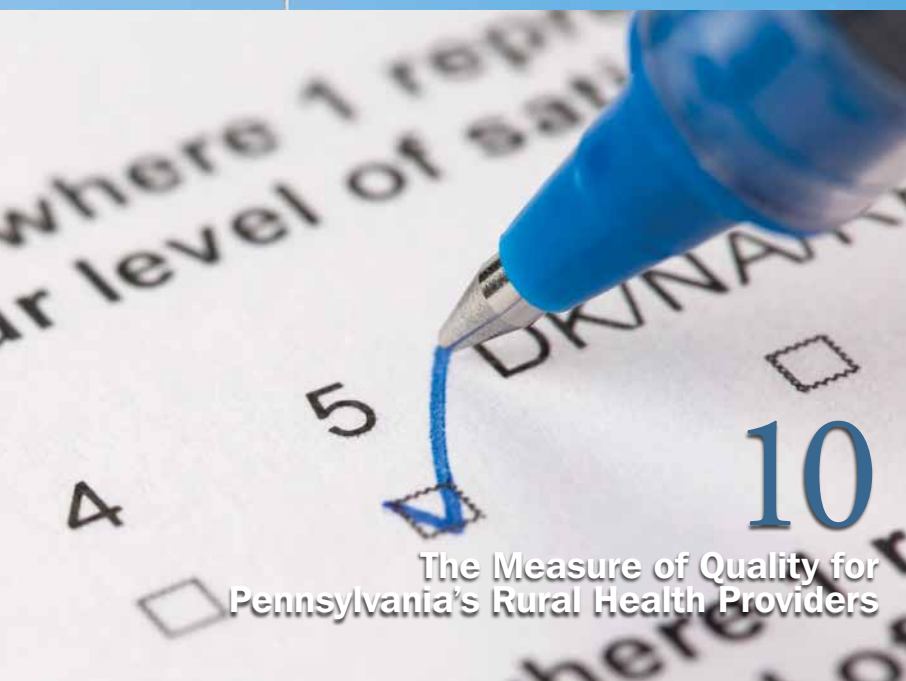
Lisa Davis

*Lisa Davis
Director*



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Pennsylvania Rural Health

Lisa Davis, *Director*

The Pennsylvania Office of Rural Health (PORH) receives support from the Federal Office of Rural Health Policy (FORHP) in the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), the Pennsylvania Department of Health, other state agencies, and The Pennsylvania State University. PORH is located at the Penn State University Park campus.

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THE PENNSYLVANIA OFFICE OF RURAL HEALTH: A Quarter Century of Progress, Challenge, and Impact

Celebrating Twenty-five Years of the State Offices of Rural Health

By Susan J. Burlingame

From the mid-1980s to early 1990s, some 400 rural hospitals in the nation closed their doors. Several factors played a part, in large part due to Medicare and Medicaid reimbursements which had changed from fee-per-service to a prospective payment system (PPS) in an effort to slow the growth of Medicare spending. While the PPS system made sense for large urban hospitals, it adversely impacted rural hospitals because they had fewer patients and fewer private insurance dollars to offset reimbursements from Medicare and Medicaid and the costs of uncompensated care.

Recognizing, perhaps for the first time, that rural and urban health care services were very different, Congress appropriated funding to establish the Federal Office of Rural Health Policy (FORHP) and charged it with being the office within the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (HHS) where all rural health activity occurs—from funding to policy analysis. FORHP was given two specific functions: to advise HHS department leadership on how FORHP programs affect health care in rural communities and to administer grant programs for rural health delivery.

“I can’t tell you how little attention was paid to rural health and especially to rural hospitals back then,” said Jerry Coopey, former director of strategic planning for FORHP. “The closure and potential closure of rural hospitals and the shortage of providers in rural America overall made the legislators in Washington stand up and take notice.”

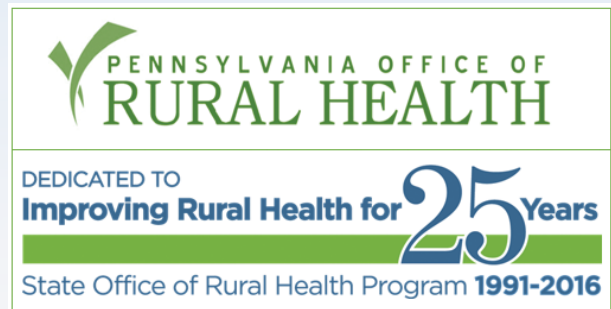
One of FORHP’s first acts was to start the State Office of Rural Health (SORH) program in 1991, which provided funding for each state to establish its own office of rural health and serve as the state’s main source for technical assistance, coordination, and networking focused on

increasing access to rural health services. The SORHs also were responsible for developing partnerships to assist in recruiting and retaining rural health care providers.

It took a year working with federal legislators to establish specifications for the SORH program, explained Coopey. Ultimately, however, “one of the greatest strengths of the program was allowing the states to establish their offices wherever they wanted. The specifications were made deliberately broad so states could serve their populations in ways that made the most sense.”

