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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.

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These photos are a glimpse into the activities and action of the Mississippi Rural Health Association over the past several months:

Jessica Hunt receives a plaque in recognition as past president of the Association.

The Association is contracted to lead the Diabetes Coalition of Mississippi. Kate Cooley serves as the director of the coalition.

Ryan Kelly, executive director, joins rural health leaders throughout Mississippi for visits to Capitol Hill.

MRHA board at 2015 Christmas party and board meeting.

Eddie Cotten and the Mississippi Cotten Club at Giving Diabetes the Blues and the 20th Annual Conference.
OLD AND NEW BOARD MEMBERS

The Mississippi Rural Health Association thanks its previous board members for their service and dedication to rural health in Mississippi:

**Robert Smith**  
North Mississippi Medical Center (past president)

**Dr. John Mitchell**  
Mississippi Office of Physician Workforce

**Dr. Libby Mahaffey**  
Hinds Community College

**Sam Dawkins**  
Delta Health Alliance (past president)

The Mississippi Rural Health Association welcomes its newest board members:

**Sharon Turcott**  
Rush Medical Center

**Zach Allen**  
Children’s International Medical Group

**LaNelle Weems**  
Mississippi Hospital Association Foundation

**Ann Sansing**  
Mississippi State University Extension Center

SUSAN CAMPBELL RECEIVES MRHA’S DISTINGUISHED LEADERSHIP AWARD

The Mary Ann Sones Distinguished Leadership Award is given each year to a member of the Mississippi Rural Health Association that goes above and beyond in his or her duty as a member, but also goes above and beyond in their activity as a rural health champion.

The 2015 award was presented at the Association’s 20th Annual Conference to Mrs. Susan Campbell of Rush Health Systems. Susan is current president of the Mississippi Rural Health Association and has been a dedicated member for many years. Susan is also active in the Alabama Rural Health Association and has served on numerous committees in order to better meet the needs of the Association and the state.

Congratulations Susan!
REP. HARPER, PALAZZO SUPPORTS THE SAVE RURAL HOSPITALS ACT

The Save Rural Hospitals Act, HR 3225, is a bipartisan piece of legislation that combines the efforts of the previously reported REACH Act, S 1648, with restoration of several harmful cuts that have been realized for hospitals. It would also repeal harmful regulations such as the Two Midnight Rule and the 96-Hour Rule. This “magic bullet bill” would solve the largest number of problems that rural and critical access hospitals face today.

Mississippi Congressman Gregg Harper co-sponsored HR 3225 on February 1, 2016. During the Association’s recent meeting with Rep. Harper, he agreed that this bill will do a great deal to help Mississippi’s hospitals and that it highly worthwhile. More recently, Rep. Steven Palazzo signed on as a co-sponsor on March 17, 2016. After several conversations with the Congressman’s office, he too agreed that this legislation is needed for Mississippi and other rural states and will help to support our needed hospital infrastructure.

We thank these two representatives of our state for standing with us in support of our hospitals and clinics. Although we acknowledge that the likelihood of this legislation passing in 2016 is very slim due to this being an election year, growing support is needed in order to build momentum for next year’s consideration. For more information on HR 3225, visit us at www.msrha.org

MRHA LEADS MISSISSIPPI EFFORT FOR MBML COLLABORATION AGREEMENT

Due to your strong show of support, in addition to that of other supporting organizations in Mississippi, the Mississippi Board of Medical Licensure has agreed to adopt a measure extending the mile radius for physician / APRN collaboration from 15 miles to 75 miles, with no limit on the number of APRNs per collaborating physician.

A letter was read aloud from the Senate floor by Sen. Terry Burton from the board stating that this measure would be adopted at their next board meeting, which was held on Thursday, March 24, 2016 in Jackson. Because of this commitment by the board, the legislation on the floor which was heavily supported by the Mississippi Rural Health Association was dropped. The measure was successfully adopted at the board’s March meeting and had several alterations before upload for the mandatory public 30 day review.

This is a huge win for nurses and physicians alike in Mississippi. Clinics and hospitals may now enjoy a regulatory easing and work to grow access to care and quality of care without worrying about scheduling conflicts or a lack of local backup collaborating physicians. We would like to thank the Board of Medical Licensure in addition to the Mississippi Nurses Association, the Mississippi Nurse Practitioner Association, the Mississippi Association of Nurse Anesthetists. In addition, we thank Sen. Angela Hill, Sen. Terry Burton, and Rep. Becky Currie, among others.
A ppropriations Chairman Raises Concerns over Inadequate Support for Rural Critical Access Hospitals

U.S. Senator Thad Cochran (R-Miss.), chairman of the Senate Appropriations Committee, recently questioned Secretary of Health and Human Services Sylvia Burwell over the Obama administration’s inadequate support for Critical Access Hospitals (CAH).

