



Mississippi Rural Health Association

Crossroads

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Winter 2013

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From the MRHA President's pen

Happy New Year to all members, affiliates, and potential members of MRHA. The Association accomplished many great things during 2012 for which we are thankful. I want to use this opportunity to highlight these and emphasize that the MRHA is a thriving organization that is making progress in providing services and opportunities for the improvement of rural health in Mississippi. During 2012, the MRHA had the great fortune to achieve the following:

- Increased membership to 480 members, exceeding our goal of 250
- Began offering the Qualtrics patient experience survey pilot program
- Provided purchasing cooperative services through FirstChoice Cooperative
- Began offering advertising options for members in the MRHA newsletter and promoted better advertisement of services, programs, and grant opportunities
- Added a beneficial and productive legislative component to the Association's annual conference
- Began offering a grant proposal development track as a part of the Association's Rural Health Clinic Workshops
- Distributed information to members on "how to start a rural health clinic" (access link on MRHA's



Sam Dawkins,
 Mississippi Rural
 Health Association
 2013 President

- website)
- Improved the members connection to local contractors that can assist with EHR (electronic health record) implementation
- Initiated a grant-funded project with the National Children's Center for Rural Agricultural Health and Safety to establish a coalition in Mississippi to decrease childhood injury

on small farms

For 2013, in addition to continuing our services in the areas above, MRHA hopes to contribute to the growth and development of the organization by:

- Further increasing the value of membership by adding tangible or identifiable benefits of joining MRHA
- Developing a health literacy program that will better connect underserved populations to health care through increased use of online technology and social media

MRHA looks forward to the opportunities to expand and improve our organization in 2013. We extend the invitation for each of you to become involved in the organization and be a part of the great services and events this year. For potential members, we encourage you to review our web site at www.msrrha.org/ and take the positive step to join our organization in 2013.

Save this date on your calendar!

Wednesday, February 6th

8 a.m. – 11 a.m.

Share your voice for rural health at the Association's Capitol Day.

Visit www.msrrha.org to learn more!

UMC hosting Tobacco Treatment Specialist Certification (CTTS) workshop

The ACT Center for Tobacco Treatment, Education and Research, a division of the University of Mississippi Medical Center's (UMC's) Oral Oncology and Biobehavioral Medicine Department of Otolaryngology and Communicative Sciences, is hosting a Tobacco Treatment Specialist Certification (CTTS) Workshop from February 25, 2012 until March 1, 2012 in Jackson. This Tobacco Treatment Specialist Training Program has received a Certificate of Accreditation 2011 – 2016 from the Council on Tobacco Treatment Training Programs (CTTTP) in collaboration with the Association for the Treatment of Tobacco Use and Dependence (ATTUD).

Offered since 2000, this workshop is designed to provide an in-depth understanding of key considerations needed to deliver an evidence-based, high-intensity intervention program for tobacco dependence. The program employs both didactic



and hands-on experiences to promote the learning of necessary information and skills.

The Tobacco Treatment Specialist Certification curriculum has been nationally accredited by the CTTTP, and meets the standards set forth by ATTUD. In the State of Mississippi, this workshop is

required training for Tobacco Treatment Specialists employed throughout our statewide tobacco treatment network.

This workshop is open to most professionals, and is geared towards healthcare professionals including physicians, dentists, psychologists, pharmacists, nurses, social workers, respiratory therapists, occupational therapists, physical therapists, alcohol/addiction counselors, health/mental health counselors, asthma/diabetes educators, Quitline counselors, and others. There are specific background, experiential, and related requirements for those seeking certification.

Registration is \$550. Mississippi residents receive a reduced registration rate of \$350, and students' registration fees are only \$300. More information about the workshop is available at www.act2quit.org/. An application form is available at www.act2quit.org/education/.



Every year, more than 500 Mississippi non-smokers die from exposure to secondhand smoke and countless others have their health compromised from secondhand smoke inhalation.

Comprehensive smoke-free policies that protect Mississippians in all public places, including restaurants and bars, have been shown to improve health outcomes without affecting businesses.

