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Crossroads is published quarterly by the Mississippi Rural Health Association.

What is Crossroads?

Crossroads is a publication of the Mississippi Rural Health Association and aims to communicate up-to-date health care news and events through relevant and timely articles.

How do I find more information about the Mississippi Rural Health Association?

You may find more information at www.msrha.org

How do I contact the editors?

You may contact the editors by calling Ryan Kelly, Executive Director, at 601.898.3001

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Learn more on Facebook
The Mississippi Rural Health Association is pleased to announce its 20th Annual Conference on November 4th-6th at the Jackson Marriott.

This year’s conference will focus on the basic theme of “TEAMWORK.”

By participating in the 20th Annual Conference, attendees will gain continuing education credit, have a number of networking opportunities, and hear the input of local healthcare leaders.

The Mississippi Rural Health Association will offer up to eighteen hours of continuing education for nurses, nursing home administrators, and hospital administrators as well as three hours of coding and twenty-one hours of accounting.

Cost is $150 for members and $175 for non members.

This conference will include four breakout sessions for administrators and providers on topics specifically designed to maximize your time and educational needs. Healthcare employees and others interested in healthcare will benefit greatly from attending this conference, as we will be addressing a number of rural health topics.

High quality speakers will present on a number of relevant topics ranging from ICD-10 updates and compliance to community resources for the intellectually challenged and case management strategies. There is even a session to determine your personality and that of your co-workers’. Further, attendees will have the opportunity to participate in roundtable discussions with other healthcare professionals. It will be a great conference, and possibly our largest on record!

REGISTER ONLINE TODAY AT WWW.MSRHA.ORG
Pinnacle Health Group, a perennial member and sponsor of the Mississippi Rural Health Association, recently sponsored a two-year membership for the Mississippi Rural Physician Scholars during their time as resident physicians.

“These students have shown an active desire to be involved with the Association, but with the financial pressures that they face with families and work during their residency programs, our Association’s membership is just too much for them,” stated executive director Ryan Kelly.

The sponsorship will cover Association membership for the current Scholars that are in residency and will cover their membership until they begin their practice. This will allow the Scholars to transition from school to their professional careers without losing the valuable connections that they have made through the Mississippi Rural Health Association.

For more information, contact us at 601.898.3001
The Mississippi Rural Health Association is pleased to partner with the Office of Tobacco Control in the Mississippi State Department of Health to offer clinics complementary posters encouraging tobacco cessation and promoting the Quitline.

These posters, designed by the Association, are perfect for waiting rooms, patient rooms, or other key locations around your clinic or hospital.

TOBACCO USE CAUSES MORE THAN 480,000 DEATHS EACH YEAR IN THE UNITED STATES. THIS IS ABOUT ONE IN FIVE DEATHS.

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- HIV
- DRUG OVERDOSE
- ALCOHOL ABUSE
- CAR ACCIDENTS
- SHOOTINGS

Like us on Facebook: www.facebook.com/pages/Mississippi-Rural-Health-Association/
Follow us on Twitter: @MSRuralHealth
Pin us on Pinterest: www.pinterest.com/msrural1
The Mississippi Rural Health Association recently accepted a contract from the Office of Preventative Health in the Mississippi State Department of Health to provide leadership and support for the Diabetes Coalition of Mississippi.

This coalition unites diabetes educators, community workers, and providers throughout Mississippi in order to provide training, resources, and support for greater diabetes reduction. As Mississippi leads the nation in diabetes rates among its citizens, the Diabetes Coalition serves as a pillar for uniting everyone interested in reducing diabetes rates in the state.

For more information on how to join the Diabetes Coalition of Mississippi, contact Kate Cooley at 601.898.3001 kate.cooley@mississippirural.org or visit www.diabetescoalition-ms.org

The goal of this conference is to provide information and resources to attendees about diabetes management, diabetes prevention, reimbursement rates, and policy changes. This annual conference for the coalition is sure to having something for anyone interested in reducing diabetes in Mississippi and improving citizens' health.

Attendance is free and you can register online at www.msrha.org or www.diabetescoalition-ms.org
The Diabetes Coalition of Mississippi presents the 3rd annual Giving Diabetes the Blues.

