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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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MISSISSIPPI’S SMOKEFREE COMMUNITIES

Mississippi has increased its number of smokefree communities to 93 local smoke free communities! Walnut Grove is our latest official addition. To see a full listing of Mississippi’s smokefree towns and cities, visit our tobacco cessation page at msrha.org.

YOUR STAFF AT WORK

Ryan Kelly
Executive Director, was recently named to the National Rural Health Association’s Communication Committee and to the board of the South Central Telchealth Resource Center. Kelly also serves on numerous state health and civic committees, including as chair of the 2015 Mississippi Health Summit.

Cindy Widdig
Special Projects Director, holds leadership or advisory roles in multiple statewide health organizations including recent appointments on the Coordinated Chronic Illness Coalition Advisory Board, the Mississippi Heart Disease and Stroke Task Force, and the Mississippi Leadership Academy Advisory Board, among several others. Widdig has also taken leadership roles in most all tobacco-related committees in the state including the Mississippi Tobacco Control Network.

Mary Smith
Education and Programs Director, was recently named to the board of director for Volunteer Starkville. Smith is significantly involved in leadership with other healthcare entities including Vice-President of the Mississippi Nurses Foundation.
As members of the Mississippi Rural Health Association, we continue to fight for you!

But, what does that mean? It is likely that you hear organizations say that they fight for their constituents, but rarely see evidence of what fight has taken place. Although grandstanding certainly has its place, our Association generally sees better results when we make things happen “behind the scenes.”

So, let’s go behind the scenes and look at what we have done so far in 2015.

WHAT ARE THE ISSUES?

Nationally, the majority of our efforts have focused on reducing hospital cuts. Rural hospitals in Mississippi face an onslaught of challenges including a 2% cut due to sequestration, major cuts (and eventual elimination) of DSH payments, and other funding expirations and minor cuts that add up to disaster for our rural and CAH hospitals. Nearly 300 hospitals nationally are on the brink of closure, and Mississippi has its fair share.

At this time, 35% of US hospitals operate at a financial loss. Mississippi has 32 CAH and 24 PPS rural hospitals, and 96 total acute care hospitals. We have 176 rural health clinics, of which more than half are owned and operated by one of those 96 hospitals. That does not include the huge number of pharmacies, therapy providers, and related healthcare businesses that operate because of the existence of these facilities. The number of patients seen by these facilities is substantial, and the economic impact that these facilities have in rural Mississippi is critical to the state’s viability.

If we let this infrastructure crumble, rural Mississippi will crumble with it.

Our primary focus to reduce or eliminate these cuts and reinforce our clinics and hospitals has been in support of several pieces of national legislation, namely the following:

- S. 258 and HR 169. Named the Critical Access Hospital Relief Act, this legislation would remove the 96-hour certification requirement for CAHs.
- S 2359, the Rural Hospital and Provider Equity Act, to extend
several CAH needs including outpatient hold-harmless, increasing the low-volume payment adjustment, improve ambulance payments, and others

• H.R. 2578, an extension of the Rural Hospital Fairness Act of 2013, to reinstate the outpatient hold-harmless payments with hospitals under 100 beds

• H.R. 3444, the Critical Flexibility Act, to allow CAHs to have an option to have an annual average daily census of 20.

• The Community Access and Rural Health Equity Act (CARE)

The CARE Act in particular was developed by the National Rural Health Association as a “silver bullet” in solving many of the issues facing rural hospitals by reducing or eliminating cuts, easing regulations, and placing greater emphasis on swing bed care.

Locally, there are more issues that we have worked to support but fewer that have as much impact as those nationally. State bills have focused more on promoting access, infrastructure, and professional needs. Among many others, we have supported the following:

• HB 308, to reduce the transportation burden faced by Mississippi’s Medicaid population in rural areas

• HB 771, HB 903, and HB 114 to help to broaden the availability of ambulance transportation to citizens of rural Mississippi

• HB 53 to encourage the development of rural grocery stores by providing up to a 10% tax credit toward the purchase of locally grown agricultural products in food deserts

• HB 80, HB 81, HB 770, and SB 2065 to develop a comprehensive smoking ban in Mississippi
• SB 2153 to authorize income tax credits to physicians who train residents in accredited residency programs

• HB 389 to ban texting while driving

Our membership is diverse, but the state’s and nation’s pressing issues affect everyone in the healthcare sector. Although some issues like Medicaid expansion result in a near 50/50 split of opinion among our members, other issues like eliminating critical access hospital cuts have near universal support. Our goal is to listen to our members and support legislation that meets the opinions that we hear from you!