“A state-by-state effort really got the program going,” said FORHP Director Tom Morris, who credited Coopey with being instrumental in reaching out to all fifty states. “To go from nothing to fifty was an amazing achievement during a time when a lot of issues were scrolling around rural health. Before our office and the fifty state offices were created, there was no real way of identifying, thinking about, and finding solutions to the challenges rural communities face. The state offices became, and continue to be, our lifeline to the communities because they are engaged at the community level.”

Some SORHs were established at universities, some were embedded in state health departments, and some were stand-alone offices. Kenneth Martin, then a research associate at Penn State, Penn State Extension Specialist Charlie Crawford,



and Larry Gamm, former associate professor of health policy and administration at Penn State, thought it made sense to establish Pennsylvania's office in a university setting. Penn State, they agreed, offered the ideal circumstances.

"I'm a rural sociologist, so I've always been in tune with what's going on in rural America," said Martin, now professor, chair, and associate director of programs for the College of Food, Agricultural, and Environmental Sciences' Department of Extension at The Ohio State University. "I know that health care in rural areas is a big challenge. I remember thinking Penn State was the perfect place for Pennsylvania's office of rural health because of its central location, extension resources, and connection to rural communities."

"At one time, we thought it made sense to create a school of public health at Penn State, an idea that didn't really get off the ground," explained Gamm, now Regents Professor Emeritus of Texas A&M University. "When the funding became available to create an office of rural health, we realized we could combine the strengths of the College of Agricultural Sciences and the College of Health and Human Development to help rural communities in another way, so we submitted an application, and the office was funded."

Originally housed in the (then) Department of Agricultural Economics and Rural Sociology in Penn State's College of Agricultural Sciences, the Pennsylvania Office of Rural Health (PORH) opened its doors in early 1992 with Crawford at the helm and Martin and Gamm as co-associate directors. Martin became PORH director when Crawford retired, serving in that capacity until 1999.

Current PORH Director Lisa Davis, an outreach associate professor of health policy and administration at Penn State, was also part of the team in the early years, serving as its first full-time staff person. She was the PORH coordinator from 1994-97, held a different position for two years, and returned to the office as director when Martin left.

"We grew the program from the ground up," said Davis. "Our vision was to make sure we were out there advocating for rural health, that we were present when important decisions and discussions were taking place, that we were viewed as a strong resource and a good partner, and that we participated in any activities that addressed the health care needs of rural residents—locally, statewide, and nationally. As all of the state offices were getting established, we wanted to be part of not only what was happening in Pennsylvania but also to learn from and inform what was happening nationally. From the very beginning, we got in the habit of never saying 'no.'"

Ted Alter, professor of agricultural, environmental, and regional economics and co-director of the Center for

Economic and Community Development at Penn State, was associate dean of the College of Agricultural Sciences as well as director of Penn State Extension and associate vice president for outreach and extension when PORH was first established in his department. "I remember being very proud of what was happening in the office," he said. "The key thing, which continues today, is the convening power of the office of rural health. Because of the relationships and the networks that Lisa and her predecessors built, maintained, and nurtured—rural communities, health care systems, the public and private sector—they have been able to bring people together to deliberate, discuss, and debate issues related to rural health. They have put forward programmatic initiatives as well as policy ideas. From my perspective, it's the most significant, lasting, and sustainable attribute about the office. It's a huge accomplishment." Davis credits Alter with playing a key role in finding a new home for PORH in the Penn State College of Health and Human Development when the College of Agricultural Sciences could no longer house them.

Partners for Decades

The Pennsylvania Area Health Education Center (PA AHEC) is one of the many partners with which PORH has had a lasting relationship. Linda Kanzleiter, M.Ps.Sc., D.Ed., principal investigator and program director for the PA AHEC, said PORH and AHEC have partnered many times through the years. "We have a shared passion for improving the health of rural communities and have worked together on projects like agromedicine, sat on each other's boards, and done conferences together. In particular, we have worked to provide access to programming for the professional development of rural providers."

"We're all living in a constantly changing health care environment," stated Cheri Rinehart, president and CEO of the Pennsylvania Association of Community Health Centers (PACHC), another PORH partner. "Organizations such as PORH and PACHC work in tandem to address issues from different angles."

PACHC represents community health centers that serve vulnerable and underserved populations in both rural and urban areas. "While we look broadly at improving access, the Pennsylvania Office of Rural Health is laser-focused on rural populations," said Rinehart. "The office has helped us in many ways, from working with us on an oral health initiative to helping get the word out on the availability of community health center-based Health Insurance Marketplace enrollment assistance."

Dennis Murphy, distinguished professor of agricultural and biological engineering at Penn State, has been an on-campus partner since PORH was first established. Recognized as one of the nation's top farm safety experts, Murphy said

the office is “vitally important” to his research and to rural Pennsylvanians overall. PORH “identifies and addresses issues within the rural community that are individualized or buried because there isn’t a critical mass to bring them to the forefront.” Murphy and PORH staff members have worked together on Penn State Extension teams and collaborated on research on farm safety and health in rural areas. “We are both concerned about the entire farm family as well as workers and operators—and how the community, volunteer organizations, and others respond to farm incidents.”