This year, you are invited to join Smokefree Mississippi in working toward the passage of a statewide smoke free law that will ensure that all citizens are protected in restaurants, bars and casinos.

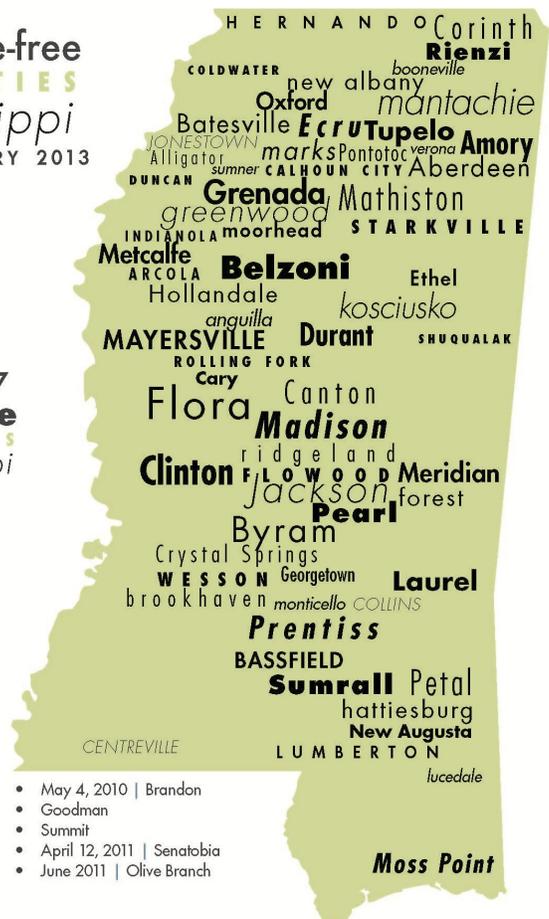
Smokefree Mississippi applauds two new efforts to improve the health of Mississippians. The University of Mississippi will fine those found smoking on its campus and the State Capitol has banned smoking at its north and south entrances.

100% Smoke-free
COMMUNITIES
in Mississippi
UPDATED | JANUARY 2013

There are 67
smoke-free
COMMUNITIES
in Mississippi

Partial Smoke-free
COMMUNITIES
in Mississippi

- October 2007 | Greenville
- November 15, 2007 | McComb
- May 1, 2008 | Gulfport
- August 1, 2008 | Walls
- June 26, 2009 | Picayune
- January 6, 2010 | Columbus



- May 4, 2010 | Brandon
- Goodman
- Summit
- April 12, 2011 | Senatobia
- June 2011 | Olive Branch

MRHA concludes 2012 with recognition – Establishes new Leadership Award

The Mississippi Rural Health Association concluded 2012 with its annual end-of-the-year luncheon and recognition for current and previous board members, liaisons, community partners, sponsors, and legislators on December 4 in its office in Madison, MS.

The Association’s president for 2012, Danny McKay of Noxubee General Hospital, led the meeting with a reflection of the year’s accomplishments. Among the accomplishments, McKay noted that the MRHA recorded an all-time high of 480 members while growing its programs and increasing statewide exposure. Additionally, an improved voice and Internet presence has made contact with the Association easier than ever.

McKay honored three board members whose terms ended in 2012, Mr. Chad Netterville of Field Memorial Community Hospital, Dr. Heather Tutor of Tutor Dentistry, and dean emeritus of Hinds Community College Mrs. Mary Ann Sones. The three board members were recognized with a plaque to commemorate their leadership with the Association.

Three new board members were voted by the Association’s membership in September to begin their first term in 2013: Mrs. Margaret Cotton of Delta Council, Mrs. Cynthia Douglas of River Region Health System, and Dr. Libby Mahaffey of Hinds Community College.

The recognition ceremony was highlighted by two significant recognitions. First, a recognition gavel and plaque was presented to president Danny McKay for his great service to the Association as president during 2012. The presentation of this plaque signifies the beginning of the Association’s 2013 president’s term. That office will be filled by Mr. Sam Dawkins of Delta Health Alliance.