EFFORTS IN WASHINGTON D.C.

In February, we joined with the Mississippi Hospital Association to form a delegation that traveled to Washington to visit with our elected and appointed officials. Along with officials from CMS, we were able to visit with the offices of Sen. Thad Cochran, Rep. Greg Harper, Rep. Steven Palazzo, and Rep. Bennie Thompson.

Our healthcare delegation consisted of Daryl Weaver of Baptist Leake, Michael Nester of John C. Stennis, Joanie Perkins of North Sunflower, Joe McNulty (and staff) from Pioneer, Steve Dickson of MHA, Mary Smith of the MRHA, Don Eicher of MSDH and myself.

Our legislators in Washington are well aware of the challenges facing our rural hospitals in Mississippi. We discussed general as well as specific examples of the challenges facing Mississippi’s clinics and hospitals, and offered a list of solutions on what they can do to help. Among those were and all of them have signed-on to key legislation that will benefit our hospitals with both financial support and regulatory leniency.

We applaud them for their efforts and are working each week to ensure that this legislation has the appropriate support. We also thank NRHA for their constant support on the national scene to ensure that legislators from all states see it the way that we do in Mississippi.

EFFORTS IN JACKSON, MS

Our Association is recognized as the leader in rural health in Mississippi. To advocate for you, we held a private legislative dinner in March with select members and legislators in downtown Jackson in order to discuss some very specific issues with them. Among those were some of the failed bills at the time (tax incentives for residency and grocery store expansion, Medicaid expansion, Smoke free air, vaccinations) and some of the bills that were still on the table (open meetings law, Medicaid study commission, bond bills, etc).

We had excellent conversations with our lawmakers in attendance, including Rep. Toby Barker, Rep. Bobby Howell, Sen. Terry Burton, Sen. John Polk, and Sen. Brice Wiggins. These legislators were candid with their answers and provided great insight into why the stated bills passed and failed in this year’s session. The information was very helpful when planning for next year’s session.

Our elected officials understand the needs that our rural healthcare system has in Mississippi, and we largely have their support. But, there are certainly challenges that we still face. The two biggest challenges come in the form of policy viability and affordability.

The environment in Jackson this year has been one that did not pass many if any bills that increased taxes or tax credits. Many of the bills that we supported provided tax credits as incentives for supporting rural Mississippi. It is unfortunate that a very commonly used “carrot” was not even considered in this year’s session. But, there has been positive support for easing regulations, loosening professional restrictions, and restricting bad behavior.

Governor Bryant signed the texting bill that prevents anyone from texting or posting to social media while driving. The conversation over Medicaid expansion will continue to grow through study commissions. And, perhaps most importantly, healthcare continue to be a growing focus area for our state. It is no longer an issue that people ignore.

MOVING FORWARD

Mississippi’s legislation session may be over, but there is still more work to do. We continue to listen to you and want to hear your challenges, opportunities, and concerns. Rural healthcare affects us all, and we must continue to work hard to support it.

If we can ever answer any questions or learn from your experiences, please never hesitate to contact our office.
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Mississippi has faced the brunt of several large natural disasters over the past decade. Among those was a devastating tornado on April 28, 2014 in North Mississippi. Winston Medical Center in Louisville took a direct hit from an EF4 tornado that demolished over 300 homes in Winston County and took the lives of 10 of its residents. The hospital, clinics, and nursing home took a direct hit.

This is one of those times where the strong rise up and help others. That is the true story of Winston Medical Center.

Heroics and training from the staff of the medical center saved the lives of 125 residents and patients. In addition, they continued to treat the patients that suffered injuries as a result of the tornado. The hospital could have easily referred all patients to sister facilities because of their own devastation. But they did not. Instead, they followed their established Emergency Preparedness Policies and Procedures and kept the facility open to treat those that needed emergency care.