The Pennsylvania Department of Agriculture (PDA) addresses farm worker safety from a different angle and has relied on PORH as an outreach partner for at least 16 years. The federal Worker Protection Standard (WPS) Act was passed to protect those who handle and apply pesticides as well as those who work in areas treated with pesticides. The PDA is responsible for making sure Pennsylvania growers comply with those standards.

“We are a compliance and enforcement agency, but we would rather educate growers before there is an issue,” said David Scott, former chief of PDA’s Division of Health and Safety, explaining that the PDA funds a worker protection standard expert at PORH. Jim Harvey, who has served in this capacity since 2004, provides growers with technical and compliance assistance in advance of a PDA compliance visit.

“People are more receptive to having someone like Jim come to their farm rather than having an inspector show up. PORH has been our connection to rural growers as well as rural health clinics in providing important information,” Scott continued. “The department looks forward to continuing the relationship we have. It’s good for both of our organizations but particularly beneficial for the farmers of Pennsylvania.”

The National Organization of State Offices of Rural Health (NOSORH), originally a small, loosely knit group of leaders of the state offices, was established in 1995. NOSORH works with all fifty state offices to build capacity and improve health care in rural America through leadership, development, advocacy, education, and partnership.

“Ultimately, our job is to try to bring a unified voice to the work of the fifty states,” said Teryl Eisinger, executive director of NOSORH. “By their very nature and the way they’re funded, the SORHs are a unique federal-state partnership. This allows each state office to assess the needs in their own state and to leverage funds to address specific needs in their own rural communities. “I have seen people in the Pennsylvania office take a leadership role in many capacities over the years. They are recognized as thought leaders and are always very future-focused,” Eisinger

continued, giving as an example the technical assistance PORH offered to critical access hospitals in the state.

Helping rural hospitals convert to designation as Critical Access Hospitals (CAHs) with assistance from the federal Medicare Rural Hospital Flexibility (Flex) program is one of the ways many SORHs—and PORH in particular—have made a major impact through the years. According to Larry Baronner, rural health systems manager and deputy director of PORH, Pennsylvania was one of the last states to implement the Flex program.

“Part of the reason these hospitals came into the program was because they would get cost-based reimbursement for their services,” explained Baronner. “We were able to convert five rural hospitals to CAHs in 2001, the first year we participated in the Flex program, and Pennsylvania now has fifteen CAHs providing quality care to our most rural communities.”

Changing Times, Changing Needs

So much has changed in health care over the last twenty-five years. People are spending less time in the hospital because many procedures can now be performed in outpatient facilities. Technology has seen dramatic changes that have led to improvements in communication, electronic medical records, and telemedicine. The fee-for-service payment model of twenty-five years ago has shifted to a pay-for-performance model, requiring rural health care providers to introduce quality and efficiency incentives.

Since the inception of the SORH program twenty-five years ago, the concept of access to care has expanded to include mental health and oral health as well as prevention and wellness initiatives—all of which are being promoted by state offices as critical to the conversation when promoting overall health of rural populations. For example, oral health is now being recognized as an important component of primary care, and medical providers are now screening and discussing oral health with patients. Some medical providers are offering preventive services (such as fluoride varnish) in their offices, and some dental providers, such as dental hygienists, are now practicing in medical offices.

Since the inception of the SORH program twenty-five years ago, the concept of access to care has expanded to include mental health and oral health as well as prevention and wellness initiatives.

The Center for Rural Pennsylvania, a legislative agency serving as a resource for rural policy within the Pennsylvania General Assembly, focuses on everything rural, from agriculture to education to transportation and more, said center director Barry Denk. “We’ve had a very, very strong relationship with PORH for nigh on twenty-five years, and I find so many parallels between our offices. When you have a commonwealth as geographically diverse as Pennsylvania with a strong urban presence on either end of the state, rural can sometimes be forgotten. For all these years, PORH has been a champion, beating the drum for rural health by advocating, educating, and operating programs that affect health care and health care delivery systems for rural Pennsylvania.”

“Though a lot has changed and a lot of progress has been made in the last twenty-five years, there are issues that remain,” said PORH Director Lisa Davis. “One relates to the training and deployment of health care providers in rural settings. We have nine medical schools in Pennsylvania, but two-thirds of those graduates work in Pennsylvania’s most urban counties, and those who do work in medically underserved areas are over age 55 and considering retirement. We need to find ways to recruit physicians to rural areas and retain them once they are here.”

The other major issues are reimbursement for services and quality of care, Davis said, explaining that because patients in rural communities tend to be older, sicker, and poorer, rural health care providers have higher percentages of Medicare and Medicaid patients. “Unlike urban hospitals, rural providers don’t receive enough funding from private insurers to make up for their deficits. We have to continue to advocate for strong payment systems for rural providers.”