The second recognition was the establishment of a new award. The new award, a leadership award, was presented to Mrs. Mary Ann Sones for her more than 15 years of service to the Association. This award, to be presented each year to an identified member that has dedicated a significant amount of time and energy for the direct benefit of the Association, will be referred to as the Mary Ann Sones Distinguished Leadership Award.

Association past president Alan Barefield remarked, “I know of no other



Incoming MRHA 2013 president Sam Dawkins, outgoing MRHA 2012 president Danny McKay, honoree and outgoing MRHA board member, Mary Ann Sones, and MRHA board member Alan Barefield are shown at the announcement of the establishment of the Mary Ann Sones Distinguished Leadership Award at the MRHA annual end-of-the year recognition luncheon.

person in the field of public health and health education that has been as dedicated to the role of promoting rural health and the Mississippi Rural Health Association as Mary Ann Sones. She has been a vital part of the rural health sector since her beginning days at Hinds Community College and her influence and

concern has not diminished since. I only hope that this award recognizes in some small way her accomplishments in the progress of rural health in the state of Mississippi.”

*Contributed by Ryan Kelly
Executive Director
Mississippi Rural Health Association*

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Mississippi ranks among the states most prepared for emergencies

In the 10th annual *Ready or Not? Protecting the Public from Diseases, Disasters, and Bioterrorism* report, 35 states and Washington, D.C. scored a six or lower on 10 key indicators of public health preparedness.

The report, issued by the Trust for America's Health (TFAH) and Robert Wood Johnson Foundation (RWJF), found that while there has been significant progress toward improving public health preparedness over the past 10 years, particularly in core capabilities, there continue to be persistent gaps in the country's ability to respond to health emergencies, ranging from bioterrorist threats to serious disease outbreaks to extreme weather events.

In the report, Kansas and Montana scored lowest—three out of 10—and Maryland, **Mississippi**, North Carolina, Vermont and Wisconsin **scored highest—eight out of 10**.

"In the past decade, there have been a series of significant health emergencies, including extreme weather events, a flu pandemic and foodborne outbreaks," said Jeffrey Levi, PhD, executive director of TFAH. "But, for some reason, as a country, we haven't learned that we need to bolster and maintain a consistent level of health emergency preparedness. Investments made after September 11th, the anthrax attacks, and Hurricane Katrina led to dramatic improvements, but now budget cuts and complacency are the biggest threats we face."

The Ready or Not? report provides a snapshot of our nation's public health emergency preparedness. Its indicators are developed in consultation with leading public health experts based on data from

publicly available sources, or information provided by public officials. Some key findings from the report include:

- 1) 29 states cut public health funding from fiscal years (FY) 2010-11 to 2011-12, with 23 of these states cutting funds for a second year in a row and 14 for three consecutive years. In addition, federal funds for state and local preparedness have decreased 38 percent from FY 2005-2012 (Centers for Disease Control and Prevention [CDC] funds, adjusted for inflation). States are reporting that gains in public health preparedness achieved in the past decade since September 11, 2001 are eroding, and since 2008, budget cuts have resulted in more than 45,700 job losses at state and local health departments;
- 2) Only two states have met the national goal of vaccinating 90 percent of young children, ages 19-36 months, against whooping cough (pertussis). This year Washington state has seen one of the most significant whooping cough outbreaks in recent history;
- 3) 35 states and Washington, D.C. do not currently have complete climate change adaptation plans, which include planning for health threats posed by extreme weather events;
- 4) 20 states do not mandate all licensed child care facilities to have a multi-hazard written evacuation plan; and 13 state public health laboratories report they do not have sufficient capacity to work five, 12-hour days for six to eight weeks in response to an infectious disease outbreak, such as novel influenza A H1N1.

"Public health preparedness has improved leaps and bounds from where

we were 10 years ago," said Paul Kuehnert, MS, RN, director of the Public Health Team at the Robert Wood Johnson Foundation. "But severe budget cuts at the federal, state, and local levels threaten to undermine that progress. We must establish a baseline of 'better safe than sorry' preparedness that should not be crossed."

