



## RURAL HEALTH CLINIC CONNECTION

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### Mississippi Rural Health Association continues to administer the *Tobacco-Free Mississippi: Engaging Mississippi's Rural Health Clinics Project.*

The Mississippi Rural Health Association (MRHA) received a grant from the Mississippi State Department of Health, Office of Tobacco Control, to provide rural health care providers with the tools to ensure that all tobacco users are offered effective tobacco cessation treatment at all clinical encounters. Providers in 37 rural health clinics have been trained to counsel all tobacco-using patients with an effective, brief, evidence-based treatment program to facilitate their patients' efforts to quit the use of tobacco products.

1. Ask all patients if they use tobacco at each visit.
2. Advise all tobacco-using patients to quit.
3. Refer all tobacco-using patients to the Mississippi Tobacco Quitline.

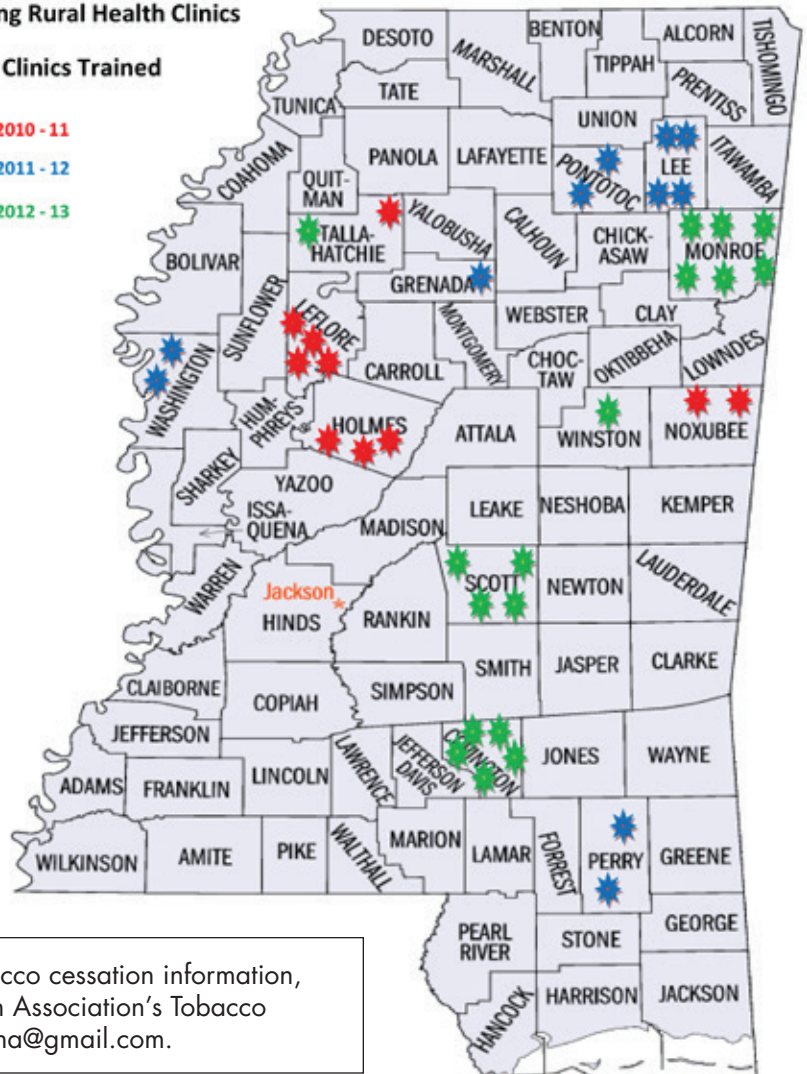
Not every patient who is identified as a tobacco user will be ready to make a quit attempt. However, studies show that even minimal intervention by a clinician (i.e., as little as three minutes of face-to-face counseling) can increase overall abstinence rates.

If your rural health clinic is interested in receiving tobacco cessation information, please contact Cindy Widdig, Mississippi Rural Health Association's Tobacco Project director, at 601.842.1359 or [cindywiddig.mrha@gmail.com](mailto:cindywiddig.mrha@gmail.com).