The payment system also ties into the quality of care issue, added Davis. “Though a recent report showed that some quality indicator benchmarks were actually higher in rural areas than in urban areas, there’s still a notion out there that the quality of care in rural areas is somehow of lower quality than urban centers. It takes a lot to convince people that going to your local community hospital actually gives you an option for better care.”

“Along with government and education, health care is one of the three top economic drivers in rural communities,” Davis continued. “Ultimately, we want people to invest in their local health systems.”

“We have more than forty-two hospitals in Pennsylvania that you can classify as rural,” said Pennsylvania Secretary of Health Karen Murphy. “Within those, we have over 27,000 jobs, so in addition to offering quality health care, those hospitals are an important economic engine in their communities. For twenty-five years, the Office of Rural

Health has supported those hospitals and focused on ways they could improve access to health care and strengthen the health of rural communities. Moving forward, the Wolf administration is working on plans to improve health outcomes in rural communities by partnering with rural hospitals. The Office of Rural Health will most definitely be an integral part of our success.”

On a national scale, the SORH program has made a tremendous difference over the last twenty-five years—creating valuable partnerships, influencing policy, and providing the resources providers need to best serve their rural citizens.

In Pennsylvania, PORH, under the leadership of three directors (first Charlie Crawford, then Ken Martin, and for the past nineteen years, Lisa Davis), has done the same. Some of its noteworthy accomplishments include leading a Critical Access Hospital benchmarking and quality improvement effort, providing technical resources to assist fifteen small rural hospitals in converting to CAH status, and providing resources for four small rural hospitals, including one CAH, to become Level 4 Trauma Centers. PORH was responsible for establishing the annual Rural Legislative Briefings for the Pennsylvania General Assembly, the annual migrant and immigrant farm worker conference, and the nation’s first Rural Health Farm Worker Protection Safety Program, “and so much more that we are proud of, but too much to summarize here” noted Davis.

“Right now, we are at a critical juncture,” stated Barry Denk of the Center for Rural Pennsylvania. “There will be some very close critical eyes looking at the role of federal government and its programs and policies, and entities such as PORH will have the chance to have greater visibility and impact. PORH is absolutely critical and pivotal in helping to develop the voice for rural health care delivery systems. If they were not on the scene, it would be a major disadvantage for this commonwealth.”

“We have accomplished so much with the help of our partners, other state offices, our legislators, and, of course, our talented and dedicated staff members,” reflected Davis. “What has never changed through all of these years is the passion, the interest, and the knowledge of the people who work on behalf of rural health.”

For more information on the State Office of Rural Health Program and on the Pennsylvania Office of Rural Health, contact Lisa Davis, director and outreach associate professor of health policy and administration at Penn State at 814-863-8214 or to lad3@psu.edu.

Pennsylvania Office of Rural Health Launches New Three-Year Strategic Plan

The Pennsylvania Office of Rural Health's (PORH) 2017-2019 Strategic Plan outlines the strategies that PORH will undertake to continue to strengthen the delivery of health care services in rural Pennsylvania in the next three years. Objectives include promoting population health, addressing areas of unmet need, advocating for rural health, supporting continuing education, and expanding infrastructure and operations to support office activities. The Plan allows for agility so that PORH can adjust its strategies to respond to new and emerging challenges and opportunities. The 2017-2019 Strategic Plan can be accessed at porh.psu.edu/porh/strategic-plans-and-annual-reports.

Federal Resources, Health Policy, and You

The Federal Office of Rural Health Policy (FORHP) has launched an e-mail box to answer rural health policy questions, including queries regarding Medicare, Medicaid, and private insurance.

RuralPolicy@hrsa.gov is a resource for providers, advocates, and stakeholders to ask questions and get updates on the health care issues most important to rural communities. Those interested in being added to the site's listserv should send an e-mail with "Subscribe" in the subject line to RuralPolicy@hrsa.gov.

Pledge to Partner for Rural Health!

The National Organization of State Offices of Rural Health (NOSORH) sponsors the annual National Rural Health Day (NRHD), held the third Thursday in November. On NRHD 2016, NOSORH launched a campaign to bring the themes of NRHD to a year-long commitment on health care issues facing rural communities across the United States.

NOSORH invites rural advocates to begin new conversations about the



power of pioneering rural partnerships, inspiring communities to address their most challenging health issues, and making a promise to stay informed and involved in 2017 with NOSORH and the nation's fifty State Offices of Rural Health. Lead change in your community that can make a difference for 62 million people! Learn more about the Pledge to Partner at powerofrural.org. To learn more about National Rural Health Day, see nosorh.org/calendar-events/nrhd/.