The Ready or Not? report provides a series of recommendations that address many of the major gaps in emergency health preparedness, including:

- 1) Reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA);
- 2) Assure sufficient, dedicated funds for public health preparedness to ensure basic capabilities to respond to threats public health departments face every day and also to have the trained experts and systems in place to act quickly in the face of major, unexpected emergencies;
- 3) Provide ongoing support to communities so they better cope and recover from emergencies;
- 4) Modernize biosurveillance to a real-time, interoperable system to better detect and respond to problems;
- 5) Seriously address antibiotic resistance;
- 6) Improve research, development and manufacturing of medical countermeasures;
- 7) Increase readiness for extreme weather events; and
- 8) Update the nation's food safety system.

The report was supported by a grant from RWJF and is available on TFAH's website at www.healthyamericans.org/ and RWJF's website at www.rwjf.org/.

Reprinted from Trust for America's Health

Governor hopes new school will improve health and economy

On January 7, 2012, Governor Phil Bryant, University of Mississippi Chancellor Dan Jones, Mayor Harvey Johnson Jr., and other state and local leaders came together for the ceremonial groundbreaking of the University of Mississippi Medical Center's new School of Medicine. Bryant hopes the 151,000-square-foot, \$63-million facility will draw in some of the nation's top medical students and provide a vital tool in

reversing the state's poor health trends.

"We just simply don't have enough doctors, and so people are dying," Bryant said at the ceremony. "This is for every citizen that needs a physician. This is for the young men and women in the white coats ... that seek to be a physician. And it is for the economy of this state."

The new facility will increase the school's incoming class size from 135 to more than 160 students. It will replace

the university's current School of Medicine, which the state constructed in 1955. That, Bryant said, is unacceptable in 2013.

"We are going to move forward with the latest, greatest technology, the most advanced medical school," Bryant said.

In October, Bryant authorized \$10 million in Community Development Block Grants to help fund the facility.

(continued on page 7)

WHAT ARE YOU DOING WITH YOUR SUMMER VACATION?

Get a Jump-Start on College and a Look at the World of a Medical Career

So you think you want to be a doctor...



Qualified high school students between their junior and senior years have the opportunity to spend 5 weeks at Mississippi State during the summer and see...



What it takes to be a doctor...

- Take two college level pre-med courses
- Talk with those in the know – visit UMMC Medical School

What it's like to be a doctor...

- "Shadow" physicians – experience the day-to-day practice of medicine



Examine a future in rural health medicine and experience college life in a 5-week summer program at Mississippi State University

More information?

www.RMS.msucare.com

The Need...

- Mississippi is next to last in the nation in the number of physicians per person.
- Between 2008 and 2018, Mississippi's health care workforce is projected to grow by 23.8%.
- 52,000 new primary care physicians will be needed nationally by 2025.



Mississippi State University Extension Service is working to address the state's ongoing need for health care providers by giving high school students a jump-start on future careers.



More than 100,000 Mississippians are employed in the health care sector – is that where you're headed? We'd like to help you make that decision.

What Next?



Qualifications

- Currently completing your junior year of high school
- Minimum composite score of 25 on the ACT
- High school grades in line with ACT scores
- Desire to learn about a career in family medicine
- Mississippi resident



Application

- Complete the student portion of the application available at www.RMS.msucare.com
- Ask one of your teachers for a recommendation
- Ask the recommending teacher to forward the application and recommendation to your guidance counselor
- Your counselor will need to attach ACT scores and an official transcript and mail the completed application **no later than March 22, 2013.**

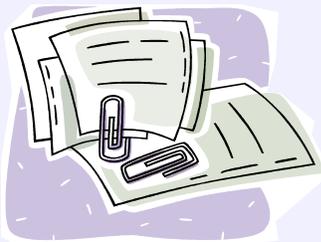
Mississippi State University Extension Service and the State Office of Rural Health at the Mississippi State Department of Health are gratefully acknowledged for their financial support of this project. Tuition and room will be provided without charge for the accepted Scholars.

