# RHC Newsletter

Issue 23

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## What Would Private Accreditation for RHCs Look Like?

Private Accreditation will become an option for RHCs throughout the US. Certification and recertification will still be available from the ISDH. As you recall, there were several months this past year when ISDH surveyors were not able to respond to RHC applications due to the loss of federal funding. Presently, there are no other options for applicants.

The National Association of Rural Health Clinics is working with the American Association for Accreditation for Ambulatory Surgery Facilities, Inc. It is expected to be available in about a year.

**Potential benefits of private accreditation for Rural Health Clinics:**

- An option for RHCs whenever an unexpected loss of federal funding halts the accreditation process for practices in the health professional shortage areas.
- Consistent interpretation of the federal regulations within and between states which lends itself to the development of national benchmarks to improve the quality of care.
- Conduit for the individual clinics to have an impact on the standards and the interpretation of those standards.
- A peer based program assures that inspectors are trained specifically to perform RHC inspections. Inspectors survey within their state.
- Guidance for surveyors is the State Operations Manual which is the same for every state. (http://www.cms.hhs.gov/manuals/downloads/som107ap_g_rhc.pdf)

**Application Process for Private Accreditation with the AAAASF:**

- The clinic downloads the application materials from AAAASF website.
- Clinic submits completed application and fee to the AAAASF office.
- The AAAASF staff checks the application for completeness and checks the credentials of the staff.
- AAAASF contacts an inspector and arrangements are made for the inspection.
- The inspector reports findings to the AAAASF office.
- If deficiencies are found the clinic has 30 days to make corrections and submit substantiation to the AAAASF office.
- If no deficiencies are found or once they are satisfied accreditation is approved and a certificate is mailed to the clinic.
- The clinic can then apply to CMS for a provider number.

**Fees for Private Accreditation:**

Accreditation fees are based on the clinic FTE as reported to CMS

- Less than 2 FTE - $1,655 annual fee
- 2 to 4 FTE - $2,095 annual fee
- More than 4 FTE - $4,000 annual fee
- The Inspection fee is $1400.

**Interested in Becoming an Inspector?**

Any Nurse Practitioner, Physician Assistant, Nurse Midwife, or Physician working in a rural health clinic can volunteer to be an inspector. (Continued on page 2)

## What's New?

**New Cap for Independent RHCs**

On January 1, Rural Health Clinics received a 1.6% increase pushing the upper payment level for the independent clinics to $76.84.

National Government Services (Administar) was awarded the FI for Indiana Rural Health Clinics on January 7, 2009.

**Status of CMS Proposed Rule**

The National Association of Rural Health Clinic's executive director and lobbyist for RHCs, Bill Finerfrock, reported that "one of the first official acts of President Obama was to notify all agencies that they were to cease work on all pending regulatory changes until the new Administration has an opportunity to review the work. This was not unexpected and follows a tradition going back to the Reagan Administration. As a result of this announcement, no further work on the RHC rule will take place in CMS until it has been reviewed by Obama Administration officials."

He went on to say, "it is not clear how long this review process will take. I expect, however, it will take several months to complete the review. It should be noted that it will take several more weeks before the new CMS Administrator is in place, as well as those political appointees below the Administrator level. It is conceivable that the review of Medicare/Medicaid rules will not commence until those political appointees are in place."

The NARHC will seek to meet with those officials reviewing proposed changes in the RHC regulations to discuss strengths and weaknesses of the proposed changes.

**Private Accreditation** (continued from page 1)

- Inspectors are trained by RHC Accreditation Program staff and senior inspectors.
- Attend the RHC Accreditation Inspector Training Course and pass a competency examination at the completion of the course.
- Inspector certifications are valid for three years.
- Certified inspectors are assigned by the RHC Accreditation Program staff.
- Inspectors are compensated $500 + travel expenses per inspection. (www.narch.org)

**Emergency**

## A Statewide Trauma System for Indiana

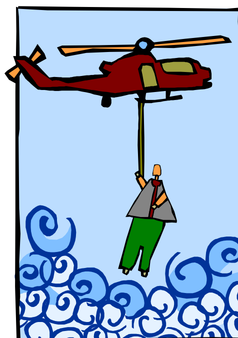
The ISDH Injury Prevention Program in 2005 cited injury as the leading cause of death for 1 to 34 year-olds. More than 95,000 Hoosiers were hospitalized; over 5,000 die from injuries each year.