**Tobacco-Free Mississippi:  
Engaging Rural Health Clinics**

**Clinics Trained**

- FY 2010 - 11
- FY 2011 - 12
- FY 2012 - 13



# Are There Effective Treatments for Tobacco Addiction?



Yes, extensive research has shown that treatments for tobacco addiction do work. Although some smokers can quit without help, many individuals need assistance with quitting. This is particularly important because smoking cessation can have immediate health benefits. For example, within 24 hours of quitting, blood pressure and chances of heart attack decrease. Long-term benefits of smoking cessation include decreased risk of stroke, lung and other cancers, and coronary heart disease. A 35-year-old man who quits smoking will, on average, increase his life expectancy by five years.

## NICOTINE REPLACEMENT TREATMENTS

Nicotine replacement therapies (NRTs), such as nicotine gum and the transdermal nicotine patch, were the first pharmacological treatments approved by the Food and Drug

Administration (FDA) for use in smoking cessation therapy. NRTs are used (in conjunction with behavioral support) to relieve withdrawal symptoms—they produce less severe physiological alterations than tobacco-based systems and generally provide users with lower overall nicotine levels than they receive with tobacco. An added benefit is that these forms of nicotine have little abuse potential since they do not produce the pleasurable effects of tobacco products, nor do they contain the carcinogens and gases associated with tobacco smoke. Behavioral treatments, even beyond what is recommended on packaging labels, have been shown to enhance the effectiveness of NRTs and improve long-term outcomes.

## ADDITIONAL MEDICATIONS

Although the primary focus of pharmacological treatments for tobacco addiction has been nicotine replacement, other treatments are also available. For example, the antidepressant bupropion was approved by the FDA in 1997 to help people quit smoking and is marketed as Zyban. Varenicline tartrate (Chantix) is a medication that received FDA approval for smoking cessation. This medication, which acts at the sites in the brain affected by nicotine, may help people quit by easing withdrawal symptoms and blocking the effects of nicotine if people resume smoking.

## BEHAVIORAL TREATMENTS

Behavioral interventions play an integral role in smoking cessation treatment, either in conjunction with medication or alone. A variety of methods can assist smokers with quitting, ranging from self-help materials to individual cognitive-behavioral therapy.

The Mississippi Tobacco Quitline is a telephone and online support service for any Mississippian who is ready to quit tobacco. Patients can call 1.800.QUIT.NOW (1.800.784.8669).

For patients who need more intensive, face-to-face assistance for overcoming tobacco addiction, the ACT Center is available. Patients can call 601.815.1180 for information on programs throughout the state.

Not every patient who is identified as a tobacco user will be ready to make a quit attempt. Quitting tobacco is never easy, but with help, your patients are twice as likely to quit tobacco for good.

Studies show that even minimal intervention by a clinician (i.e., as little as three minutes of face-to-face counseling) can increase overall abstinence rates.

# What Are the Medical Consequences of Tobacco Use?

Cigarette smoking kills an estimated 440,000 U.S. citizens each year—more than alcohol, illegal drug use, homicide, suicide, car accidents and AIDS combined. Between 1964 and 2004, more than 12 million Americans died prematurely from smoking, and another 25 million U.S. smokers alive today will most likely die of a smoking-related illness.

Cigarette smoking harms nearly every organ in the body. It has been conclusively linked to cataracts and pneumonia and accounts for about one-third of all cancer deaths. The overall rates of death from cancer are twice as high among smokers as nonsmokers, with heavy smokers having rates that are four times greater than those of nonsmokers. Foremost among the cancers caused by tobacco use is lung cancer—cigarette smoking has been linked to about 90 percent of all cases of lung cancer. Smoking is also associated with cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder and acute myeloid leukemia.