As a result, the Medical Center was able to report zero deaths and only one minor injury to the many residents, patients, visitors and staff who were in the Medical Center and surrounding clinic buildings at the time that the tornado hit.

Winston Medical Center since the tragedy has moved into a temporary facility that houses a simplistic but functional hospital with triage, x-ray and laboratory facilities, an emergency room, inpatient rooms, and therapy. The accommodations are modest at best, but a higher level of healthcare is still available in Louisville.

This facility, although functional, was only intended to be temporary. At this moment, a new transitional facility is nearing finalization in Louisville. Located next to the temporary facility, this transitional facility will raise the level of healthcare back to the pre-tornado level. Complete services will be offered including emergency care, x-ray and laboratory, mammography, CT, and geri-psych. In-patient rooms will again be private with their own private bathrooms, and the facility will be completely self-contained. This is in contrast to the individual pods that makeup the temporary facility.

The anticipated date of transition to the temporary facility is April 1, 2015.

But even then, the transitional facility will only be temporary. The long-term plan will not only return healthcare to normal in Louisville, but it will create a new, better normal.
The rebuilt Winston Medical Center will return to the original location of the destroyed facility in Louisville. Not only will all services return to a revitalized and slightly altered facility, but the nursing home will develop a “cottage concept.” This change will greatly improve the quality of care and environment that the senior citizens receive. This new facility will accommodate up to 120 residents.

Because the Federal Emergency Management Association (FEMA) is handling much of the disaster claim, the process is slow. But Winston Medical Center is currently working with an architect to finalize the design plans and implement a time line for construction. And there is no doubt that the residents of Louisville and Winston County look forward to the new facility.

As mentioned, the story is not one of tragedy but of heroics and perseverance. Paul Black is the CEO of Winston Medical Center. When asked about how the medical center has continued to offer services in the face of this disaster, he was quick to point out that the strength of the facility is in the people.

“I can’t be any prouder of the employees. Not many people would walk patients across a cold temporary sidewalk from an inpatient room to the rest room. But our physicians, nurses, and professional staff dedicate their lives to our patients. They are what has made the difference.”

Black went on to comment that “the transitional facility will allow Winston Medical Center to not only increase services, but also hire more people. This will increase economic development of Winston County and make lives better for everyone.”

For more on the heroic story of the medical center and for more photos, visit www.winstonmedical.org.
More than 11 million plan participants enrolled in UnitedHealthcare’s individual, employer-sponsored, Medicare and Medicaid plans are now accessing care from a growing list of providers who are being compensated based on quality, better patient outcomes and lowering the overall cost of care. These arrangements are increasingly improving the care quality and overall value realized by UnitedHealthcare’s customers.
As UnitedHealthcare continues to lead the shift toward value-based care, the company expects to contract with up to 250 new Accountable Care Programs in 2015, engaging in deeper, more collaborative relationships with physicians and hospitals across the United States. UnitedHealthcare has more than 520 Accountable Care Programs active today.

Value-based health care can take many forms. From performance-based contracting and bundled payments for treating specific illnesses, to primary care bonuses and fully integrated population health, every value-based arrangement is centered on rewarding performance and helping care providers build a more integrated relationship with UnitedHealthcare and the patients they serve.

Care providers are showing strong interest. UnitedHealthcare’s total payments to physicians and hospitals that are tied to value-based arrangements have nearly tripled in the last three years to $36 billion. Those payments are expected to increase 20 percent to $43 billion in 2015 and hit $65 billion by the end of 2018.

“UnitedHealthcare is building more collaborative relationships with more care providers to ensure our plan participants have access to higher-quality, cost-effective care,” said Dan Rosenthal, president, UnitedHealthcare Networks. “Working with care providers to ensure they have the right support and incentives will help connect the people we serve to the most effective care, place a greater focus on the quality of their care, and compensate providers for improving patients’ health.”

UnitedHealthcare complements care providers’ practices by giving the additional support needed to manage overall population health rather than isolated individual health episodes, including technology and information that will help them take specific actions that improve quality and lower costs. Actionable data may include patient profiles, unaddressed care issues, and real-time emergency room and inpatient admissions data. In some instances, community-based care coordination programs are used to support patients, such as for transition plans after leaving the hospital.