Cochran raised the issue of access to healthcare in rural areas at a Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee hearing to review the FY2017 budget request for the U.S. Department of Health and Human Services.

“Critical Access Hospitals play an important role in states like mine where we have a high of number of people with a hard time getting access to and paying for health care. However, your budget request again proposes prohibiting Critical Access Hospital designations for facilities located less than 10 miles from another hospital and reducing reimbursements for these facilities,” Cochran said.

“We get tangled up sometimes in the procedures and lose sight of what the big picture really is,” Cochran said. “I hope we can look within our budget limits for opportunities to be more sensitive and generous. That will mean stretching dollars to provide funding where it can make it easier for people in rural areas to access emergency and medical care.”

CAHs provide important care in many of Mississippi’s small rural towns. Across the country, Critical Access Hospitals are closing because of tightening regulations by the Centers for Medicare and Medicaid Services (CMS). In Mississippi, 31 hospitals are identified as Critical Access Hospitals.

The subcommittee has been consistently critical of HHS handling of the Critical Access Hospital program, including language in its FY2016 appropriations bill directing CMS to work with the Health Resources and Service Administration Office of Rural Health to alleviate the disproportionate impact of CMS regulations, reimbursement cuts, and workforce issues on rural hospitals.

Note: Senator Cochran’s office consulted with the Mississippi Rural Health Association prior to this meeting for input and needs that may be used when addressing the Secretary.
The Mississippi Rural Health Association is proud to announce its newest venture, a professional credential designed to highlight seasoned rural professionals.

In order to foster a greater understanding of rural-specific policies, regulations, and needs in the field of healthcare, a new credential has been established with the Mississippi Rural Health Association to empower and educate members. These credentials, the Mississippi Rural Health Fellow (MRHF) and the Mississippi Rural Health Student Fellow (MRHSF), are established to reward healthcare professionals in their efforts to become experts in rural health matters.

"Being credentialed as an MRHF and MRHSF is a great honor that comes with hard work, study, and a dedication to improving the health of rural Mississippians," says Ryan Kelly, executive director.

Obtaining a credential through the Mississippi Rural Health Association is an excellent way to market yourself as a certified rural professional in Mississippi. As the only known credential available in the nation for rural health, the MRHF and MRHSF credentials will demonstrate to employers and colleagues alike that you have experience, dedication, and a history of success in leading and improving rural health.

Applicants to the credentials must have completed a minimum of 75 hours of rural-specific education in the past three years and have completed a community improvement project with a 4-page written report. This project may include a student project, a community health needs assessment, or another created project as part of one’s professional experience. Applicants for the MRHF must have a minimum of 3 years of professional experience in rural areas. MRHSF applicants must be active students in a health-related career field.

To learn more about the MRHF and MRHSF credentials, visit www.msrha.org or call 601.898.3001.
HOMETOWN GIRL RETURNS TO PRESTON AS PRACTICING PHYSICIAN

By Ryan Kelly

Preston is an unincorporated town in Kemper County, MS. With as low of a population as the town has, access to local healthcare has been all but non-existent for its residents. For one resident, it was time to change that fact.

Dr. Anna Marie Hailey-Sharp is a lifelong resident of Preston. The only daughter of Billy and Janice Hailey, she grew up with asthma and needed treatment for this chronic condition...treatment not available in the town.

She did well in school and graduated from Kemper Academy. She went a few miles down the road to East Mississippi Community College and then to The University of Mississippi to complete her undergraduate education. Having always wanted to be a family physician, she then enrolled in the School of Medicine at the University of Mississippi Medical Center.

Dr. Hailey-Sharp began her medical training open minded about the direction that she should take. It didn’t take long for her to realize her lifelong passion of family medicine, though, and her desire to return to her hometown to practice. With this passion, she joined the Mississippi Rural Physician Scholars Program during her second year in medical school, and also joined the Mississippi Rural Health Association as a student member.

In 2012 she graduated from UMMC and stayed in Jackson for three years to complete her residency training. After completing this training, she returned to Preston along with her husband Jason and her son Wyatt to start a new clinic, the Rush Medical Clinic of Preston. The clinic opened in December of 2015 and currently averages around ten patients per day.