Using advanced neuroimaging technology, scientists can see the dramatic effect of cigarette smoking on the brain and body and are finding a marked decrease in the levels of



monoamine oxidase (MAO B), an important enzyme that is responsible for the breakdown of dopamine. (Source: Fowler et al., 2003)

In addition to cancer, smoking causes lung diseases such as chronic bronchitis and emphysema, and it has been found to exacerbate asthma symptoms in adults and children. About 90 percent of all deaths from chronic obstructive pulmonary diseases are attributable to cigarette smoking. It has also been well-documented that smoking substantially increases the risk of heart disease, including stroke, heart attack, vascular disease and aneurysm. Smoking causes coronary heart disease, the leading cause of death in the United States: cigarette smokers are two

to four times more likely to develop coronary heart disease than nonsmokers.

Sticky, brown tar coats the lungs of tobacco smokers. Along with thousands of other damaging chemicals, tar can lead to lung cancer and acute respiratory diseases.

Although we often think of medical consequences that result from direct use of tobacco products, passive or secondary smoke also increases the risk for many diseases. Environmental tobacco smoke is a major source of indoor air contaminants; secondhand smoke is estimated to cause approximately 3,000 lung cancer deaths per year among nonsmokers and contributes to more than 35,000 deaths related to cardiovascular disease. Exposure to tobacco smoke in the home is also a risk factor for new cases and increased severity of childhood asthma. Additionally, dropped cigarettes are the leading cause of residential fire fatalities, leading to more than 1,000 deaths each year.

Resource:  
NIH Pub Number: 12-4342  
Published: July 1998  
Revised: July 2012

# Smoking Cessation Medication Options

## Prescription Non-nicotine Medications

Chantix (varenicline) and (bupropion) are the only two non-nicotine medications approved by the U.S. Food and Drug Administration (FDA) for smoking cessation; both are available in pill form and only by prescription. Chantix received FDA approval in 2006; Zyban was approved in 1997.

### HOW CHANTIX WORKS

Chantix works by interfering with the receptors in the brain that respond to nicotine. This provides two benefits. It reduces the amount of physical and mental pleasure a person receives from smoking, and it also weakens the symptoms that come with nicotine withdrawal.

Chantix instructions are very specific:

- For the first three days, take one 0.5 milligram (mg) pill in the morning.
- During the next four days, take one 0.5 mg pill twice a day.
- During the second week and thereafter, take two 1 mg doses, one in the morning and one at night.

Always take Chantix after meals with a full glass of water. When taking two doses a day, be sure to wait at least six hours between doses. The recommended length of use is 12 weeks, but that time can be extended another 12 weeks for patients who successfully quit so they can boost their chances of remaining smoke-free.

### THE PROS AND CONS OF TAKING CHANTIX

Three points in favor of Chantix:

- Chantix more than doubles a person's chances of successfully quitting smoking.
- Chantix has been proven to be the best smoking cessation aid in preventing relapse and withdrawal symptoms.
- It's easy to use.

Chantix has also been shown to have some serious possible side effects:

- Headaches
- Nausea and vomiting
- Trouble sleeping and vivid dreams
- Agitation
- Depression and thoughts of suicide

### HOW ZYBAN WORKS

Zyban is an extended-release antidepressant pill that can alleviate nicotine withdrawal symptoms. It works by acting on brain chemicals associated with cravings for nicotine.

Zyban costs only \$4 per day and comes with specific instructions:

- For best results, start taking Zyban one week to two weeks prior to your quit date.
- Take 150 mg each day for the first three days.

- From there, many people will increase to the recommended dose of 300 mg per day, taken in two 150 mg doses eight hours apart.

Treatment with Zyban typically lasts seven to 12 weeks. If you don't show significant progress by the seventh week, treatment usually is suspended.

### THE PROS AND CONS OF TAKING ZYBAN

Patients using Zyban are generally successful at quitting, according to research. Zyban has been shown to be particularly effective when used along with a nicotine replacement therapy like the patch or gum.

The pros associated with taking this medication are as follows:

- It's easy to take.
- It contains no nicotine so there is no problem with toxicity if you still smoke.

- It can be used with other nicotine replacement therapies.
- It can help if the patient is also depressed.