UnitedHealthcare is seeing greater consistency in the delivery of quality care among its existing Accountable Care Organizations for individual, employer-sponsored and Medicaid plan customers. Results to date include:

- Medicaid members have shown a 21 percent increase in primary care visits and a 14 percent decrease in readmissions within 30 days of leaving the hospital
- Individual and employer-sponsored plan participants experienced an 11 percent reduction in hospital admissions and an eight percent reduction in emergency room admissions

New York-based WESTMED Medical Group and UnitedHealthcare launched in 2012 an accountable care arrangement serving 13,000 employer-sponsored plan participants.

“Deeper, more integrated relationships with health plans like UnitedHealthcare are making a tangible impact on patients' health,” said Simeon Schwartz, M.D., president and CEO of WESTMED. “We were already considered to be among the leaders in clinical care in our community. However, in the first year of our arrangement, our program improved nine of 10 health quality metrics, increased patient satisfaction and reduced health care costs. For example, there were significant improvements in patients taking their prescription medications properly and people with diabetes receiving more routine screenings to better control their blood sugar levels.”

A value-based approach to health care can help improve patient health and lower costs in a number of ways, including by:

- Integrating how the patient’s care is monitored among primary care physicians, specialists and facilities so that all aspects of an individual’s ongoing health care needs are connected in one place
- Rewarding physicians who encourage specific preventive care actions with their patients, such as proactive appointment scheduling, prescription adherence and follow-up care, while also following evidence-based care guidelines to make sure patients stay healthy
- Transitioning care providers away from a fee-for-service model that pays based on the number of procedures they perform (and may encourage unnecessary services) and instead pays based on overall value provided to the patient

For more information about the full spectrum of UnitedHealthcare’s value-based programs, including case studies and more detailed results data on quality and cost improvements, visit www.AccountableCareAnswers.com.
The Mississippi State Department of Health Office of Preventive Health, in partnership with the Mississippi Rural Health Association, recently awarded grant funds to three Federal Qualified Health Systems, one private practice clinic and one rural health clinic in the state to implement the Mississippi Quality Improvement Initiative II (MSQII 2).

The Mississippi Quality Improvement Initiative 2 is led by Augusta Bilbro, director and Alicia Barnes, Healthcare IT Specialist. This group strives to see Mississippi become a healthier state. The MQII2 approach is based on learning collaboratives which consists of a pre-work period, a series of learning sessions, action periods and a time for the teams to share their successes with the other teams.

Each team is very passionate about their work and how they engage the entire staff with the patients in a collaborative type plan of care.

North Hills Family Medical Clinic (NHFMC) is a division of John C. Stennis Hospital. The clinic and hospital are part of Rush Health Systems in Meridian. According to Kim Lee, case manager and North Hills Family Medical Clinic team member, “It is exciting to be a part of a team of patients that have had uncontrolled diabetes and uncontrolled hypertension for years and to see the patients start having positive results.”

The teams consist of physicians, nurse practitioners, pharmacists, certified diabetic educators, case managers, executive health systems leaders, clinic managers, IT System Analysis, team leaders and others. Each team has at least one Quality Improvement Meeting throughout the month. The teams prepare a monthly patient performance report and quarterly reports that are sent to MSQII to measure the team’s success.

Bilbro and Barnes are leading these teams down the road as they direct each team on their journey. They give each team all the support they need to be successful. They also do site visits and provide monthly conference calls to make sure each team has all the help and support they need to see their patients add quality years to their lives.
Mississippi Rural Health Association serves as the liaison to the rural health clinics involved in the MSQII-2 projects. They also serve as the subject matter expert for the rural health clinics and hospitals on the MSQII-2 leadership team.

Staff members find it rewarding to care for patients and share in the excitement as they talk about their success.

According to a patient from the North Hills team, she was very scared when she was diagnosed with diabetes. She stated that she was determined not to have to go on any medications. On the first visit, her blood sugar was in the 300’s. After a great deal of encouragement, education and support from Tearrah Conerly, FNP, and Gayle Luke, CDE, her blood sugar was in normal range for her three month follow-up. At a recent visit, her blood sugar was 88. She is so very proud of her success because she was able to get herself under control without any medications. She stated that she was thankful for all the help she received from the NHFMC team to point her in the right direction.

