CAH Chronicle

Michigan Department of Community Health ♦ Michigan Center for Rural Health ♦ Michigan Health & Hospital Association

MICHIGAN CRITICAL ACCESS HOSPITALS

Keweenaw
Ontonagon
Baraga
Bell
Grand View
Munising
Helen Newberry Joy
Iron County
Schoolcraft
Mackinac Straits
Charlevoix
Kalkaska
Paul Oliver
ReedCity
Gladwin
Standish
Scheurer
Harbor Beach
Lakeshore
Hills&Dales
Kelsey
Caro
Deckerville
Marlette
McKenzie
Sheridan
Ionia
Clinton Memorial
Allegan
Hayes Green Beach
Eaton Rapids
Lakeview
Borgess - Lee
Herrick

Non-Metropolitan Service Area

Designated CAH (34)

2007 CAH Conference –Boyne Mt. Resort

The party's over, and by all accounts, it was a great celebration. The staff at MCRH sends thanks to all 125 participants, the 18 supportive vendors, and all the volunteer speakers who shared their expertise. You all make it happen. Plan on an early November 2008 Conference at Boyne Mt. More information will follow in mid 2008.

FCC Launches Initiative to Increase Access to Health Care in Rural America Through Broadband Telehealth Services

The Federal Communications Commission has dedicated over $417 million for the construction of 69 statewide or regional broadband telehealth networks in 42 states and three U.S. territories under the Rural Health Care Pilot Program (RHCPP).

The Commission's RHCPP will support the connection of more than 6,000 public and non-profit health care providers nationwide to broadband telehealth networks. The health care facilities participating in the Pilot Program include: hospitals, clinics, universities and research centers, behavioral health sites, correctional facility clinics, and community health centers.

Telehealth and telemedicine services provide patients in rural areas with access to critically needed medical specialists in a variety of practices, including cardiology, pediatrics, and radiology, in some instances without leaving their homes or communities. Intensive care doctors and nurses can monitor critically ill patients around the clock and video conferencing Specialists and mental health professionals will now be able to care for patients in different rural locations, often hundreds of miles away.

The networks will deliver services efficiently, reduce costs and travel time for consumers, decrease medical errors, and enable health care providers to share critical information. Rapid and coordinated responses to public health emergencies, such as bioterrorism attacks, pandemics or disease-related outbreaks, will be expedited through coordination with the U.S. Department of Health and Human Services (HHS), the U.S. Centers for Disease Control and Prevention, and other public health officials during public health emergencies.

The Michigan Public Health Institute – has been awarded $20,910,000 to provide a new network infrastructure to connect existing state health networks to each other and Internet2 at speeds ranging from 1.5 Mbps to 100 Mbps. The network will link approximately 390 facilities, primarily rural, in underserved areas of the state.

More information is available at www.fcc.gov.

Preventing Injuries and Fatalities in Rural Areas

People who live in rural areas are at a much higher risk of injury or death from motor vehicle crashes. About 60 percent of traffic fatalities occur in rural areas, the majority of them on two-lane roads, according to the Center for Excellence in Rural

Safety Center for Excellence in Rural Safety (CERS). One-fifth of the American population lives in rural areas, yet three-fifths of the 42,642 fatalities from motor vehicle crashes last year occurred on rural roads.

Engineering improvements, such as redesigning rural roads and building electronic control stability into vehicles that easily roll over, are effective preventive methods. Engineering may be accompanied by legislation for effectiveness; for instance, the National Highway Traffic Safety Administration (NHTSA) has mandated phasing side air bags into new vehicles over a period of years.

Education and enforcement go hand in hand. Legislating mandatory use of motorcycle helmets is more likely to reduce injuries than public education encouraging helmet usage. More rural people than urban people die from not wearing seat belts or not using helmets on motorcycles and ATVs. Rural people tend to value individual freedoms, so legislating change is difficult and unpopular in rural areas. The NHTSA's high visibility educational campaigns, accompanied by law enforcement, have significantly contributed to improved seat belt usage nationwide. In 2006, 78 percent of motorists in rural areas used seat belts, compared to 84 percent in suburban areas and 81 percent overall, according to the National Occupant Protection Use Survey (NOPUS).

The failure to decrease crashes related to driving while impaired by alcohol usage is distressing. The number of fatalities in alcohol-related crashes has remained essentially the same for several years. NHTSA conducted a major educational and enforcement campaign this fall aimed at young males who drink and drive. Research indicated this target group is unlikely to change drinking and driving behavior because of societal disapproval, but they are afraid of consequences that may impact them personally. The campaign focused heavily on outcomes of driving drunk, such as losing licenses and spending time in jail. NHTSA also encouraged increased law enforcement presence, such as sobriety checkpoints. In 2006, 15,121 fatalities involved a driver or motorcycle rider whose blood alcohol content was above the legal blood limit in all states.