Some of the negatives of this drug are similar to those of Chantix:

- It can cause mood and behavioral changes and thoughts of suicide.
- Zyban cannot be used by anyone who has
  - ▶ A history of seizures,
  - ▶ A history of severe head trauma,
  - ▶ A previous or current eating disorder, such as anorexia or bulimia, or
  - ▶ A current or past history of heavy alcohol drinking.
- Side effects of Zyban include insomnia, dry mouth, reduced appetite, increased anxiety, nausea and dizziness.

With careful monitoring, these non-nicotine-based medications are worth considering when assisting your patients in quitting tobacco use.

## Mississippi tobaccoQUITLINE 1.800.QUITNOW

1.800.784.8669

**Callers to the Mississippi Tobacco Quitline who want to stop using tobacco can receive up to eight weeks of nicotine replacement therapy (NRT), patch or gum, at no charge. Callers must complete an intake and agree to participate in cessation counseling in order to receive the products. Medical clearance is necessary when medications are provided.**

**The approach of combining counseling and medication has been shown to be one of the most effective options currently available.**

#### ***Will I get all eight weeks at one time?***

No, once medically cleared to participate, NRT will be ordered in two-week increments and delivered to the participant. Cessation counseling is required between the orders.

#### ***Who can call the Tobacco Quitline?***

Any Mississippian can call the toll-free number from anywhere in the state—1-800-784-8669.

#### ***What are the hours?***

The Tobacco Quitline is available from 7:00 am until 9:00 pm, Monday through Thursday, 7:00 am until 7:00 pm, Friday and 9:00 am until 5:30 pm on Saturday. Voicemail is available.

# HIPAA as a Hurdle

Family members are often barred from becoming engaged in patients' care.

By Carol Levine

Every hospital and health care facility has some variation of this sign: "It's the law. Be careful not to discuss patients in public." Like World War II posters warning that "Loose lips sink ships," these notices stress that information falling into the wrong hands can lead to disaster. Staff training that emphasizes the punitive consequences of improper disclosures of protected health information reinforces this caution.

The source is, of course, HIPAA, the federal Health Insurance Portability and Accountability Act. As a longtime advocate for patients' rights, especially the right to privacy, I am chagrined that a law intended to protect patients' medical information is so often used as a bar to communication.

And even with my knowledge of what the law really says, I was waylaid by HIPAA when I was denied permission to accompany my sister, who was suffering severe pain, into the office with the triage nurse in an emergency department. My sister practically begged the nurse to let me come with her. Not a chance. But later, when my sister was on a gurney in the ED corridor for two days, patient privacy was absent. We couldn't help but hear about everyone's medical, financial and relationship problems.

At a time when "patient engagement" and "person- and family-centered care" are buzzwords in health care, it is an unfortunate reality that a family member has to leap over a HIPAA barrier to become engaged. The irony, of course, is that patients with complex medical needs are discharged from hospitals to the care of untrained and unprepared family members and all too often are readmitted because of failures in communication around discharge planning.

HIPAA is often presented as a series of "don'ts." And there are good reasons to establish strong security protections and procedures that prevent disclosure to individuals and groups

that want this information for reasons that have nothing to do with patient care. After a yearlong examination of cybersecurity and vulnerability to hackers, the *Washington Post* concluded that health care is among the most vulnerable industries in the country, in part because of aging technology and failures to fix known software flaws.

But HIPAA's strong statements about permissible disclosures are often overlooked. When family members ask about a patient's test results, condition or follow-up care, they may be told, "I can't tell you because of HIPAA." But here is what HHS' Office for Civil Rights, responsible for monitoring HIPAA, says: "The HIPAA Privacy Rule at 45 CFR 164.510(b) specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends or other persons identified by a patient, in the patient's care or payment for health care." The one caveat: Information cannot be shared if the patient objects.

Of course, this statement doesn't answer all the questions, such as what to do when the patient cannot communicate (information can be shared if it can reasonably be inferred that the patient would not object). The Office for Civil Rights typically defers to professional judgment and experience with common practice in making decisions about the patient's best interests.