Some of the teams are able to network with community organizations to provide exercise classes and cooking classes to ensure patients know how to prepare healthy meals. Some of the teams also network with drug companies such as Lilly, Novo-Nordisk and AstraZeneca to provide education to the staff and print colorful education for the patients.

NHFMC team has had much success. They have experienced patients A1Cs drop by 5 or 6 points, blood sugar drop by 150 points, and a reduction in their blood pressure along with a reduction in their weight. They are taking the successes of their team and implementing them throughout other Rush Health Systems clinics.

The nurse practitioners, Tearrah Conerly and Cindy Luther, have been setting small goals for their patients, and this develops the best outcomes for their patients. Better outcomes can also be contributed to having our pharmacists review the patient’s medication and having the diabetic educator work alongside Conerly and Luther.

It is all of these things that contribute to the success of this team. This team is also excited this year to be able to share with Rush Health Systems as they celebrate 100 years of providing healthcare to east Mississippi, west Alabama and surrounding areas.

As our forefathers stated in the Rush Builder’s Creed, I am my brother’s keeper.

A second phase of the MSQII project is currently underway. For more information on the MSQII project, visit the Projects tab on msrha.org.

Photo: Pictured from Left to right Tearrah Conerly, FNP, Evelyn Harper, patient, Gayle Luke, CDE
Big things are happening in Carthage, Mississippi. Baptist Medical Center – Leake now joins only a handful of facilities in rural Mississippi that have new facilities. And with a new facility comes efficiency and expansion…good news for the citizens of Leake County.

Baptist-Leake is a 25-bed critical access hospital that was originally build circa-1950. A recent addition by Baptist Medical Center, Baptist-Leake is now able to offer its quality healthcare in a new, high-quality facility.

The new facility still offers all of the core services as the former facility, but is now able to expand services to be competitive with its urban counterparts. The hospital now has adequate space for visiting specialists to come in and practice. The new facility has allowed a doubling of the gastrointestinal specialist visits, and by summer Baptist-Leake will also begin to offer orthopedics and cardiology…a unique addition for Carthage.

A large rural health clinic has been constructed at the entrance to the emergency department. This particular “megaclinic” is a combination of three former clinics and features 16 patient rooms. The new clinic will also feature expanded clinic hours, Monday-Saturday until 8 p.m. and a half day on Sunday.

And this is a growing trend.

In addition, this clinic can serve as a patient’s medical home where they once have ‘doctor-shopped’. National statistics show that patients with a medical home are more likely to seek care and use prevention, therefore reducing chronic illness and creating a healthier lifestyle for themselves and others.

Having only been open since mid-December, the hospital has been at or near its 25 bed capacity.

“Anytime you undertake a venture of this magnitude, you ask yourself ‘if you build it, will they come’? At this point, the answer is a resounding ‘yes,’” quotes Daryl Weaver, Baptist-Leake administrator.

Weaver goes on to describe a new confidence in the healthcare delivered in Carthage. “Local patients feel more confident in coming here and using our facilities because they feel more modern, and our urban partners feel more confident in moving patients for swingbed than they did in the old facility.”

And not only is the hospital itself observing a significantly higher census, but the clinics have as well. The facility’s clinics have observed a 50% increase in volume over this time last year, a remarkable improvement.

In a world where quality of care matters, the citizens of Carthage and Leake County are privileged to have a facility that fully meets their needs.

Weaver concluded, “It is very satisfying to have a facility that finally reflects the quality of care that we have always provided here at Baptist-Leake.”
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The phrase, Mississippi Delta, conjures up a multitude of thoughts or memories for individuals, some good, some not so good, and some frankly bad. However, it is home to many wonderful Mississippians. Their past has not always been bright, but there is no reason that their future can’t be made brighter and healthier.

This region, known simply as the Delta by many, has been called “The Most Southern Place on Earth” because of its unique racial, cultural, and economic history. Its residents range from the wealthy to the most impoverished, from the famous to the forgotten. One thing for sure, the world thinks of the Delta as synonymous with Mississippi. To ultimately change that image, we must change the perception and reality of the Delta.