“This is what God wanted for me...to come back to my hometown and work for all of those in need,” state’s Dr. Hailey-Sharp.

The Rush Medical Clinic of Preston is open on Tuesday and Thursday from 7:00 a.m. – 4:00 p.m. Dr. Hailey-Sharp also commutes to the county seat of Dekalb to work on Monday and Wednesdays.

Dr. Hailey-Sharp has gone full circle with her residence in Preston, her desire to become a physician, and her membership in the Mississippi Rural Health Association. She is now an active member of the Association and one of a growing list of physicians that desired to be a part of one of the nation’s largest rural health associations.

For the residents of Preston, they now have access to healthcare. This is one great example of how Mississippians are reaching those in need and breaking the boundaries of access to care.

“It’s been a long road, but I am very blessed. I’m very glad to now be home.”
He delayed his journey to become a doctor, but Johnny Lippincott has been intrigued by the field since childhood.

“Growing up, I was always interested in medicine,” the Tupelo native said. “My dad was a psychiatrist so I was aware of the field. I was a member of a club in high school that fostered students interested in careers in medicine.”

Through the club, he found out about the Rural Medical Scholars program. The program introduces high school students to careers as family medicine physicians. It is directed and funded by the Mississippi State University Extension Service and the Mississippi State Office of Rural Health.

The program was held for the first time in 1998 to introduce high school students interested in the medical field to the rigorous academics and lifestyle requirements of a family practitioner in a rural setting.

Mississippi students between their junior and senior years of high school with ACT composite scores of at least 24 and high GPAs are eligible to apply. Students accepted to the program live on the MSU campus for five weeks.

Rural Medical Scholars take two pre-med courses, follow various local physicians in their day-to-day activities, tour a major medical facility, and attend lectures targeted at aspiring physicians. Students begin the program in a study skills workshop and go on to earn college credit for the two academic courses.

“The Rural Medical Scholars program certainly confirmed and increased my desire to become a doctor,” said Lippincott, who completed the 2004 program. “I enjoyed the classes, and we got an idea of what college would really be like by living in the dorms and attending classes. The program really provided a stronger foundation for me when I started college.”

Observing the doctors was perhaps the most influential portion of the rigorous program. Lippincott chose to shadow an ear, nose, and throat specialist, an area of medicine in which he was especially interested at the time.

“One day when I was with him, he diagnosed a patient with throat cancer,” Lippincott said. “And I thought, ‘This is what I’ll be doing.’ That part of the program allowed us to see what physicians actually do on a day-to-day basis.”

Although he left the program with an enhanced understanding of what it would take to complete medical school, Lippincott did not pursue that goal right away.

“Once I got to college, I realized I wanted to explore other things before I dove into medicine,” he said.

Lippincott graduated in 2009 from Emory University in Atlanta with a degree in philosophy. Afterward he explored law school and worked as a paralegal for the Federal Trade Commission in Washington, D.C., while he earned a master’s degree in physiology.

Now a first-year medical student at University of Mississippi Medical Center in Jackson, he is not sure exactly what type of medicine he wants to practice, but he knows he’s in the right field.

“There is certainly a need for family practice physicians in the state,” Lippincott said. “But Mississippi has a wide range of needs when it comes to medicine. There is also a great need for mental health physicians. Right now I’m not committed to one path. I think that will become apparent as I advance in school and get more experience in different specialty areas.”

According to statistics from the federal government, Mississippi ranks last in the number of doctors per
person, and at least a portion of every county in the state is designated as medically underserved.

Since the Rural Medical Scholars Program launched in 1998, more than 300 students have completed it. Thirty-five of those students have entered medical school, and 24 have graduated and are in residency or private practice, said Bonnie Carew, assistant Extension professor and director of RMS.

About 70 percent of the students who complete the program go on to a career in healthcare, Carew said. Several have become nurses, pharmacists, dentists or medical researchers.

“Most of them go into medicine right away or within two years, but sometimes they take a different path,” she says. “Johnny was one of those. I haven’t seen him since about a year after he finished the program, but he would email me sometimes. And I always felt strongly that he would pursue a degree in medicine.

“Sometimes people need to take other paths to get where they are going. Those paths broaden them as a person, and that makes them better doctors,” Carew says.

Each year, between 20 and 25 students are selected through an application process. County Extension offices receive detailed information and instructions for application in late January or early February each year. To be considered for the program, prospective participants must apply by the March deadline.