Event Information:
- **Date**: Friday, November 6, 2015
- **Location**: The Jackson Marriott, 200 East Amite Street, Jackson, MS 39201
- **Concert**: Featuring Eddie Cotton and the Mississippi Cotton Club
- **Time**: Thursday, November 5th | 7:30 PM
- **Admission**: $30 (free admission)

Questions?
Kate Cooley
601-898-3001 | 888-810-4313
Email: Kate.Cooley@MississippiRural.org

Visit: www.diabetescoalition-ms.org/giving-diabetes-the-blues
The following updates to legislation or health policy have been suggested or made since the last issue of Crossroads.

**Enforcement Delay for Two Midnight Rule**
On August 12, 2015, CMS issued updates to the inpatient hospital review program, usually called the Two Midnight Rule. This update extends the current enforcement delay through the end of December, 2015. Quality Improvement Organizations (QIOs) will begin conducting inpatient status reviews October 1, 2015, but they will not refer cases to Recovery Audit Contractors until January, 2016. Work is currently underway to further extent or modify the Two Midnight Rule.

**340B Mega-Guidance Rule Released**
The Health Resources Services Administration (HRSA) released mega-guidance on the 340B drug pricing program. This long awaited proposed rule will have a 60 day comment period. Comments will be due on October 26, 2015.

**Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act**
H.R. 876, the NOTICE Act, was signed into law on August 6, 2015 (became Public Law 114-42). This law requires that a person receiving observation services in a hospital or critical access hospital (CAH) for more than 24 hours must be given notice within 36 hours of the start of treatment explaining the individual’s status as an outpatient and not as an inpatient, the reasons for that status, and the implications of that status on services furnished, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility. The Centers for Medicare & Medicaid Services (CMS) will develop regulations to implement the notification requirements of this law.

**Support for New Broadband Bill**
Broadband bill aims to improve rural health care access Sen. John Thune (R-S.D.) recently introduced a bill to make skilled nursing facilities (SNFs) eligible for the Universal Service Fund’s (USF) Rural Health Care Program (RHCP), which provides funding for telecommunications and broadband services to rural communities. Currently, SNFs are not included in the Telecommunications Act of 1996 as eligible providers to receive financial support from the RHCP administered by the FCC. Thune’s Rural Health Care Connectivity Act of 2015 seeks to remove the restriction.

**Support for Telehealth bill**
On July 7th, U.S. Reps. Mike Thompson (D-CA), Gregg Harper (R-MS), Diane Black (R-TN) and Peter Welch (D-VT) introduced and sponsored the Medicare Telehealth Parity Act of 2015, legislation that would expand coverage of telehealth services under Medicare by removing geographic barriers under current law and allowing the provision of telehealth services in rural, underserved and metropolitan areas. Rep. Steven Palazzo (R-MS) recently signed-on as a co-sponsor. If H.R. 2948 is made into law, this key piece of legislation will break down one of the biggest obstacles facing national telehealth adoption today.

**Proposed 2016 Payment and Policy Changes to Medicare SNFs**
On April 15, 2015, CMS issued a proposed rule [CMS-1622-P] outlining proposed FY 2016 Medicare payment rates for skilled nursing facilities. The changes include an increase in 1.4% of aggregate payments, and the requirement of a SNF quality reporting program (by 2018). Details are provided regarding the quality reporting program at cms.gov.
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Tallahatchie General Hospital and its administrator Jim Blackwood are meeting the needs of citizens of Tallahatchie County by opening a new 20,000 square foot wellness center in Charleston.

The new center houses traditional fitness equipment, group exercise classes, an indoor walking track, recreational equipment, and the hospital’s outpatient occupational therapy and physical therapy, as well as an outpatient geri-psych program called The Horizon.

The facility was funded by Jim Kennedy, chairman of Cox Enterprises, who responded to a 2012 community health needs assessment of Tallahatchie County conducted by Dr. Catherine Woodyard, who now serves as the center’s Executive Director.

“For over a decade, I’ve owned property in Tallahatchie County and have spent many days enjoying that property’s bounty. For years, I’ve been trying to find the right way to give back to this community,” said Kennedy.

The 2012 study shed light on the needs of Tallahatchie County and laid the groundwork for many of the programs currently offered at the wellness center.
The findings showed that residents of Charleston and Tallahatchie County lack healthy food options and access to health education professionals and need more resources for wellness, exercise, and recreation.