Pennsylvania Department of Health Launches Database

In 2016, the Pennsylvania Department of Health (PADOH) launched LiveHealthyPA, a website where partners such as communities, schools, organizations, and businesses can share and review activities that address challenges in improving the health of their members. The site was developed in response to conversations between PADOH staff and external partners that indicated a need for a centralized location to store activities that address chronic disease occurring throughout Pennsylvania. The LiveHealthyPA Healthy Living Practices database was created as the core component of the website and provides a forum for partners to submit activities and search for information on chronic disease activities occurring in Pennsylvania. Visit livehealthypa.com for more information.

Pennsylvania Rural Health Association Releases Revised Document on Rural Health Issues

The revised edition of the Pennsylvania Rural Health Association's (PRHA) flagship publication, *Status Check VI*, provides an update on Pennsylvania rural health care. The document raises awareness on the issues impacting the delivery of health care services in rural areas of the state, including rural emergency services, the rural elderly, migrant farm worker health needs, oral health issues, telehealth services, behavioral health, and more. *Status Check VI* is tailored to inform discussions among those who can make a difference in the health of, and health care for, rural residents. To learn more about PRHA and to access *Status Check VI*, visit paruralhealth.org.

A Medical Student's Perspective

By Ashley Baronner

This column chronicles Ashley Baronner's experiences as a medical student in the Physician Shortage Area Program at the Sidney Kimmel Medical College in Philadelphia. Ashley is the daughter of Larry Baronner, PORH's rural health systems manager and deputy director.



Approximately four years ago, the all-consuming stress of my human anatomy class, dominated my life from August until mid-October. Mastering the anatomy of the human body in three short months was the most challenging academic experience I had faced at that time. I spent countless hours in the library and cadaver lab and eventually found a

group of classmates to endure the rigorous studying process in a slightly more enjoyable way. These study mates became my best friends, and my anatomy class laid the foundation for much of what I learned in the following two years. Anatomy was revisited in my third-year surgery rotation in the operating room, during internal medicine bedside rounds listening to heart sounds, and in my fourth-year oncology rotation reviewing PET scans.

The human anatomy course is considered to be a “right of passage” at Jefferson. Over the next few years, I encountered several other rights of passage in medical school. Most notably, the United States Medical Licensing Examination (USMLE) Step 1 and Step 2 exams, third-year shelf exams, and presently, the Electronic Residency Application Service (ERAS). My third year of clinical rotations influenced my decision to apply to Internal Medicine for residency training. Far different from my first year of medical school; this fall is dedicated to interview travels on top of clinical rotations. Presently, I have completed ERAS and have heard back from the majority of residency programs I selected. I have also started the process of interviewing at these programs, primarily in the northeastern region of the country.

While daunting, the interview trail has presented several pleasant surprises and unique challenges. I initially expected my interviews to feel very similar to medical school interviews. However, I have found residency interviews to

be strikingly different. Most programs host a pre-interview dinner for applicants to meet the current residents and get a general feel for the type of individuals at their program. The dinners offer an opportunity to share drinks and fancy food with a group of Internal Medicine residents. In a sense, the programs are trying to sell themselves to the applicants and ensure that we feel comfortable with the people who could potentially be our colleagues in the coming years. The interviews themselves are much more conversational. Many programs are extremely welcoming and strive to ensure that I have a positive experience and the opportunity to ask any questions I have about their program. While the Accreditation Council for Graduate Medical Education (ACGME) has standardized the core requirements for Internal Medicine residencies, the leadership at individual institutions can have distinctive ideas about the teaching that occurs during residency. Furthermore, the emphasis on patient-centered care, research, and academic teaching opportunities varies on an institutional basis.

With nine of my interviews completed to date, I can certainly say this process during the fall of my fourth year beats the way I spent the fall of my first year of medical school. Nevertheless, selecting the right residency program is an intimidating task. Jefferson has prepared me very well for residency in an academic manner, but it is the next three years that truly determine the doctor I will become. The importance of this decision, along with the stress of interview travels, is an entirely different type of exhausting experience compared to the rest of medical school. I feel extremely fortunate to have interviewed at numerous strong programs. Once the interviewing process wraps up, I will submit a ranking list to the National Resident Matching Program (NRMP). I am both anxious and excited to open my letter on March 17, 2017, which is Match Day across the country when the National Resident Matching Program placements are announced and I will discover where I will complete the culminating years of my medical training.

PENNSYLVANIA OFFICE OF RURAL HEALTH PRESENTS: 2016 State Rural Health Awards



Community volunteer Ann Mumper (far left) accepts the Rural Health Hero of the Year Award from Lisa Davis, PORH director, together with Dan Blough, CEO of Punxsutawney Area Hospital (center) and The Reverend Brett Swanson, Presbyterian Church, Punxsutawney, Pennsylvania.

Rural Health Hero of the Year

Ann Mumper, Punxsutawney community volunteer, received the 2016 Rural Health Hero of the Year Award. Mumper was recognized for demonstrating a personal commitment to rural health needs by utilizing Punxsutawney Presbyterian Church resources for the benefit of the Punxsutawney Area Hospital community. Mumper spearheaded the “Flight Packs for Patients Project,” which provides care packages for patients and their families who are life-flighted from the Punxsutawney Area Hospital to tertiary care hospitals in Pittsburgh. The flight packs consist of handmade cloth bags filled with snacks, cash, crossword puzzles, maps and directions, tissues, pens and paper, and other supplies for those who need to travel to a new area unexpectedly and in distress.