For more information on the Rural Medical Scholars Program, visit www.RMS.msucares.com
Dr. Brent Smith could have taken his medical degree and set up his practice in a city big enough for a Target and a Cracker Barrel.

Instead, he passed up more lucrative opportunities for a family medicine career in 14,000-population Cleveland, Miss.

“Part of me always wanted to go home,” said Smith, 32, who played high school football in Cleveland, where most of his family still lives. “I thought about doing orthopedic surgery when I was in medical school, but I didn’t like not being able to connect on a personal level with patients.

“I realized family medicine is where I’m supposed to be. It’s a very rural area here, and we need all the primary care we can get.”

Smith is being recognized for his devotion to the state’s rural population with Mississippi’s 2015 Rural Health Champion Award, an honor bestowed by the Myrlie Evers-Williams Institute for the Elimination of Health Disparities at the University of Mississippi Medical Center. It goes to “an unsung hero who makes a notable contribution to health, health care,
or a health-care delivery system in a rural Mississippi community,” said Erica Collins-Young, recruitment and retention coordinator in the Institute’s Office of Population Health.

The award is presented in conjunction with National Rural Health Day, celebrated the third Thursday in November. On Nov. 30, Gov. Phil Bryant is scheduled to sign a proclamation recognizing Nov. 20 as Rural Health Day in Mississippi. Collins-Young and others from the Institute honored Smith Nov. 19 at his office with a plaque and a celebration for family and staff.

A total 12 health-care providers were nominated for Rural Health Champion, all of them excellent candidates, Collins-Young said. “What’s so great about Dr. Smith is that he’s a UMMC graduate,” Collins said. “He is a really great guy, very approachable, and he really cares about the children in the Cleveland area. Everyone has something positive to say about him.”

Dr. Jeanann Suggs, a UMMC resident in radiation oncology, has known Smith since he was in medical school. “He started from the get-go trying to improve health care for all Mississippians. He was a Rural Physicians Scholar. He knew where he’d come from, and what improvements he could make. He’s always been a champion of the hometown,” said Suggs, who nominated Smith.

Smith is “making his mark, not only doing rural medicine, but also in increasing access to health care for athletes,” Suggs said. “He’s played football, so he can relate to them. He’s walked through everybody’s steps. He’s Delta-born and bred, and he’s grown up with the challenges they face.”

When he was in high school, Smith said, he suffered a shoulder injury “and ended up seeing a doctor locally who misdiagnosed it. It led me to have ongoing issues with my shoulder, and it could have threatened my ability to play football and life going forward.

“I realized there needs to be resources here, or otherwise, athletes end up going two hours away,” said Smith, who also provides emergency room care at two rural hospitals. “When you talk about orthopedics for young athletes, you need to be specialized in the area to get good results.”

Smith serves on the sports medicine advisory committee for the Mississippi High School Activities Association and was a primary care sports medicine fellow at the University of Alabama. He’s served as a team physician for Delta State University and is passionate about keeping young athletes healthy and safe.

“Between Medicaid and CHIP (Mississippi’s Children’s Health Insurance Program), they should have some type access to health care. But that doesn’t take care of transportation issues, or parents working during those hours, or other difficulties,” Smith said. “Sports physicals at school often get that done.”

Despite the state’s reputation for diseases including diabetes, obesity and hypertension, “we also know that Mississippi has a great deal of good things going on that sometimes go unnoticed,” said Dr. Michael Jones, chief community health officer in the Office of Population Studies and the Institute’s deputy director.

“That includes the men and women who are in the trenches working to improve the health of the citizens of our state,” Jones said. “Dr. Brent Smith is one such individual who works to ensure the poor and underserved have access to healthcare and provides the highest quality of services in his community. We are very proud of him and others who do similar work at the community level.”

In his three years of practice, Smith said, he’s enjoyed taking care of family and friends he grew up with. “It’s rewarding to see that they put their faith in you. I grew up admiring and respecting members of my church and neighbors that I now take care of. You’re giving back to the people who did so much for you.”

“It’s so impressive that he is such a young man and making such an impact,” Suggs said. “He knows the challenges that need to be addressed, and that the mentality needs to be changed on being overweight and leading an unhealthy lifestyle. That makes him very effective in the education of his patients.”

“People who dedicate themselves to rural health can go anywhere,” Collins-Young said. “They are very talented and go so much further than required. We need to recognize them, and to let them know that we are watching them and appreciate them.”
GOVERNOR’S PROCLAMATION
FOR MISSISSIPPI RURAL HEALTH DAY

During National Rural Health Week in 2015, Governor Phil Bryant signed a proclamation declaring November 20th of each year to be Mississippi Rural Health Day.