“The findings from the needs assessment identified community needs, environmental concerns and priority health issues. Our assessment found that similar to other rural areas, there is a shortage of opportunities for health education and the community lacks resources to help residents live healthier lives,” said Woodyard.

Operating out of temporary facility for the last two years, new facility will officially open by January 2016. But as stated, the wellness center is more than just a gym. Woodyard comments, “10% of our offerings are for that of a traditional gym, while 90% of our efforts are focused on outreach, programming, events, and community engagement.”

Tallahatchie General Hospital recently received a $550,000 grant from the Health Resources and Services Administration (HRSA). The grant funding will cover the cost of the majority of the programming offered through Tallahatchie Wellness over the next three years and will provide additional services for the community. These programs include a hospital worksite wellness program, youth programs, the national Chronic Disease Self-Management Program (CDSMP), Living Well, an annual health fair, and a wellness challenge.

Woodyard also has plans for developing an annual health carnival and has launched a fundraising campaign to build a community playground for children, as there is currently not one playground in the community aside from one at a local elementary school.

The facility also has an on-site vegetable garden which doubles as produce to use for cooking classes and nutritional counseling, and a 1-mile outdoor Path to Wellness with healthy messages along the path to encourage positive behavior and educate about health.

The Wellness Center itself has a fee for membership. Programming is free to the members and available for the broader community at a nominal fee. The playground and outdoor Path to Wellness are available to the public and do not have an associated fee for use.

The Grand Opening of the new facility will take place on January 15, 2016.
Mississippi is a rural state. More than 1.6 million of the 2.9 million people that live in Mississippi live in rural areas. We think rural, we live rural, and we desire to stay rural.

And, as a rural state, we have rural-specific needs. One of these major needs is access to quality healthcare.

Meeting this need is an excellent system of rural and critical access hospitals. These hospitals are in many of our rural counties and serve a vast majority of our rural citizens. Couple these hospitals with our vast system of rural health clinics and community health centers, and you have a strong network of quality health care that allows citizens to enjoy a healthy and happy life in rural Mississippi.

But, as most have seen in the news lately, there is a great strain placed on our nation’s hospitals, and Mississippi’s rural and critical access hospitals are among the most strained.

Because of their size, modest assets and financial reserves, and higher percentages of older and lower income patients, small and rural hospitals disproportionately rely on government payments. These payments are primarily in the form of Medicare payments, with the other bulk being in Medicaid payments.

Rural and critical access hospitals serve residents that are often older, poorer, and suffer from greater rates of chronic disease than urban residents. Further, they are smaller than urban hospitals and often appear out-of-date; again, because of their limited resources for physical improvements.

In contrast to the older “look and feel” of the rural hospitals is their quality of care. Study after study will show that the quality of care produced in rural Mississippi hospitals is greater, and less expensive, than that which is delivered in larger urban hospitals. They are statistically a “better bang for your buck” and deliver high quality healthcare with the same equipment that you will find at any major hospital in our country. The floors may be 60’s tile and the countertops may be Formica, but the technology, equipment, and skill of the professionals is very high.

So if rural and critical access hospitals are so great, what’s the fuss over their financial woes? Shouldn’t they do better than their urban counterparts?

The answer is simple. These hospitals are designed to treat a low volume group of people that often use
Medicare or Medicaid to pay for services. They were designed for a different type of payment structure, and that structure has now changed.

Medicare and Medicaid payment systems often fail to recognize the unique circumstances of small or rural hospitals. A sustained workforce shortage and rising health care liability premiums continue to drive costs higher. The average age of hospital facilities begs improvement and the demand for expensive new information systems climbs, yet access to capital financing is very limited.

Critical access hospitals (CAH) in particular are in a financial strain because their basic method of obtaining revenue is flawed. CAHs must be located in a rural area and be more than 35 miles from another hospital. Additionally, to be considered a CAH, the hospital must have an emergency room that operates 24 hours a day and 7 days a week using either on-site or on-call staff. A CAH is normally limited to 25 inpatient beds used for either inpatient or swing bed services. CAHs are also subject to a 96-hour (4-day) limit on the average length of stay.

Most importantly about CAHs is that they receive 101% of financial reimbursement based on their cost report. So, if the hospital submitted $10.0 million in cost, they would theoretically receive $10.1 back in payment for services. Not a bad deal, right?