The physical description of the Delta varies remarkably depending on the context of the document, who is describing it, and for the purpose for which the description is needed. David Cohn, an essayist from the Delta, summed up his native region more poetically when he wrote, “the Mississippi Delta begins in the lobby of the Peabody Hotel in Memphis and ends on Catfish Row in Vicksburg.” This leaf-shaped section in the northwest quadrant of Mississippi is bordered by the Mississippi River to the west and the ridgeline of hills to the east, just beyond the Yazoo River. This region is formed by the confluence of the two main

**MISSISSIPPI DELTA MISSION: POSSIBLE**

*By: John Mitchell, MD-Director of the Office of Mississippi Physician Workforce
Hugh Gamble, MD-Chairman of Advisory Board, Office of Mississippi Physician Workforce*
rivers just below Vicksburg. The eastern border varies slightly by county, or parts of counties, again depending on the document being produced and the interests of those producing it.

The Mississippi Delta is one of the most impoverished, underserved, and medically uninsured regions in the United States. Metrics for chronic healthcare issues such as diabetes, hypertension, stroke, obesity and high mortality rates are some of the highest in the nation. Contributing factors to these statistics include decades of high unemployment rates, poverty, lack of healthcare access, and educational deficiencies. Many state and federal agencies have placed emphasis on this region with less than stellar success.

Sounds a bit like the old TV show, Mission: Impossible. We could talk about the past ad infinitum, but, it is my mission to focus on its future. One of the tasks of the Office of Mississippi Physician Workforce (OMPW) is to study existing physician supply statewide, devise strategies and make recommendations to policy makers to help change the course of dismal physician numbers, and ultimately improve access throughout the state. It won’t be quick, easy or inexpensive, but, I believe that with the proper focus, partnerships and collaborative arrangements we can and will succeed. We will move forward with the mindset, Mission: Possible.

A focus to improve the quantity of primary care physicians practicing in rural areas began by identifying potential students from rural and underserved areas of Mississippi and developing a plan that would nurture and support them through educational and financial resources. The hope was that, if their education was subsidized these individuals would be able to afford to return to their home regions to live and practice. Identifying potential candidates that are capable and who possess a desire to return to rural areas to practice primary care, resulted in the development of the Mississippi Rural Physician Scholarship Program (MRPSP) in 2007. The mantra, then and now is, “Growing our own.” The pipeline for identifying and training individuals from rural areas who possess a desire to return to those regions is strong and growing. A missing critical link to this overall pipeline plan is inadequate in-state training available for these individuals.

More importantly, there is a major gap of training availability in regions where need is the greatest.

Statistics on medical training supports the fact that almost 60% of physicians remain within a 100 mile radius of the location in which they train. Mississippi Allopathic and Osteopathic medical schools are increasing their enrollment and are projected to produce approximately 265 medical graduates per year within the next 5 to 6 years. Due to the Mississippi Rural Physician Scholarship Program, there is an increased interest in primary care, so it becomes critical that Mississippi establish graduate medical training opportunities in multiple areas around the state. Ideally these training sites can be strategically placed in areas of most need. The Mississippi Delta is not unique to this need but it has characteristics and deficiencies that make it even more challenging than others.

In 2004 there was an attempt to establish a family medicine training program in the Delta. A great deal of time, effort, and financial resources went into that effort but it never materialized due to a multitude of reasons. What has changed in the ensuing 10 years that would make this attempt successful? The short answer is, not much. New efforts must be strategically altered if we are to be successful. Graduate Medical Education (GME) is complex, highly regulated, and an expensive process. There are many requirements that must be in place for a new GME program to be successful. One of the more difficult requirements is identifying and securing a financially sound sponsoring institution.

The Delta has the clinical landscape for successful primary care physician training. Unfortunately, it lacks financial stability in any single sponsoring institution to establish such a program. This does not diminish the need for improved medical access, in fact it magnifies it. A sustainable training platform would go a long way in supplying the medical needs of the area. However no single entity in the delta region has all the required components: physical, financial and clinical. Collectively all components are available and I believe possible to unite. To move Mississippi forward in healthcare, we need a well-organized collaborative training platform in this region and many others.
There are other underserved and impoverished areas around the country who have been successful in bringing graduate medical education to similar areas through a consortium approach. The consortium model, a 501(c)(3) legal entity, brings multiple medical institutions and communities together, pooling resources in a collaborative effort for the good of all. I know we live in a highly competitive world, but, I believe this is the way to be successful in improving healthcare delivery in these areas. Success will come through a concerted collaborative effort.