Jack Dennis, grants and development manager for Wayne Memorial Hospital and Community Health Centers, receives the Rural Health Leader of the Year Award from PORH director Lisa Davis.

Community Rural Health Leader of the Year

Jack Dennis, Wayne Memorial Health Systems grants and development manager, received the 2016 Community Rural Health Leader of the Year Award. Dennis was recognized for his focus on addressing two major rural health issues in his position at Wayne Memorial Hospital: access and breadth of services. In the past twenty years, he has secured millions of dollars in competitive grants to increase access to and expand health care services in northern Pennsylvania. Dennis helped implement multiple telehealth programs, open a low-cost dental clinic for children, and secure federally qualified health center (FQHC) designations for local health centers. Dennis is revered as a vital component of the Wayne Memorial Health System; his commitment to the community impacts individuals in tremendous ways.

A community volunteer, a grants and development manager, a comprehensive rural health program, and a senator were the recipients of the Pennsylvania Office of Rural Health's (PORH) 2016 Pennsylvania Rural Health Awards. PORH presents the awards each year to recognize rural health programs and individuals who have made substantial contributions to rural health

in Pennsylvania. The 2016 award winners were honored at ceremonies held in their local communities during Rural Health Week in Pennsylvania, November 14-18. This week encompassed the sixth annual National Rural Health Day on November 17. The awards were presented by Lisa Davis, director of the Pennsylvania Office of Rural Health (PORH) and outreach professor of health policy and administration at Penn State.



Micah Gursky, rural health clinic administrator (center row, third from left), accepts the Rural Health Program of the Year Award from Lisa Davis, PORH director. Joining him is Kelly Malone, executive director of the Schuylkill County United Way in Pottsville, Pennsylvania (center row, fourth from left), leadership from St. Luke's Miners Hospital, and Rural Health Clinic staff.

Rural Health Program of the Year

St. Luke's Miners Rural Health Clinics received the 2016 Rural Health Program of the Year Award. The St. Luke's Miners Rural Health Program is described as a unique, creative, and innovative approach to providing accessible care to an underserved population. The program is a result of the collaboration of community leaders from Schuylkill and Carbon counties that meet regularly as the St. Luke's Miners Community Health Initiative Team. The St. Luke's Miners Rural Health Program provides access to high-quality primary care integrated with preventive, specialty, and acute care services while also implementing community and preventive health initiatives. It provides more than 12,000 face-to-face primary care visits, on-site diagnostic and therapeutic mental health services, and transportation for patients regardless of insurance or ability to pay. The rural health programs at St. Luke's Miners also have implemented the Flinders Chronic Condition Management Program, which is used to measure and improve outcomes for their diabetes patients and emergency department utilization.

Rural Health Legislator of the Year Awards

Senator Bob Casey (D-PA) was awarded the 2016 Rural Health Legislator of the Year Award. Casey was recognized for sponsoring legislation that addresses rural health needs and for his demonstrated effective leadership in rural communities. A major focus of his recent efforts is focused on fighting the opioid epidemic, a prevalent epidemic in many rural Pennsylvania counties. In addressing opioid abuse, Senator Casey encouraged the Committee on Health, Education, Labor, and Pensions (HELP) to initiate a work group on prescription drug abuse in 2014. Members of the HELP Committee sent letters reporting their findings and recommendations to key stakeholders, thus raising awareness of opioid abuse and helping to combat the epidemic. Many bills he supported granted funding towards access to services through treatment and/or recovery for substance abusers. The nominators notes that Casey has proven himself as an out-

standing Pennsylvania legislator and has demonstrated unrelenting commitment to improving the lives of all residents in the commonwealth. He will be presented with the award in 2017.

State Senator Sean Wiley (D-49th District) was selected to receive the 2016 Rural Health Legislator of the Year Award. During his tenure in the Pennsylvania Senate, Wiley was recognized for his advocacy and sponsorship of a wide variety of bills that addressed the health care needs of vulnerable populations, behavioral health issues, and the expansion of the state's 2-1-1 system. He also was a strong supporter of community paramedicine and community health worker models to increase access to quality care in underserved and rural areas. The award will be presented to Wiley in the spring of 2017.

The Measure of Quality for Pennsylvania's Rural Health Providers

By Susan J. Burlingame

“Quality improvement, as it relates to health care, evaluates the way hospital systems deliver care. It looks at all key players, including clinical staff, patient registration, the billing department, and all other ancillary staff,” said Lannette Johnston, MS, BSN, RN, CHC, the new quality improvement coordinator for the Pennsylvania Office of Rural Health (PORH). “The ultimate goal of quality improvement is to provide safe, efficient care that will lead to optimal patient outcomes.”