Well, when the 2013 government shutdown occurred and sequestration affected a 2% cut to payments to all government entities, this also cut 2% from CAH hospital payments. In addition, a number of small cuts alongside sequestration have now created an environment where the average CAH receives 97.5% reimbursement. A number of other health care reforms have done them no favors, either, but instead strain an already tired staff and stretch employees too thin to be effective their multiple jobs.

So, to keep their doors open, no matter how many patients they see or how low they keep their costs, CAHs will only make around 97.5% of their cost. The only way that some of our hospitals are able to stay in the black is with a heavy focus on outpatient and ancillary services, which are not reflected on the cost report. But even with this small amount of revenue, they cannot win. They best that they can do is survive. The system has failed them, and therefore failed all of us that live and work in rural Mississippi.

This is the core of our problem today. There is a great quality of health care in rural Mississippi and tens of thousands of patients each year are able to receive treatment without leaving their own communities. But our hospitals are still losing money and will eventually close without a major change to either the health care laws or the very definition and reimbursement structure of our hospitals.

So this is where we are today. The problem is recognized, and many great minds are working on solutions. These minds include our state’s elected officials in Washington, who have been overwhelmingly supportive of measures to decrease regulation and increase direct support of our state’s hospitals. Several ways that they have done this are referenced in in this issue of Crossroads.

One possible solution to the hospitals’ financial woes that has been discussed is a reformatting of our rural and CAH hospitals into more outpatient-driven centers. As the hospitals are currently surviving by outpatient and ancillary services, a priority in offering these services has the potential to restructure the payment formula and redesign the hospital systems.

This will cause inpatient and emergency care to shrink, or in some cases to possibly be eliminated, which would reduce the uncompensated care and the highest costs associated with the hospitals. Of course, it would require a complete federal restructuring of the hospital regulations and will create substantial system change. And, there is a looming question of whether it would properly meet the needs of rural citizens.

So here is the ask.
Support your rural and critical access hospitals. Don’t be quick to go to an urban alternative when your community hospital can provide better care closer to home. Don’t look at the antiquated building and assume that the doctors are second rate and the equipment is old. Rather, trust that your community friends and family are going to provide you with the high quality healthcare that thousands of Mississippians have grown to love and appreciate.

Lastly, let your Congressman and local officials know that rural healthcare is important to you. Not only are our rural hospitals leading economic drivers in our local communities, but they save and improve lives. You can make the difference that allows our hospitals to survive and thrive!
The Myrlie Evers-Williams Institute for the Elimination of Health Disparities at the University of Mississippi Medical Center is committed to improving the health, healthcare and healthcare delivery systems of rural Mississippi communities. As such, we admire individuals who share this commitment. Most often, this work goes unnoticed. In recognition of these individuals, one Rural Health Champion from the state of Mississippi will be selected.

This prestigious award will be given to an “unsung hero” who makes a notable contribution to health, healthcare, or a healthcare delivery system in a rural Mississippi community.

This award is given in conjunction with National Rural Health Day, which is November 19, 2014. The third Thursday of November each year has been designated for this auspicious day.

The award winner will be presented with a plaque and a $100 gift card by an Evers-Williams Institute representative in the community in which the recipient lives.

We invite you to please nominate someone or nominate yourself.

For questions regarding the award, please feel free to contact Erica Collins-Young by email at ecollinsyoung@umc.edu or by phone at 601-815-9016.

This effort is supported by the Mississippi Rural Health Association.

Rural Health Clinic Workshop
Complete/Improve Your Annual Program Evaluation

November 3, 2015
8:00 am to 3:00 pm
Mississippi Rural Health Association
31 Woodgreen Place, Madison, MS 39110

The workshop costs $150, and members of the Mississippi Rural Health Association are able to register at a discounted rate of $125.

Joanie Perkins, CPC, North Sunflower Medical Center, is preparing Rural Health Clinics to complete their Annual Program Evaluations. This workshop is designed for clinic administrators, clinic managers, billers, clinic financial personnel, and quality assurance officers.
It’s a New Age for Dispensing Medication

One of the common complaints from those taking multiple medications is that they easily get them confused. This is especially true when refills occur at different times of the month, therefore requiring one to keep a calendar of when to refill different prescriptions.