The Office of Physician Workforce has taken the lead coupled with resources from the Mississippi Development Authority to bring together a group of enlightened and determined hospital executives to explore the possibilities of the formation of a delta educational and research consortium. On September 9, 2014 we finalized a resolution of commitment between these individuals and OMPW to formally begin this investigation. It is my hope and belief that we will be able to proceed with formative stages of a consortium in the near future. This entity then can, in turn, become the sponsoring agent and formal platform for GME residency programs in the Delta region. As I sat at my desk signing this document, I realized that it was one year to the day, September 9, 2013, that I officially began my journey as Director of the Office of Physician Workforce. It will take a concerted effort from local, state and, quite possibly, federal partnerships to bring about success. I believe OMPW has been very productive in this first year in numerous ways. This document and plan signifies a major step in addressing healthcare access and physician training for the Delta region through the development of graduate medical education programs. Step one in Mission: Possible.

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**Rural Health Clinic Conference**

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DECREASING READMISSIONS
A SMALL HOSPITAL’S STORY
Submitted by IQH / Atom Alliance

When a small, rural hospital in Mississippi was penalized one percent in 2013 by Medicare for readmissions, hospital administration took note. They made it a priority to focus on decreasing readmission rates by 20 percent for patients with Medicare.

A first step they took included developing a collaborative team comprised of the chief executive officer, chief financial officer and staff nursing, pharmacy, laboratory, dietary and medical billing. The team also included representatives from the area’s skilled nursing facilities (SNFs) to share their thoughts and experiences about the contributing factors leading to 30-day readmissions from SNFs allowing hospital discharge. To help determine specific interventions to implement, the team conducted a retrospective chart review, examined results in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and used the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

After several meetings, they decided to implement the Project RED quality improvement model to improve the hospital discharge process, enhance care coordination and decrease 30-day readmissions following hospital discharge. Project RED (Re-engineered Discharge), created by a research group at Boston University Medical Center, is founded on 12 components proven to reduce readmissions and increase patient satisfaction.

“We wanted to create an interdisciplinary approach to the coordination of care prior to discharge, increase patient understanding of the discharge plan of care and enhance post-discharge follow-up,” said the chief nursing officer. The team implemented several interventions, such as hourly rounding, bedside reporting and postdischarge phone calls. Nursing staff assisted in developing customized, patient-centered education folders to encourage patient engagement, increase patient comprehension of discharge instructions and promote active patient participation in chronic illness self-management. The Joint Commission, which accredits and certifies more than 20,500 healthcare organizations and programs in the United States, recognized the folders as a best practice and shared them in their online Leading Practice Library.

Another intervention the hospital used was the Hybrid Primary Care Provider Program to ensure that each discharged patient had a primary care provider to followup with post discharge. When a patient did not have an established primary care provider at discharge, the hospital assigned one from a rotating call list. Interventions implemented have been permanently incorporated into the hospital discharge and education process, and they have been effective. The hospital decreased its Medicare readmission reduction penalty from one percent in fiscal year (FY) 2013 to 0.52 percent in FY 2014.

The hospital’s chief nursing officer notes additional benefits to implementing quality improvement interventions: “The nursing staff has taken more ownership of the patient education process prior to discharge. They have become patient advocates and more patient-focused instead of task-oriented.” The hospital also found help in reducing readmissions from Information & Quality Healthcare (IQH), Mississippi’s healthcare quality improvement organization, now a member of atom Alliance.

IQH encouraged participation in an established community coalition, composed of the local Area Agency on Aging and eight participating hospitals.

To date, the Medicare readmission reduction penalty for this small hospital has remained at 0.52 percent. They look forward to the challenge of decreasing that percentage to zero by continuing these and other effective interventions.
Draft regulations the CMS issued recently would make significant changes to the federal incentive program that requires doctors and hospitals to adopt and meaningfully use electronic health records.

With some exceptions, hospitals, physicians and other eligible professionals would be expected to conform to the rules (PDF) by 2018.

Physicians and hospitals have lobbied aggressively for the CMS to relax the program’s parameters. The agency said in January it would issue separate regulations narrowing the reporting period to 90 days for attesting to meeting the requirements for 2015.