More information?

www.RMS.msucare.com

SUMMER 2013

Rural Medical Scholars • Mississippi State University • June 2-July 8, 2013



Coding Corner

Billing for EKGs in the RHC Setting

An EKG by itself does not qualify as a rural health encounter. The provider must have a medical reason to have a face-to-face visit with the patient. When billing an EKG in addition to the office visit, your claim should go out like this:

Medicare A – Revenue code 521 = office visit plus professional fee for reading the EKG if it is not over-read by another provider and your healthcare provider follows these rules for documenting their impression:

When billing the professional component of the EKG, a formal interpretation must be provided by the interpreting physician. Such an interpretation may be separately entered into the clinical notes or the physician may place his/her interpretation on the EKG proper. The physician may not just "agree" with the machine's interpretation. The interpretation needs to include the date (and preferably time) of their interpretation, make reference to the various intervals, underlying rate and rhythm; address any abnormal findings and their conclusion along with a CMS-approved signature. Of course, all of the wording must be readily legible.

Example – Office visit = \$100 dollars, 93010 = \$25. Bundle both services on one line into Revenue Code 521 and charge \$125 for both services.

Split off the Technical Component 93005 = \$25 to Medicare Part B on a 1500 claim form.

Total Charge for the service is \$150 dollars. You will be reimbursed your RHC rate from Medicare and you will collect \$25 from the patient (20% of your charge) The Part B will be reimbursed at the fee schedule rate.

Delta BLUES Beacon Community using technology to improve health

Delta BLUES (Better Living Utilizing Electronic Systems) Beacon Community is one of 17 Office of the National Coordinator for Health Information Technology (ONC)-funded Beacon Communities that is building and strengthening local health information technology (IT) infrastructure and testing innovative approaches to make measurable improvements in health, care, and cost. Meaningful use of electronic health records (EHRs) is the foundation of the exciting work in each community.

With leadership provided by the Delta Health Alliance (DHA), Delta BLUES Beacon (DBB) is focused on:

- Improving health outcomes for diabetic patients in the Delta by promoting effective use of EHRs and optimizing care delivery in primary care settings
- Increasing medication adherence rates among diabetic patients by maximizing the contributions of clinical pharmacists and helping patients to develop skills around self-management of chronic disease
- Ensuring seamless, cost-efficient transitions for patients moving from hospital to home by deploying technology-supported staff dedicated to enhanced care coordination
- Fostering community-wide health information exchange by enabling information sharing between hospitals and providers

The Delta BLUES Beacon's major partners include: DHA; University of Mississippi School of Pharmacy; Mississippi State Medical Association; Mississippi Health Information Network; eQHealth; Information & Quality Healthcare; the Mississippi Department of Health; Northwest Regional Mississippi Medical Center; Greenwood Leflore Hospital; Delta Regional Medical Center; North Sunflower Medical Center, and South Sunflower County Hospital.

Building and Strengthening Health IT Infrastructure

The Delta BLUES Beacon is helping local providers achieve meaningful use by upgrading EHR systems to certified software and deploying technical assistance resources focused on meeting requirements. DBB is also working with telecommunications vendors to address limited broadband availability in the Delta, which prevents many providers from fully

utilizing their EHRs. Finally, Beacon is fostering health information exchange (HIE) through a partnership with the state Mississippi Health Information Network (MSHIN). By the end of Beacon, four hospitals and approximately 40 practice locations in the Delta will be exchanging health information via MSHIN.

Progress toward these goals includes:

- 146 primary care providers in the region served by the Delta BLUES Beacon have signed up for assistance with the Regional Extension Center to meet meaningful use criteria.
- Broadband infrastructure upgrades have been completed for approximately 30 practices participating in Beacon initiatives.
- Interfaces with the state HIE have been developed for 11 clinics representing over 30 sites and four labs, and providers in these clinics have all received training around how to effectively utilize the HIE.