Given the fact that many do not have the education to understand what medications they are taking or the ability to drive to the pharmacy multiple times per month, the need for pre-packaged medication has become increasingly important. But, cost usually prohibits individuals from seeking pre-packaged medications from their local pharmacy.

To help alleviate the strain on the elderly, disabled, or chronically ill, the closed-door pharmacy at the Golden Triangle Planning and Development District (GTPDD) has purchased a Parata PASS 500 strip packaging system. The PASS 500 is able to prepare 28-day cycles of medication that are pre-packaged for each day of the week. All the patient must do is open the package and take the pill as labeled on that day’s package. Furthermore, the service is complementary to the pharmacy’s patients.

No long will these patients need to juggle pill bottles or rush to the pharmacy to get prescriptions refilled… all they need to do is take the single package per day and go about their lives.

The GTPDD has more than 200 patients receiving this service, some of which receive their medications directly on their doorstep each month. This prevents them from having to make the drive to the pharmacy to pick up their prescriptions, therefore eliminating one major variable in receiving treatment.

Many groups have praised this system as an excellent alternative to traditional pharmacy for those with chronic conditions or high numbers of prescriptions medications. Further, it is a best practice for encouraging patient compliance and reducing hospital readmissions.

Rudy Johnson, executive director of the GTPDD states, “When patients take their medications at the prescribed time, their health improves and their life improves. It’s as simple as that.”

For more information about the Golden Triangle Planning and Develop District’s closed-door pharmacy, contact Anna Lancaster, pharmacist, at 662.320.2011 or pharmhit@gtpdd.com.
ICD-10: ANOTHER WAVE OF CHANGE IS HERE

ICD-10 is more than an update to medical coding...it is a leap forward. And now, we have made that leap!

Many members of the Mississippi Rural Health Association are very aware of ICD-10 and have been expertly trained through ICD-10 bootcamps, webinars, or book studies. The increase from 14,000 to 69,000 medical codes is a huge increase, and therefore it requires significant study as well as supporting tools in order to keep billing and coding services running seamlessly.

But why have we switched from ICD-9 to ICD-10? Here is a brief summary of why we have switched and what we can look for moving forward:

What is ICD-10?
The World Health Organization’s (WHO) International Classification of Diseases has served the healthcare community for over a century. The United States implemented the current version (ICD-9) in 1979. While most industrialized countries moved to ICD-10 several years ago, the United States is just now transitioning with a final compliance date of October 1, 2015.

Do I have to participate in ICD-10 coding?
Yes. ICD-10 compliance is mandatory for all HIPAA-covered entities, including those who do not handle Medicare claims. There are no exceptions to any HIPAA-covered entities. Organizations that are not governed by HIPAA who use ICD-9 codes should be aware that their coding may become obsolete in the transition to ICD-10.

Why ICD-10?
Under the sponsorship of the WHO, a select group of physicians created the basic ICD-10 structure. Following this, each physician specialty within the United States as well as other hospital and clinical staff offered their input on the subset of diagnosis codes required. In most cases, the specialties advocated capturing additional detail based on information that physicians intuitively use in delivering patient care.

These changes were designed to enhance current medical documentation standards to capture a greater level of detail in patient care. Accurate analysis of health data is believed to help improve the quality and efficiency of delivering patient care, particularly as electronic sharing and exchange of health records grows.

What is different about ICD-10?
The basic idea of coding medical procedures has been the same since the coding profession began. But with ICD-10 all codes have changed, and there are significantly more of them. Here is a brief overview of the differences:

ICD-9 Codes
- 3-5 digits per code
- First digit is either a letter or numeric
- Second – fifth digit is numeric
- A decimal is placed after the third character
- There are no placeholders
- There are approximately 14,000 codes

ICD-10 Codes
- 7 digits per code
- First digit is a letter
- Second digit is numeric
- Third – seventh digit is either a letter or numeric
- A decimal is placed after the third character (the same as with ICD-9)
- There are now “X” placeholders
- There are approximately 69,000 total codes

There are other changes as well.
With ICD-10, injuries are grouped by anatomical site rather than by type of injury. Further, there is an incorporation of E and V codes (influences of health
status and external causes of injury and poisoning, respectively), and new definitions reflecting modern medical practice. Finally, there is a complete restructuring, reorganizational, and reclassification of chapters and sections in order to reflect current medical knowledge.