Trauma refers to people who have sustained severe injures that require rapid evaluation and transport to hospitals with trauma care capabilities. This includes staff and equipment.

A trauma system is an organized, coordinated effort in a geographical area that delivers the full range of care to all injured patients.

Not all hospital emergency departments are trauma centers. Indiana has seven hospitals that are designated as Level I or II. Wishard, Methodist, and Riley are Level I. All are in Indianapolis. There are four Level II: Parkview Hospital in Fort Wayne, Memorial Hospital in South Bend, and St. Mary's and Deaconess Hospitals in Evansville.

Indiana is one of the last states without a statewide trauma system. Public Law 155 gives authority to the ISDH to be the lead agency from an Indiana trauma care system.



Health care facilities would not be mandated but rather volunteer to become part of the statewide trauma system.

They would be provided with protocols, staffing requirements, education, etc. Level III and Level IV trauma centers descriptions are described below. These levels would be appropriate for rural providers, clinics and hospitals.

**The Level III** trauma center would serve communities that do not have immediate access to a Level I or II institution. Level III trauma centers would provide prompt assessment, resuscitation, emergency operations, and stabilization and also arrange for possible transfer to a facility that can provide definitive trauma care.

General surgeons are required in a Level III facility. Planning for care of injured patients in these hospitals requires transfer agreements and standardized treatment protocols.

**The Level IV** trauma facilities would provide advanced trauma life support before patient transfer in remote areas where no higher level of care is available.

Such a facility might be a clinic rather than a hospital and may or may not have a physician available. Because of geographic isolation, the Level IV trauma facility is the de facto primary care provider. If willing to make the commitment to provide optimal care and given its resources, the Level IV trauma facility would be an integral part of the inclusive trauma care system.

Likewise, treatment protocols for resuscitation and transfer, data reporting, and participation in system performance improvement would be a part of trauma IV facilities.

A Level IV trauma facility must have a good working relationship with the nearest Level I, II, or III trauma center. This relationship is vital to the development of a rural trauma system in which realistic standards must be based on available resources.

Optimal care in rural areas can be provided by use of existing professional and institutional resources supplemented by guidelines that result in enhanced education, resource allocation, and appropriate designation for all levels of providers.

IRHA's Public Policy Forum will feature the Indiana Trauma System Initiative. State Health Commissioner Dr. Judith Monroe, Senator Tom Wyss, State Representative Charlie Brown, President of the IN Emergency Nurses Association Larry Addison, and Dr. Mary Aaland will present different aspects of the program. Come to IRHA's Public Policy Forum February 20th at the Indianapolis Hyatt Regency to learn more about the benefit of a statewide trauma system for our state, communities, practices, and families.

## Preparedness: Prevent Frostbite

Burrrrr, it's cold outside! Plan ahead to make sure you're prepared for the winter weather.

"When you're wet or exposed to high winds, core body temperatures can drop quickly and you can get into trouble pretty fast," Thomas Tallman, DO emergency medicine specialist

**What is frostbite?** It is literally the freezing of body tissue, e.g. fingers, toes, or ears, and the nose being the most vulnerable to frostbite. Frostbite is caused by either prolonged exposure to cold temperatures or shorter exposure to very cold temperatures.

Deep frostbite: Skin and underlying tissue freezes. Permanent damage is possible, depending on how long and how deeply the tissue is frozen.

**Symptoms:** Many experience numbness. A "pins and needles" sensation, severe pain, itching, and burning are all common when the affected area is warmed and blood starts flowing again. Skin may look white, grayish-yellow, or even black with severe frostbite, and it may feel hard, waxy, and numb. Blistering is also common.

**Treatments for frostnip or frostbite:** Get out of the cold and get out of wet clothing as soon as possible and remove all constrictive jewelry and clothing. Then immerse the affected area in warm, but not hot, water.

If water is not available, warm your hands by tucking them into your armpits. Warm your nose, ears, or face by covering them with dry hands.

**Do not:**

✦ Thaw the frostbitten tissue if there is a chance that it will refreeze before you get medical attention, as this increases the likelihood of permanent damage.

✦ Rub or massage frostbitten skin or disturb blisters, which can further damage tissue.