Improving Health, Care, and Costs

DBB is training primary care practices to effectively utilize clinical decision support (CDS) tools that help ensure care for diabetic patients is always based on best practices and national care standards. In addition, primary care practices are conducting data-driven quality improvement initiatives around improving care quality for diabetics. Practices work with consultants to review their performance history on key indicators and design strategies to improve results in collaboration with their peers. DBB is also working to improve medication adherence rates among diabetic patients by embedding clinical pharmacists within primary care practices who deliver targeted disease state education and review medication needs with patients and providers. Finally, DBB is focused on reducing avoidable hospital readmissions by enabling successful care transitions for patients moving from hospitalization to primary care. Through a partnership with eQHealth (the Louisiana Quality Improvement Organization), this initiative offers a 45-day coaching program to patients with a primary diagnosis of diabetes, chronic obstructive pulmonary disease, congestive heart failure, or pneumonia discharged from four area hospitals.

Progress in this area includes:

- CDS tools have been used in the care of over 10,000 diabetic patients to date.

Clinics that have embraced CDS have demonstrated improvements in uncontrolled A1c and cholesterol, and have recorded an increase in foot checks, diabetic eye screenings, and other best practices for diabetic care.

- Over 200 patients have received care management services following discharge from a participating hospital through DBB's care transitions program. Only 2% of these patients have experienced a readmission within 30 days.
- Pharmacists participating in the medication adherence program have found over half of participating patients have a drug therapy problem requiring mitigation by the pharmacist, such as medication that is inadequate to meet treatment goals. Patients participating in this project have seen reductions in their hemoglobin A1C values of up to 2 percentage points, as well as promising results for blood pressure, cholesterol, and triglycerides values.

Testing Innovative Approaches

The Delta BLUES Beacon is also demonstrating how Delta providers can deliver previously unavailable screening resources for diabetic retinopathy. As part of an initiative led by the University of Tennessee Hamilton Eye Institute, six specialized eye screening cameras have been deployed in federally qualified health centers, rural health centers, and independent providers' offices. The Delta BLUES Beacon has provided an eye camera technician to address implementation challenges, consistently produced quality screening images, and trained other technicians on how to produce images that pass the rigorous quality inspection. As a result, patients with diabetes who might not have traveled to an eye doctor will be screened and avoid blindness.

Progress toward these goals includes:

- To date, over 600 eye screenings have been conducted in four locations and 10% have been identified for medical follow-up.
- Since the inception of the eye camera project, over 1,000 patients have received services through the program, 43 community-based education events have been held, and more than 40 clinicians have received specialized training.

For more information on the Delta Blues Beacon Community, visit: www.deltahealthalliance.org.

Six stage 2 meaningful use hurdles and how to clear them

As rural and critical access hospitals (CAHs) turn their attention to stage 2 meaningful use of electronic medical records (EHRs), they face hurdles that will make the compliance journey even more daunting.

These are six identified challenges that can be prioritized and tackled head on for successful attestation:

- 1. Computerized physician order entry (CPOE).** Stage 1 required providers to use CPOE for at least one order for 30 percent of patients being treated with medication orders. Stage 2 raises the threshold to 60 percent and expands the CPOE mandate to 30 percent of laboratory orders and 30 percent of radiology orders. To achieve compliance, hospitals may need to replace legacy and stage 1-certified EHRs that doctors failed to adopt. Turn instead to an EHR with a simple order entry process (e.g., limited number of clicks, configurable order sets and one order entry screen for all order types). If you have yet to implement and interface laboratory and radiology systems to your EHR, now is the time to tackle this task, train the two departments to use the solution and incorporate CPOE into the lab and radiology workflows before the compliance deadline.
- 2. Higher thresholds.** The government purposely set the bar low for stage 1 to ease providers' transition to meaningful use with the full intention of raising it progressively higher for stages 2 and 3. For stage 2, for example, facilities must record demographics for 80 percent of admitted patients, up from 50 percent in stage 1. The increased thresholds will challenge rural and community hospitals — especially those that barely cleared stage 1 — with low patient volume. Unlike urban facilities

that admit hundreds or thousands of patients monthly, CAHs may only admit 10. With such a low patient volume, missing one or two patients drastically impacts your overall percentage. Community hospitals can overcome this by choosing an EHR with an adaptable workflow, so capturing the meaningful use-required data is an easy and natural process for your users.