**Now that ICD-10 is in place, what now?**

There has been a great deal of legislative work and private advocacy among those in favor of or against ICD-10 implementation. Ironically, although physician groups were the principal leaders in developing ICD-10 codes, physician groups were also the leading opponents to its implementation.

There were multiple pieces of legislation over the last year designed to either delay or prevent ICD-10. One bill, which had more support than the others, offered a “trial period” for ICD-10 by requiring dual ICD-9 / ICD-10 coding.

All of these measures failed, and now we have ICD-10 as our coding measure in the United States.

**So, what now?**

There will be a very close eye on problems that ICD-10 may cause. Physicians have been advised by various peer groups to expect up to a 3-5 month delay in reimbursement due to errors in coding or delays in the system. This is a pessimistic view of transition, but may indeed be a good rule of thumb in case there are challenges beyond what are expected.

HIM professionals will need to continue to gain education and training for ICD-10 as they “get their feet wet” with live coding. And, the entire staff of a clinic or hospital will need experience during the transition. Everyone will need command or understanding of the codes and will need to transition their practice to accommodate. After all, the livelihood of the facility depends on it!

It is highly unlikely that any legislation will move us back to ICD-9, so this is the world that we now live in.

As we move forward, pay particular attention to using all available diagnostic codes and empower your billing and coding staff. These professionals are leaders in health reform and they need a great deal of support.

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For more information on ICD-10, visit peer resources at www.roadto10.org, www.ahima.org www.aapc.com, or the Resources Tab on our website at www.msrha.org
YOU HAVE A PARTNER ON YOUR JOURNEY

Supporting Mississippians in managing their healthcare costs, is why now, more than ever, it’s good to be Blue.

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Medicare will nearly triple the number of hospitals and medical groups that are candidates to test bundled payments, one of the health reform law’s efforts to revamp healthcare financing.

The CMS announced recently that it will add roughly 4,100 providers to about 2,400 already exploring the possible use of bundled payments for some or all of four dozen medical conditions and procedures, such as diabetes, joint replacements and pacemaker implants. Providers have to apply to become candidates.

Medicare launched the payment bundles in January 2013 under the healthcare reform law. So far, the CMS has signed 243 providers to bundled-payment contracts, which began in October and January.

CMS officials said in a statement that they were pleased with the growing list of candidates and expect to see some eventually enter into contracts. “Through the Bundled Payments for Care Improvement initiative, CMS is taking another step forward in identifying models that will provide better quality of care and improved health for Medicare beneficiaries, at lower costs for our nation’s taxpayers,” the statement said.

The initiatives amount to sprawling market tests of new incentives that hold potential but also pose risks, health policy experts say. Bundles and accountable care may reduce waste and fragmentation under existing financing, which pays providers for each procedure, visit or service, creating an incentive to do more regardless of need. But the incentive to control spending may also entice providers to reduce necessary care or avoid costly patients.

Because the model “bundles” payments for multiple services connected to an episode of care, participating providers profit when their spending on that care falls below Medicare’s savings target. Hospitals and doctors can test any of four bundles that include some or all medical expenses for care provided throughout a hospital stay; one to three months after patients leave; or both.
Lead author Dr. Brian A. Primack, of the University of Pittsburgh School of Medicine, PA, and colleagues reached their findings by analyzing the survey results of a national sample of 694 individuals aged 16-26 who had never smoked conventional cigarettes.

Between 2012 and 2013, participants were required to complete a survey detailing their use of electronic cigarettes (e-cigarettes) and whether they were likely to use conventional cigarettes over the next year.

According to the researchers, all participants were deemed “non-susceptible” to initiating conventional smoking because they answered “definitely no” when
asked if they were likely to take up the habit in the next year or if they would try a cigarette that was offered by a friend.

Participants' uptake of conventional smoking was assessed 1 year later.

Almost 70% of e-cigarette users progressed to conventional cigarette use.

At the beginning of the study, 16 participants reported using e-cigarettes, while 678 said they did not use the devices.
After the 1-year follow-up, the researchers found that 11 of the 16 e-cigarette users (68.9%) had taken up smoking, compared with 128 of 678 participants (18.9%) who did not use e-cigarettes at study baseline. The team says these results remained even after accounting for potential risk factors for tobacco use, such as age, sex, race, ethnicity, socioeconomic status, sensation seeking, parental smoking status and friends’ smoking status.