Preventing or reducing injuries involves a complex process with many variables and no certain outcomes. Senior citizens are more likely to have fatal falls, some communities have more suicides and motor vehicle crashes occur more often on certain rural stretches of roads. Ultimately, when injury prevention efforts fail, a good trauma system should be in place to provide care for the patient and family.

According to the CERS, crash victims are five to seven times more likely to die if their arrival at a hospital exceeds 30 minutes. In urban areas, that time averages 34 minutes compared to 52 minutes in rural areas.

Interesting Web Site:

http://www.remsttac.org/

Rural EMS and Trauma Technical Assistance Center's (REMSTTAC)

Through the provision of technical assistance REMSTTAC will promote both the local (horizontal) and regional/statewide (vertical) integration of rural EMS within existing EMS, trauma, healthcare, mental health, public health, public safety and disaster response systems.

REMSTTAC is dedicated to supporting EMS, trauma and rural health policy makers, EMS agencies, EMS professionals and the communities they serve to help ensure that vital EMS and trauma services can continue to survive and thrive in rural and frontier communities.

REMSTTAC technical assistance is focused to:

- Support integration of rural and urban EMS and trauma care systems
- Promote infrastructure improvement and systems enhancement
- Emphasize disaster preparedness for rural and frontier areas
- Emphasize financial sustainability
- Integrate prevention, special populations, faith-based, family-centered care and cultural competency
- Support the need for formal research and evaluation of rural EMS and trauma response

- Provide appropriate referrals to other technical assistance resources

Increased Transparency Essential to Goals of Improving Health System Performance and Reducing Spending; Large Majorities Favor Requiring Reporting of Drug Prices, Medical Loss Ratios

Health care providers, insurance companies and drug makers should make information about prices available to the public, according to a new survey of leaders in health care and health policy. The latest Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey finds widespread support for such measures:

In addition to the reporting of provider quality and prices, 86 percent of respondents support public reporting of drug prices charged to major purchasers, and 82 percent support the public reporting of medical loss ratios—the share of premium dollars that private insurance companies spend on actual medical care, rather than marketing, administration, and other expense or profit.

The survey focused on transparency in health care quality and pricing, the public reporting of such information by name of hospital, physician practice, or other health care provider. Three-quarters of health care leaders believe increased transparency in quality and price is essential to improving the performance of the U.S. health care system.

Improved transparency can help reduce the ever-increasing spiral of health care costs, the respondents said, but only to a small degree. Two-thirds (69%) of opinion leaders see improved transparency as a means of reducing health care spending. There is great variability of opinion on how great an impact transparency would have on cost. Seventeen percent believe it will reduce spending by more than 5 percent, while 31 percent think it will reduce spending by 1 percent to 5 percent.

On the other hand, four out of five (81%) opinion leaders think that more widespread public reporting of information could stimulate providers to improve their performance through quality improvement activities. "Transparency is important because it motivates physicians and hospitals to assess and improve their care," said Commonwealth Fund President Karen Davis. "For those providers that aren't doing well, public reporting serves as a wake-up call to identify problems and improve performance."

Two thirds of the opinion leaders surveyed believe increased transparency could also help patients make more informed decisions about their health care. However, only 8 percent think patients will be able to make such decisions in the next two to three years, given the information available to them.

Despite the broad support for improved transparency, there are significant barriers to implementation, including the logistical issues of collecting data and making information comparable across plans and comprehensible to patients. Survey respondents named the following key strategies to improve health care quality and cost transparency:

- sharing the costs of data collection for performance measurement across providers, insurers, and the government (75%);
- ensuring widespread adoption of health information technology (88%);
- establishing a new public/private national entity to set standards for measurement and reporting and to be accountable for health system transparency (56%); and
- paying providers based on publicly reported quality and price data (54%).

Opinion leaders surveyed included experts from four broad health care sectors: academia and research organizations; health care delivery; business, insurance, and other health industry, and government and advocacy groups. Elected officials and media representatives were excluded.

Improving the Quality of Stroke Care at Critical Access/Rural Hospitals

You are invited to attend a conference call specifically for Critical Access and Rural Hospitals about how to improve the quality of stroke care targeting the unique needs of CAH & rural hospitals. Pat Biery, RN, Tipton Memorial Hospital will be discussing how to educate staff about stroke and in the NIH Stroke Scale and Donna Sexton, RN, from Dunn Memorial will be discussing how to create documentation systems that doctors and nurses will use. Speaker presentations will be available to download approximately 1 week prior to the call at http://glrsn.uic.edu.

Date: **January 31, 2008**
Time: 1:00 pm CT /2:00 pm ET
Presentation Time: Approximately 45 minutes
Discussion Time: Approximately 15 minutes

Dial In Number: 877-723-9522 **Pass code:** GWTG
Recommended audience: ED Staff/Quality/Nursing
Learning Objectives

1. Participants will educate their staff in the correct completion of the NIHSS in an efficient and effective manner.
2. Participants will be better prepared to educate their professional staff on how to complete the NIHSS, by using strategies and tools presented.
3. To understand and overcome the barriers that hinder compliance with implementation of a stroke protocol set.
4. Obtaining and maintaining staff competency for stroke protocol at a rural/critical access hospital.