“When a hospital isn’t doing well, it needs to review the current processes in place and develop an action plan to maximize patient outcomes,” added Johnston. “A sound quality improvement program helps hospitals see where their deficiencies are, not just around patient care but related to a variety of other measures. Quality improvement involves the entire hospital team in making positive patient care experiences.”

Johnston, who assists Critical Access Hospitals (CAHs) in Pennsylvania in utilizing quality improvement resources, explained that hospitals are always being evaluated and evaluating themselves. “Critical Access Hospital” is a designation given by the Centers for Medicare and Medicaid Services (CMS) to rural hospitals meeting certain criteria including having twenty-five or fewer acute care inpatient beds and being thirty-five miles from another hospital. Pennsylvania has fifteen CAHs.

In 2010, CMS initiated a three-phase program for rural health care providers. The Medical Beneficiary Quality Improvement Program (MBQIP) established guidelines for standards of care for certain disease processes. By using MBQIP and other quality improvement programs, CAHs, as well as other rural health care providers, are able to see how they compare to other providers and where they need to improve so they can develop meaningful quality improvement initiatives.

“MBQIP was an experiment that started with baby steps,” said Paul Moore, senior health policy advisor for the Federal Office of Rural Health Policy (FORHP). “During Phase I, we wanted the measures hospitals were collecting to actually represent the




Lannette Johnston, MS, BSN, RN, CHC, quality improvement coordinator for the Pennsylvania Office of Rural Health

work they do, so we started with measures related to pneumonia and heart failure because those are the types of medical situations we see most in rural areas where the patients are older, sicker, and poorer. In Phase II, we added outpatient measures and then patient satisfaction measures to show that dimension of quality. In Phase III, we asked rural health providers to measure how well they were doing at stabilizing emergency room patients until they could be transferred to a more upstream hospital.”

“Through MBQIP, FORHP wanted to demonstrate to CMS that we don’t want to just do our own thing,” Moore added. “We want to align what we measure as closely as we can to what CMS is measuring in all hospitals. We want rural residents to know that rural health care providers are high quality. Moving forward, however, requires proving your own value, and you do that with data.” To date, Moore said, participation in MBQIP is voluntary, but approximately 1,290 of the nation’s 1,330 CAHs have opted in.

“As the market moves more toward a value-based model as opposed to the cost-based model employed by many CAHs, you could end up with a two-faced system where rural providers are on the outside looking in,” cautioned Moore. “The forward-looking organizations are saying ‘we want to be part of wher-



“I believe that rural providers do provide quality health care but they need to find a way to tell their own story.”

Paul Moore, senior health policy advisor for the Federal Office of Rural Health Policy (FORHP)

ever the health system is going so we retain our relevance and continue to serve the folks in our communities.’ One way you do that is by measuring and reporting your own quality.”

“Quality is an ongoing, always thing,” said Brenda Stevenson, RN, quality director at Titusville Area Hospital, in Titusville, Pennsylvania, which was designated as a CAH in 2014. “Patients who come to our hospital expect quality care, and MBQIP allows us to track and report our quality. I am constantly interacting with physicians, staff members, and department heads who genuinely want to do a better job, who want to constantly improve—especially when they see the results we share and see how we compare with national benchmarks.”

“Quality improvement is both macro and micro,” Stevenson added, explaining that when even one patient’s needs are not met, the hospital must move quickly to address that need. “On the micro scale, every patient experience matters. On the macro scale, we report information about inpatient experiences, outpatient experiences, patient satisfaction, and emergency department transfer ratings on *Hospital Compare*.” (*Hospital Compare* is a website maintained by CMS where anyone can go for quality data about specific hospitals. The website can be accessed at medicare.gov/hospitalcompare.)

“Originally, CAHs were not required to participate in CMS Hospital Compare but all other hospitals were,” said Larry Baronner, rural health systems manager and deputy director of PORH. “Anybody can go online to see where hospitals measure up, so FORHP created MBQIP. Even though it is a voluntary

program, there are a lot of grant dollars tied to participation. Pennsylvania was one of the first states to have 100 percent of our CAHs participate.”

According to Baronner, quality improvement is important from both altruistic and business perspectives. “It’s our duty as health care providers to give patients the best possible care so they can achieve the best possible outcomes,” he said. “But quality improvement is also critical from the hospital perspective. If you want your hospital to remain viable and solvent, your community needs to know you are a quality provider.” Baronner said both FORHP and PORH offer resources to help CAHs meet their quality improvement goals, ranging from technical assistance to collecting and reporting information to sharing information.

“Ultimately, something’s got to be done to make sure rural health care providers are the best they can be,” concluded Moore, who said CMS is gradually making participation in MBQIP mandatory. “I believe that rural providers do provide quality health care but they need to find a way to tell their own story. Data drives things now, as do quantifiable results and outcomes. It’s time rural providers see the necessity of moving into measuring quality, reporting, and proving value to patients and purchasers. Thanks to MBQIP, we are seeing a real willingness among rural providers to move toward this, and Pennsylvania is one of our leaders. Since I’ve been a fed, I know that if I want to see where something is working and working right, that’s where I want to go.”