While they admit a key limitation of the study is the small number of participants who reported e-cigarette use at study baseline, the researchers believe the findings have implications for regulation of the devices and warrant further investigation.

Study co-author Dr. James D. Sargent, professor of pediatrics at the Geisel School of Medicine at the Dartmouth-Hitchcock Norris Cotton Cancer Center in Lebanon, NH, adds:

"[...] Recent data suggest that more youth than ever are using e-cigarettes and that as many as half of these adolescents are not smoking traditional cigarettes. Therefore, it is important to continue surveillance of both e-cigarettes and tobacco products among young people so policymakers can establish research-informed regulations to help prevent e-cigarettes from becoming gateway products on the road to youth smoking."

How might e-cigarette use lead to conventional smoking?

While the team is unable to determine exactly why e-cigarettes may act as a gateway to traditional cigarette use, they have some theories.

They note that e-cigarettes deliver nicotine more slowly than standard cigarettes, meaning a user may progress to conventional smoking as they become more tolerant of the substance’s side effects.

They also point out that because e-cigarettes are designed to simulate the behavioral and sensory characteristics of conventional cigarette smoking, the

FAST FACTS ABOUT E-CIGARETTES

- There are currently more than 250 different e-cigarette brands on the market in the US
- Though e-cigarettes are often promoted as being safer than conventional cigarettes, there is still limited evidence on the health risks of the devices
- Earlier this year, a report from the Centers for Disease Control and Prevention (CDC) found e-cigarette use tripled among middle and high school students in 2013-14.

While they admit a key limitation of the study is the small number of participants who reported e-cigarette use at study baseline, the researchers believe the finds
Join us as we honor America’s heart & soul - our rural citizens & communities!

National Rural Health Day
Celebrating the Power of Rural!

11.19.15

Rural communities - and the people that call them home - are the heart and soul of America. These are communities where people know each other, listen to and respect each other, and work together for the greater good. They are communities fueled by the creative energy of their leaders - ordinary individuals who are willing to step forward, share their vision, and drive changes that benefit their neighbors.

But rural communities also face daily challenges keeping our heart “healthy.” Today more than ever, rural communities must confront accessibility issues, a lack of healthcare providers, an aging population suffering from a greater number of chronic conditions, and larger percentages of un- and underinsured citizens. Rural hospitals, which are frequently the economic foundation of their communities, struggle daily to overcome fiscal hurdles that inhibit their ability to care for citizens. State Offices of Rural Health and other rural stakeholders work together on sharing resources and creating innovative models of care, but more work remains to help overcome the health disparities faced by rural citizens.

That is why we encourage you to join NOSORH and all 50 State Offices of Rural Health for our fourth annual National Rural Health Day on November 19, 2015. National Rural Health Day provides an opportunity to honor the selfless, community-minded, spirit that prevails in rural America. It also gives us a chance to bring to light the unique healthcare challenges that rural citizens face – and showcase the efforts of rural healthcare providers, SORHs and other rural stakeholders in meeting those challenges.

NOSORH, SORHs and others already have a host of events planned on November 19, but we'd love to see more! Please visit our website or contact (Matt Strycker 574-855-4671 stryckerm@nosorh.org) to learn how you can help spread the word and/or plan your own National Rural Health Day celebration!

celebratepowerofrural.org
FULLY COMPREHENSIVE SOFTWARE SOLUTION

• Includes EHR, HIS, CPOE, EMAR, Revenue Cycle Management, Inventory, LIS, PACS/RIS, Pharmacy, Patient Portal, Accounting, Payroll, HR, Reporting, and more
• The encoder inside powered by TruCode™

ONE SEAMLESS EXPERIENCE

• Single database solution eliminates double entry of data
• Intuitive and consistent user interface for inpatient, outpatient, and emergency department environments
• No need to ‘cobble together’ different programs or learn disparate systems

CUSTOM TEMPLATE AND WORKFLOW DESIGN

• Our software is designed, customized, and configured to conform to your hospital’s specific workflows
• Ability to create and configure as many templates as you need for unique use cases

VersaSuite Complete EHR v8.2 is 2014 Edition compliant and has been certified by ICSA Labs, an ONC-ACB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services.