- 3. Physician adoption.** Unlike stage 1, stage 2 requires physicians to enter orders in the EHR. To make training easy for physicians, particularly for those using disparate EHRs in their private practice or clinics, facilities can schedule one-on-one-training at the physician's convenience. During the session, trainers and administrators should emphasize the doctor's role in meaningful use success and, if a rural hospital, securing additional incentive dollars. To further encourage physician usage, hospitals can appoint a highly respected peer to the EHR selection committee to champion 100 percent EHR adoption. During the selection process (whether for first-time buyers or hospitals looking to replace their system), focus on the EHR's usability, speed and mobile access to best appease physicians.
- 4. Electronic prescribing.** In stage 2, hospitals must generate and transmit permissible discharge prescriptions electronically. Providers can meet the requirement with an EHR that incorporates e-prescribing software and allows them to seamlessly fax or email prescriptions to pharmacies unable to receive electronic scripts.
- 5. Health information exchange.** Hospitals must provide a summary of care record when they transition or refer a discharged patient to another provider. They can accomplish this

with EHRs that automatically create a Continuity of Care Document (CCD), an electronic exchange standard for sharing critical patient information including history, medications, allergies, vital signs and laboratory results. It is essential that providers test transmitting the CCD as soon as possible to eliminate technical problems and ensure all involved parties are mapping to the same formats. Providers will have an easy time accomplishing CCD transmission goals if partnering with IT vendors committed to interoperability.

- 6. Patient portals.** A patient engagement core measure requires information for more than 50 percent of patients to be available online within 36 hours of discharge *and* that at least 5 percent of unique patients view, download or transmit information about their admission. To meet the 5 percent requirement, many hospitals are exploring patient portals that can be easily implemented. But galvanizing people to use the technology will prove challenging. The unavailability of home broadband Internet access in rural communities where many patients are elderly and uncomfortable using computers further exacerbates this problem. Creative ways to overcome this barrier include installing touchscreen computer kiosks and tablets in the hospital lobby, having staff work with patients to create a user ID and password and then having patients access their information before leaving. An important success factor is educating patients about the benefits of using the portal before, during and after their hospitalization or visit to encourage adoption.

Contributed by

Ramsey Evans, CEO

Prognosis Health Information Systems

Governor hopes new school will improve health and economy (continued)

(continued from page 4)
fund the facility. He hopes the state will receive more help from the federal government to finance the construction of the facility. The state will sell bonds for the remainder of the funding.

Bryant said the facility, through the doctors it will train, will create 19,000 new jobs and generate \$1.7 billion in the state by 2025. Those jobs include administrative, nursing, pharmaceutical and other jobs which doctors support. Currently, UMMC-

trained physicians generate \$6.3 billion in economic activity and support 60,000 jobs in hospitals, clinics and private practices in the state, Bryant said.

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Article by Jacob Fuller

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*A voice for health
in rural Mississippi*

We're on the Web!
www.msaha.org



You are invited to join us for the first meeting of persons interested in serving on the Mississippi Coalition for the Prevention of Agricultural Injury Among Youth.

The Mississippi Rural Health Association was recently awarded a grant from the National Children's Center for Rural and Agricultural Health and Safety that will facilitate the development of a coalition for the prevention of childhood injuries on farmlands in the State of Mississippi. This grant directs us to form the Mississippi Coalition for the Prevention of Agricultural Injury among Youth in order to influence safety measures and improve health outcomes in the state. **We invite you or any interested colleagues to join this coalition and welcome any feedback to assist us with this goal.**

The MRHA will host its first meeting to discuss the childhood agricultural prevention needs in our state and begin steps to develop a Plan for the Prevention of Agricultural Injuries Among Children in Mississippi. Interested persons are asked to join us at 10 a.m. on February 22, 2013 at the Association's office, located at 31 Woodgreen Place in Madison, MS. Lunch will be provided at the conclusion of the meeting. RSVP to Traci Breland at 601.898.3001.

Please visit our website for more information about the Child Agricultural Safety Program.
www.msaha.org/content/agricultural-child-safety-program