Email gwtg@heart.org with your name, address, phone number, and email to register. In order to receive nursing CEU credits, *participants must register and include the above-required information, participate on the call and complete the online evaluation.*

Questions? Please contact Angela Bray Hedworth at hedworth@uic.edu.

**The American Nurses Credentialing Center's Commission on Accreditation accredits Oakton Community College, Alliance for Lifelong Learning, and Continuing Education for Health Professionals as a provider of continuing nursing education.*

EMS Teleconference

Thursday, December 6, 2007, 6:00 – 7:00 p.m.
Topic: Assessing Patients in the Pre-Hospital Setting
Presenter: Shelly Dove RN/EMT-P
Flight Nurse Survival Flight Specialist; University of Michigan
Sponsored by: The Michigan Center for Rural Health and the Michigan Association of Ambulance Services.
Education Credits: Participants who participate for the entire program will receive 1 credit for Patient Assessment.
Cost: There is no cost to participate in the conference call.
For More Information:
Please contact Phyllis Ball, Education Coordinator, at (517) 355-8250 or E-mail: ballp@msu.edu.

2008 EMS Instructor/Coordinator Course

This is a comprehensive program sponsored by the Sanilac Medical Services. Doug Smith, Platinum Educational Group, LLC will cover topics including instructional and presentation techniques, learning styles, course planning, evaluating student performance, and course coordination. Upon successful completion of the course, students will be eligible to take the Michigan EMS I/C Exam.
Prerequisites: 3-years field experience at the MFR level or above by exam date, written endorsement of two active Instructor/Coordinators, and must obtain a CPR Instructor card by course completion.
Course Dates: Classes are Friday, Saturday and Sunday from 8 a.m. to 6 p.m. (occasionally 7 p.m.)
January 4 - 6; January 11 - 13; January 18 - 20; February 1- 3; February 15 -, 17

Course Tuition: $650 for Huron or Sanilac County Residents - $950 for out-of-county residents
For More information contact Leslie Hall, Huron-Sanilac EMS Network Director: 989-284-5345

GRAND ROUNDS:

ARTHRITIS

Held the second Wednesday of each month from Noon to 1:00 p.m. except in July and August.

Sponsored by: The Michigan Center for Rural Health and the Michigan Arthritis Collaborative Partnership.

- December 12 – Rheumatologic Emergencies, -Joseph McCune

Accreditation: St. Mary Mercy Hospital, an organization accredited by the MSMS Committee on CME Accreditation, designates that this activity meets the criteria for a maximum of one (1) credit hour in Category 1 credit towards the AMA Physician's Recognition Award.

GERIATRIC

Held the first Wednesday of each month from Noon to 1:00 p.m. except July and August.

Sponsored by: The Michigan Center for Rural Health and the Geriatric Education Center of Michigan.

- December 5- Rehabilitation Issues in Patients with Conditions of Chronic Illness – Lawrence Prokop, DO and Mark Ensberg, MD

Accreditation: This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Michigan State University College of Osteopathic Medicine and the Michigan Center for Rural Health.

NURSING

Held quarterly from Noon to 1:00 p.m.

Sponsored by: The Michigan Center for Rural Health and MSU College of Nursing

- February – 2008 TBD

Accreditation: Participants who attend the entire session and complete an evaluation form will receive a certificate for 1.5 contact hours. *Michigan State University College of Nursing is an approved provider of continuing nursing education by the Michigan Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.*

PSYCHIATRY

Held quarterly from Noon to 1:00 p.m.

Sponsored by: The Michigan Center for Rural Health and the MSU Department of Psychiatry.

- January – 2008 TBD

Accreditation: This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Michigan State University College of Human Medicine and the Michigan Center for Rural Health.

SOCIAL WORK

Held quarterly from noon – 1:15 pm

Sponsored by: The Michigan Center for Rural Health and the MSU School of Social Work

- Dec. 6 - Understanding and Managing Pain: The Social Worker's Role in Assessment and Intervention

Speaker: Yvette Colón, PhD, MSW

Accreditation: Michigan State University School of Social Work (Provider No. 1136) is approved by the Association of Social Work boards (ASWB) approved continuing Education (ACE) program: www.aswb.org: 1-800-335-6880. ASWB ACE-approved programs are recognized in Michigan. In addition, Wisconsin, Illinois, and Indiana recognize ACE-approve providers. Social workers should verify recognition of ACE approval with their state boards.

For more information, contact Phyllis Ball, Education Coordinator at: ballp@msu.edu or 517-355-8250.

INTERESTING QUOTE:

"Service to others is the rent you pay for your room here on earth."

-Muhammad Ali

MARK YOUR CALENDARS
Soaring Eagle Resort, Mt. Pleasant