There are boundaries, however. Sharing of information should be limited to a few people who the patient identifies or have been identified as directly involved in care. These designated individuals can share information with other family members as they choose. Then, when long-absent Cousin Joe calls and demands to know what is being done to his beloved Aunt Mary, he can be told to contact the designated family member. And the information that can be shared should be limited to the current condition and patient needs. There is no need to go back 20 years to report an STD or a clinical depression.

HIPAA rules have been periodically updated since they went into effect in 2003. In the most recent revisions, the most significant changes involved the incorporation of the Health Information Technology for Clinical and Economic Health Act, or HITECH, into HIPAA, which significantly increased its enforcement provisions, especially around security and transfer of electronic protected health information. There were no changes regarding sharing information with family or others identified by the patient.

Here are some suggestions to ensure compliance with HIPAA's don'ts and its permissible disclosures:

Convene a group of senior leaders and staff to review relevant elements of the organization's privacy policies and practices. This should include any specific practices that deviate from the basic HIPAA rules (requiring written consent, for example, for disclosures to family members).

If this discussion reveals concerns or contradictions, establish a task force to come up with suggestions based on the organization's mission and practice.

Encourage staff training (or retraining) on HIPAA and HITECH so that all staff follow the same principles and rules.

Create a simple statement of the organization's policy and practices for patients and families. The United Hospital Fund's Next Step in Care family caregiver guide to HIPAA may be useful.

Discuss cases that present challenging issues with the organization's privacy officer before taking any action. Raising potentially serious problems is an important step in reducing HIPAA violations and in protecting the institution as well as patient privacy.

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Reprinted from *Modern Healthcare*



## MRHA Webinar Series Announced

The Mississippi Rural Health Association will host a webinar series throughout 2013 in order to provide members with the best presentations available throughout the nation on rural health needs. Topics will vary but will include information for hospital administrators, billing and coding clerks, health policy experts, physicians and nurses, and various health education for a variety of health professions. Visit [www.msrrha.org](http://www.msrrha.org) for a full listing of webinars available to members.

# Rural Health Clinic Workshop

The Mississippi Rural Health Association will host a Rural Health Clinic Workshop on Friday, June 14, 2013, at Rush Health System in Meridian, Miss. This workshop is hosted by Ms. Joanie Perkins, CPC, of North Sunflower Medical Center and **includes four hours of CEUs from AAPC.**

The workshop will feature the following topics:

- Rural health legislative updates
- Advanced RHC billing concerns
- EHR Stage 1 requirements and meaningful use
- RHC Medicaid reimbursement
- Survey and recertification
- Surviving the audits



Registration is \$100 for current members and \$125 for non-members.\* Registration includes the full workshop, a take-home tool kit and lunch, as well as a certificate for four hours of CEUs from AAPC.

## TO REGISTER

Download, complete and return the registration form or register online at [www.msrha.org/events](http://www.msrha.org/events).

**Only 50 spots are open, so be sure to register today!**

*\*Non-member registration includes membership in the Association.*

## CMS Starts Conducting EHR Incentive Program Pre-Payment Audits

By Jennifer Bresnick

As promised, the Centers for Medicare and Medicaid Services (CMS) are sending out letters informing a random segment of providers that their Medicare billing activities will be audited. Eligible providers (EPs) and hospitals who attested in January of 2013 might find themselves under the microscope as CMS tries to ensure that meaningful use payments are going to the right people for the right reasons.

"We have a fiduciary responsibility to make sure that we are paying appropriately," explained Elizabeth Holland, Director of the HIT Initiatives Group at HHS during HIMSS13. After widespread concern about questionable billing practices among providers vying for government funds – and accusations that CMS hasn't been doing enough to combat fraud – the agency has ramped up

its efforts to keep an eye on meaningful use participants. And with budgets being slashed due to sequestration, every dollar counts for both CMS and providers who can't afford to take an additional hit due to auditing.