✦ Use direct dry heat, like heating pads or a campfire to thaw frostbitten tissue.

**Stay safe:**

✦ Extreme cold, high winds, wet clothing, and poor planning all contribute to cold-weather injury.

✦ Wear adequate clothing, e.g. several layers of clothing, with the innermost layer being a fabric that wicks moisture from the skin. The outer layer should serve as a windbreaker.

## Preventive Medicine:

**Those making a resolution are about 10 times more likely to succeed than those not making a resolution.**

**Resolve to quit smoking this New Year! Call 1-800-Quit-Now for help.**

### IN Statewide Smokefree Bill Moves Forward

HB1213, one of the comprehensive statewide smoke-free workplace bills, has a hearing scheduled for the Indiana House Public Policy Committee next Wednesday, February 4th at 9am.

### Another New Product from RJ Reynolds

Camel Sticks, Camel Orbs, and Camel Strips

Release date: January 2009

**Description**

The dissolvable products -- a pellet (Camel Orbs), a twisted stick the size of a toothpick (Camel Sticks) and a film strip for the tongue (Camel Strips) The products melt in the mouth within three to 30 minutes.

The nicotine delivery of the products is said to be high: whereas a cigarette smoker typically takes in about 1 milligram of nicotine, the Camel Dissolvables are said to deliver about **0.6 to 3.1 mg** of nicotine each! These products are now available in Indianapolis and will go national this spring.

**Advertising Catchlines:**

- The Best Tobacco You Never Smoked
- Face the Future Join the Movement
- Revolution in Pleasure
- No Spitting Required
- Dissolves in Your Mouth

Please be aware of these products and discourage their usage. Remember to talk to your teens and teen patients about the dangers of using all tobacco products. They continue to be filled with dangerous chemicals. Higher nicotine levels increase addictiveness. The cost of tobacco products remains high.

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## Upcoming Events

**February 20**

**IRHA Public Policy Forum**
Hyatt Regency in downtown Indianapolis, IN

**March 8-10**

**NARHC Spring Institute**
San Antonio, Texas
http://www.narhc.org/events/events.php

**March 24**

**IRHA Spring Into Quality**
To include RHC breakout sessions. Plainfield, IN

**March 24-25**

**WIPFLI 16th Annual Rural Health Clinic Forum**
Green Bay WI
www.wipfli.com/event/RHC

**June 9-11**

**IRHA Annual Conference**
RHC preconference June 9
Marriott East Indianapolis

# 7th Annual Indiana Rural Health Public Policy Forum

**February 20, 2009**

**Hyatt Regency, South Capitol Avenue, Indianapolis, Indiana**

| Session | Speaker | Time |
|---|---|---|
| **Registration, Continental Breakfast<br>Visit with Exhibitors** | | **8:00 am** |
| **Welcome** | **Bruce Hancock, President, IRHA** | **9:00 am** |
| **Welcome from U.S. Senator Richard G. Lugar's Office** | **Lane Ralph, Deputy State Director** | **9:05 am** |
| **Healthcare Issues from the National Perspective** | **Tim Fry, NRHA** | **9:10 am** |
| **Secretary of State's Impact on Rural Indiana** | **Todd Rokita, Secretary of State** | **9:45 am** |
| **Break and Exhibitors** | | **10:15 am** |
| **Smoking Ordinances, Healthy Indiana Plan, the State's Commitment to the Trauma System, Attracting Primary Care Physicians to Shortage Areas, and Other ISDH Issues** | **Dr. Judith Monroe<br><br>State Health Commissioner** | **10:45 am** |
| **Lunch and Visit with Exhibitors** | **Karla Sneegas, Executive Director Indiana Tobacco Prevention & Cessation<br>(last 15 min. of lunch)** | **noon** |
| **The Trauma Care Hospital Fund** | **Senator Tom Wyss<br>Rep. Charlie Brown** | **Panel Discussion<br><br>1:15 pm** |
| **A Trauma System Helps Rural Populations** | **Mary Aaland, M.D.** | |
| **Rural Improvements in Trauma Care** | **Larry Addison, RN<br>President<br>Emergency Nurses Association** | |
| **The 118th General Assembly and Rural Health** | **Brian Tabor, VP of Government Relations<br>IN Hospital Association** | **2:15 pm** |
| **Summary & Adjourn** | | **3:00 pm** |