For more information on MBQIP, contact Paul Moore, senior health policy advisor for the Federal Office of Rural Health Policy, at 301-443-1271 or to pmoore2@hrsa.gov. For more information on the MBQIP and CAH programs in Pennsylvania, contact Lannette Johnston, quality improvement coordinator at the Pennsylvania Office of Rural Health at 814-863-8214 or to lmj29@psu.edu or Larry Baronner, rural health systems manager and deputy director at the Pennsylvania Office of Rural Health at 814-863-8214 or to ldb10@psu.edu.

THE POWER OF THERAPEUTIC HORSEBACK RIDING: One County's Remarkable Program

By Susan J. Burlingame

It started as a small program on one acre of leased land. It started because a 4-H educator saw an opportunity to do something for kids and adults with physical, mental, and emotional challenges—people who were either left out or unable to participate in other programs. It involved two horses, a couple of riders, and a few volunteers.

What began in 1982 as a small but meaningful experiment is today the Franklin County 4-H Therapeutic Riding Program—where some seventy-five to eighty children and adults reap the benefits of riding horses every year.

Therapeutic horseback riding, also known as equine therapy, has been shown by research to have a positive impact on a person's physical, psychological, educational, and social well-being. For those who can't walk, riding a horse allows them to exercise muscles they normally are unable to use and to feel the sensation of walking. For people in wheelchairs who always have to look up in order to interact, riding atop a horse builds confidence and self-esteem. For those on the autism spectrum, connecting with, caring for, and riding a horse can stimulate communication skills and much more.

According to program director Susan Rotz, the Franklin County 4-H Therapeutic Riding program is about much

more than riding. Each student in the program comes once per week during an eight-week session of "riding lessons" and learns, to the best of their ability, to groom and care for horses and become better riders. Ultimately, Rotz wants participants to be able to develop a skillset they can apply outside the program.

"I see students start out having never had contact with a horse," Rotz said. "Over the course of their sessions, or in many cases over the course of several years, they have grown physically and emotionally, and they have also become better riders."

Riders range in age from three years to over sixty, and their challenges are wide-ranging as well. Some riders are advanced and strong enough to learn dressage or jumping, while others celebrate "simple victories." Rotz recalled the first time her own niece, who had cerebral palsy, was able to hold the reins with her



one good arm and turn the horse for the first time. The program holds two horse shows every year—one competitive and one non-competitive—to showcase what the students have learned.

“Volunteers are absolutely critical to the program,” noted Rotz, explaining that, for the most part, each horse and rider require a leader and two sidewalkers. “Luckily, we have people, many of whom are in the 4-H program, who love to help and who get as much from volunteering as the riders do from riding. We are always looking for more, though.”

Today, the program sits on twenty-five acres of Franklin County government farmland, which includes both pasture and a “sensory” trail where riders can experience different terrain atop a horse and stop at stations to stimulate their senses through music or light or other means. Two outdoor riding arenas and one indoor arena allow for five eight-week sessions from February through mid-December. There are nine horses ranging from ponies to draft horses and one thoroughbred. “Whether horses are given to us as gifts or purchased, we make sure they have the right temperament to work with our students. We look for the older, calmer horses because safety is, of course, our highest priority.”

“For the children and adults who participate in the program, riding a horse is just magic,” said Penn State Extension District 4-H educator Michael Martin, who serves as the liaison between the program and the university. “It has grown substantially over the years, however, and we rely heavily on fundraisers, sponsors, the United Way, and fees from riders’ families (which are on a generous sliding scale) to keep the program going.” Martin explained that expenses include caring for and boarding horses, maintaining the pastures and arenas, and making improvements when necessary.

“There are other 4-H therapeutic riding programs in other counties, but none are as well-equipped or have such a well-developed facility as Franklin County’s,” explained Christy Bartley, assistant director of programs for Penn State Extension, who oversees the Pennsylvania 4-H program. “4-H has been working with Easter Seals and other organizations in Pennsylvania to offer programs like these for years because they are so beneficial.”

Bartley explained that students and volunteers find out about the program by word-of-mouth, newspaper stories, physicians’ offices, and other means. “There is an application process for each student and an extensive screening process for volunteers,” she added.

Rotz, who has been part of the program in a variety of capacities since 1983 and was named director in 2015, said her goal is to increase the program to 100 riders. “People are on waiting lists,” she explained. “I want to be able to hire another therapeutic instructor to accommodate and help more people.” Another of Rotz’s goals focuses on helping students develop enough skills to become volunteers themselves, something she has seen happen several times. “This is a program that is uplifting for everyone. It’s wonderful when a student who has received the benefits of the program grows enough to become someone who gives.”

To become a volunteer, give to, or to find out more about the Franklin County 4-H Therapeutic Riding Program, contact Michael Martin, District 4-H educator with Penn State Extension, at 717-263-9226 or to mjm20@psu.edu.



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