The proposed rule would require nearly all providers to report on a full calendar-year cycle beginning in 2017 and would require electronic reporting of clinical quality measures beginning in 2018.

“The release of today’s rule demonstrates that the agency continues to create policies for the future without fixing the problems the program faces today,” the American Hospital Association said in a statement Friday. “It is difficult to understand the rush to raise the bar yet again, when only 35% of hospitals and a small fraction of physicians have met the Stage 2 requirements.”

Physicians and other eligible professionals who fail to meet the requirements are expected to pay $500 million in Medicare penalties between 2018 and 2020, according to the proposed rule. The agency said it expects all hospitals to achieve meaningful use by 2018.

Upgrading EHRs to meet the requirements, the agency estimates, will cost physicians $54,000, plus $10,000 in annual maintenance costs. That’s at the high end of what the Congressional Budget Office calculated in 2008. The CMS said upgrades would cost hospitals $5 million, plus $1 million for annual maintenance.

The rule would give providers three options for ensuring patient engagement with their care, of which providers must fulfill two: access to their own records; secure messaging between patients and providers; and collection of patient-generated health data.

The first two elements had attracted consistent criticism from providers in previous stages of the
program, but the exact impact is unclear. In the Stage 2 rules, 5% of patients would have to view, download or transmit data from their records, which providers said made them responsible for the engagement regardless of whether patients were interested.

The new rule would raise that engagement threshold to 25% of patients downloading or transmitting their health data. But providers can now satisfy the requirement with an application programming interface, or API, that allows third-party developers to access the data on their patients’ behalf.

The rule would also impose a similar increase in the rate of secure messaging: from 5% in Stage 2, to 25% in Stage 3.

Meanwhile, the provision would compel providers to collect patient-generated health data in their EHRs from devices such as Fitbits or mobile apps developed with Apple’s HealthKit API. Providers would have to capture data from 15% of their patients to comply.

The digital health industry pushed aggressively for the CMS to push providers to collect the data their products generate. “I’m beyond pleased and finally vindicated,” said Robert Jarrin, Qualcomm’s senior director of government affairs.

The proposal also raises the thresholds for “computerized physician order entry,” which allows doctors to send requests for drugs, lab tests and imaging electronically. Providers would be expected to order 80% of medications electronically, up from 60% under Stage 2 of the program. The requirement for electronic lab and imaging orders would rise to 60% from 30%.

For imaging, the proposed rule expands the requirement from radiology to a broader array of tests, including ultrasound, MRI and CT scans.

Separate regulations proposed by HHS’ Office of the National Coordinator for Health Information Technology overhaul the certification program (PDF) for healthcare IT, which is intended to give healthcare providers certainty that the software they buy can perform the functions required under the meaningful-use program.
One of the country’s leading rural health advocate will assume the No. 2 position at the Department of Health and Human Services (HHS).

Mary Wakefield, who has spent five years overseeing the government’s programs for vulnerable populations at HHS, was tapped Thursday as the department’s acting deputy secretary, according to a release provided first to The Hill.

Wakefield said in an interview Thursday that rural health will continue to be one of her top priorities, as well as reforms to make healthcare delivery more efficient across the board.

She also pledged to focus on “strengthening HHS as an agency.”

Until now, Wakefield has spent five years at the helm of the Health Resources and Services Administration. The agency has an annual budget of more than $10 billion, which runs to fund more than 9,000 sites nationwide.

In a staff-wide letter sent Thursday, HHS Secretary Sylvia Mathews Burwell praised Wakefield’s ability to lead “through a time of marked transformation.”

“She has improved access to health for millions of patients, strengthening America’s health care workforce, and modernized HRSA’s organizational infrastructure,” Burwell wrote.

A trained nurse, Wakefield will also bring more than a decade of Capitol Hill experience. She is the previous chief of staff to Sen. Kent Conrad (D-N.D.)

During her tenure at HRSA, she oversaw growth of its community health centers. The centers now serve 22 million patients a year, about 5 million more than when she took the helm. She has also helped grow programs like the National Health Service Corps, which has more than doubled its number of clinicians to 9,200.

Community health — particularly in hard-to-reach, rural areas — has been a top focus for Burwell, who was raised in West Virginia.
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