The signing of the proclamation took place on Friday, November 20, 2015. We would like to thank the hard work of the Myrlie Evers-Williams Institute for the Elimination of Health Disparities at UMMC for their work to make this happen! More information will be made available this fall about activities to celebrate the Mississippi Rural Health Day.
CAN A PETABYTE A DAY KEEP THE DOCTOR AWAY? BIG DATA MAY HOLD THE KEY TO PERSONALIZED HEALTHCARE

By Hu Meena, CEO, C-Spire

Technology likes to show off. It’s easy to notice when the latest innovation has arrived because when technology gets better, we notice. In education-tech, we heralded the arrival of the SMART Board and interactive learning. Government-tech showed off its ability with advanced NSA surveillance. Every time you see a stunning new Pixar movie, you’re experiencing some of the best of entertainment-tech.

But how far have we advanced in the health-tech sector? Think about the last time you visited your doctor. It probably looked pretty similar to the way it looked back when you were excited to get that sick day home from school. You signed in on a clipboard chained to the front desk, filled out your brick of paperwork on another clipboard, and followed the nurse down the hall to the room where she hung the clipboard on the door. The world must have been lawless chaos before the clipboard was invented.

So aside from a few extra computers and iPads at your doctor’s office, where are we seeing technology affect positive change in health care? The changes I’m excited about are a little behind the scenes. Let’s talk about a couple of them.

BIG DATA AND PERSONALIZED MEDICINE

Everyone knows the marketing world loves to collect data about us. They love to know our preferences and our patterns. It helps them sell the right stuff to the right people. By drawing from a huge pool of data, marketers are able to make very informed decisions. This is Big Data in the commercial world.

Big Data in healthcare is trying to improve your health with that same kind of insight—but with less pop-up ads. For a long time, the problem was the data on that clipboard needed to be converted into digital information. In the past 6 years, widespread adoption of electronic medical records (EMR) has provided enough digital medical data to benefit from data analysis. It went from data to Big Data.

It’s easy to see how evidence-based medicine is immediately bolstered by Big Data: the pool of available evidence instantly becomes much larger. Doctors now can electronically compare patients’ conditions to similar patients and their respective health outcomes. This leads to better diagnoses and better treatment plans because you’re working with better intel. Your doctor’s perspective is no longer limited to what they’re most familiar with. Medical decisions can be more tailored and less standardized. This is the gateway to personalized medicine.

Personalized medicine is still taking shape but has the capacity to really change healthcare delivery. A key tenant of personalized medicine is that the genetic information inside each of us maps out our susceptibility to most diseases. Researchers have begun recording the specific genes of their patients, aka “sequencing their genomes.” Combine this genetic info with a personal narrative (diet, behaviors, health history, traumas) and a map legend begins to be formed.

What exactly do all these patients with this very specific type of cancer have in common? What drugs do they respond best to? Big Data could answer this.

But is data analysis really the highest level of general development for health-tech? Is this really state-of-the-art? You’d be surprised. These are huge amounts of data we’re talking about.

PETABYTES.

The Washington Post estimates that the current amount of human genomic data in existence is around
25 petabytes. That’s 2,500 times more data than every piece of text in the Library of Congress. Within the next decade, it’s estimated that genomic data will take up more data space than every video currently stored on YouTube. This is all raw data that has to be extracted, curated, compressed, stored, and ultimately made sense of. Only recently has the technology—the algorithms, the processors, the bandwidth—reached a benchmark that could carry such a weight.

It isn’t cheap either. But innovation has dramatically lowered the cost. During his battle with pancreatic cancer, Steve Jobs had the genome of his tumor sequenced multiple times to help decide which drug therapy to use. According to the New York Times, each sequence cost him $100,000. A decade earlier, in 2001, it would have cost $100 million. Now, just 4 years after his death, it costs barely over $1,000. That is a remarkable cost reduction resulting purely from an improvement in technology.

Not only is DNA sequencing more efficient and cost-effective than ever before, but it’s also becoming more share-friendly. Fast Company reports that just last month the FDA released a website, precision.fda.org, that makes it easier for researchers to explore the existing community-based genomic information. This DNA library makes it easy for scientists to collaborate with each other, share genomes they’ve sequenced, and build off of each other’s discoveries. This socialization of genomic research, combined with the power of Big Data, is important. Some experts believe it’s the way we’re going to cure the big diseases.

So, we know Big Data analytics has the power to radically personalize medicine. But how are these broad concept macro-innovations being fueled on the ground level?

SENSORS

In the past five years, we’ve seen a huge rise in the popularity of activity trackers. There’s a good chance you use something like a Fitbit, and if not you definitely know ten people who do. Such rapid adoption has encouraged companies and their engineers to innovate and make products that give us more and more insight on our health metrics and help us live healthier lives.

But what about the really chronically sick? Sensor technology has an even bigger opportunity to help these individuals. In August, Y Combinator—a Silicon Valley incubator for startup companies—released their “Request for Startups” report. In their healthcare section they state:

Healthcare in the United States is badly broken. We are getting close to spending 20% of our GDP on healthcare; this is unsustainable.
We’re interested in ways to make healthcare better for less money, not in companies that are able to exploit the system by overcharging. We’re especially interested in preventative healthcare, as this is probably the highest-leverage way to improve health. Sensors and data are interesting in lots of different areas, but especially for healthcare.

This is the most prestigious startup accelerator in the country. Only 3 percent of the companies that apply to participate in their program are accepted and they’ve made an explicit request for innovators to explore the possibilities and the promise through use of sensors and data in healthcare. They see a gap and an opportunity.

In 2014, C Spire partnered with the University of Mississippi Medical Center in a pilot program to improve healthcare in rural Mississippi through remote monitoring and data analytics involving individuals with diabetes. Thousands of people in our state suffer from more than one chronic disease and live outside the reach of consistent quality health care. Our plan combined the power and ubiquity of our high-speed mobile broadband communications network with Intel-GE sensors that link UMMC specialists to patients in their homes to deliver more connected, collaborative and cost-effective care. Patients are issued tablets and sensors equipped to monitor metrics like glucose levels, provide educational health information, and transmit a seamless stream of data to specialists at UMMC.

UMMC estimates $339,000 in combined savings for the 100 patients in the diabetes pilot program, resulting from the elimination of hospital stays and emergency room visits. Assuming 20 percent of Mississippi’s diabetic population enrolls, this could add up to $189 million in Medicare savings for our state every year.

In fact, that pilot was so successful that C Spire, UMMC and Intel-GE Care Innovations have agreed to partner together on a five-year program that promises to dramatically lower the cost of care and improve the health of thousands of chronically ill and underserved consumers in the southeastern U.S.

This approach helps to close the gap between the medically underserved and everyone else. This saves our state a significant amount of money. This even promises better health outcomes for the many individuals who struggle with chronic diseases every day. This is the medical equivalent of Fitbit, but with much higher stakes.

So as far as health-tech goes, with Big Data and sensors, we’re in a pretty good place. And if history is any indicator, we’ll soon be heading to an even better one.
As many of you know, beginning January 1, 2016, RHCs will be able to bill Medicare for Chronic Care Management (CCM) services.

Effective care management—particularly of chronic conditions—demands more than just an occasional face-to-face patient encounter. It requires outreach, telephone conversations, medication reconciliation and coordination between caregivers, among other activities.

Dedicated clinicians have long gone the extra mile to ensure their patients receive this level of high-touch care. Until recently, however, their efforts went unreimbursed. That changed this year with the introduction of a CPT code for Chronic Care Management (CCM): 99490. Rural Health Clinics and Federally Qualified Health Centers can now bill code 99490 for chronic care management.

What does CCM code 99490 cover?
Payment for CPT 99490 averages $42.60 per month, and reimburses non-face-to-face services provided to Medicare patients with two or more significant chronic conditions.

Allowed services include:
• Communication with the patient (electronically or by phone)
• Care coordination (both electronically and by phone)

• Medication management
• 24-hour accessibility to patients and any care providers
• Creation and revision of electronic care plans

To report 99490, providers must provide 20 minutes of service (non-face-to-face), with a comprehensive care plan documented in a certified EHR. Only one provider can bill the code each month for each patient and co-payments apply.

Clinics can conduct this service by using in-house staff to complete the minimum of 20 minutes non-face-to-face encounter with the patient, or they could outsource this service to one of many available partners in the field.

Few healthcare organizations are staffed to meet the full 20-minute billing requirement for all eligible patients—but third-party companies such as Allscripts delivers comprehensive services to augment your care team. Their clinical resources reach out to patients to schedule an initial visit and will coordinate and manage the resulting care plan.

Whether you conduct chronic care management with your team or you contract with another entity like Allscripts, you can be sure that this wave of payment for care management is part of the evolution of healthcare in our state’s clinics.
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.