Providers who have already received their incentive payments for January are safe, according to Holland, but anyone who's missing a check should look in their mailboxes for a letter from Figliozi & Co., the firm contracted by CMS to conduct its pre-payment investigations. These pre-payment audits follow a round of post-payment inquiries started in July of 2012. More than 2,000 post-payment audits are currently underway, some targeted due to flagged data and others entirely random. During these sweeps, CMS has found that some EPs can't provide the documentation to support their attestation, prompting the agency to release additional guidance in the coming months.

"EPs, eligible hospitals and critical access hospitals should retain all relevant supporting documentation in either paper or electronic format, [including] documentation to support attestation data for meaningful use objectives and quality measures for six years post-attestation," the CMS audit fact sheet recommends. "Documentation to support payment calculations (such as cost report data) should follow the current documentation retention processes." Audits by Figliozi may include an on-site visit and a demonstration of the provider's EHR system. If the provider is found ineligible after a review, the payment will be recouped. Providers who wish to appeal may do so, and the process will be handled by the provider's home state.

Reprinted from *EHR Intelligence*

# Nurse Practitioner Home-Based Program for the Rural Homebound Elderly and Disabled Population

**By Mary Atkinson Smith, DNP, FNP-BC**

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Healthy People 2020 includes goals of achieving health equality, eliminating health disparities, and improving health in all groups.<sup>1</sup> With the elderly population growing quickly, and a shortage of primary health care providers nationwide, meeting the goals of Healthy People 2020 among the elderly population will be particularly challenging in the rural areas.<sup>2</sup> The 2010 census showed the highest number of individuals who are age 65 and older, when compared to previous census reports.<sup>3</sup> There are 36 million people residing in the U.S. who are considered disabled, with 37 percent being age 65 and older.<sup>4</sup> The number of individuals with specific disabilities includes the following: 10.2 million with hearing difficulty, 6.5 million with vision impairment, 13.5 million with cognitive difficulties, and 19.4 million with limitations of physical mobility.<sup>4</sup> These disabilities can significantly limit an individual's access to timely health care services.

Due to my own experiences with my aging grandparents, I saw a need in the Golden Triangle area for a home call program to service the homebound elderly and disabled. In the beginning of 2012, with the support of one local internal medicine physician and other nurse practitioner (NP) colleagues, I began organizing a NP home call program. The overall goals of the program included increasing access to timely, high-quality health care services, decreasing fragmentation of care, and ensuring continuity of care among the homebound elderly and disabled population in the rural areas of the Golden Triangle. In addition to the overall goals, the desired outcomes included enhancing the patients' quality of life, improved systematic management of chronic illnesses and improved patient/caregiver compliance to decrease exacerbations, ER visits, hospitalizations and rehospitalizations.

Golden Triangle Geriatric Collaborative, started seeing patients in July 2012. In November 2012, I was hired as director of Health Care Services for the Golden Triangle Planning and Development District (GTPDD) in Starkville, Miss., and Golden Triangle Geriatric Collaborative was added as a subsidiary of the GTPDD beginning January 1, 2013. This merger created GTPDD Senior Medical Services that consists of three full-time NPs and a patient care coordinator who provide home call visits and a transitional care program with a coordinated team approach, to homebound elderly and disabled patients across the GTPDD's seven-county area.



Merging Golden Triangle Geriatric Collaborative with the GTPDD has proved to be very successful and beneficial to the homebound elderly and disabled patients in the seven rural counties served by the GTPDD. This success can be contributed to the fact that the GTPDD had extremely valuable resources in existence prior to incorporating the services of Golden Triangle Geriatric Collaborative. These existing resources include the Area Agency on Aging, the Elderly and Disabled Medicaid Waiver Program with 15 registered nurses who are case managers and 14 licensed social workers, meals on wheels, in-home respite and homemaker services, personal care attendants and escorted transportation. Adding the Senior Medical Services program staffed by nurse practitioners to these already-existing resources, has created a comprehensive and collaborative team approach to managing the health of homebound rural elderly and disabled patients.

The mission of GTPDD Senior Medical Services is to increase access to compassionate, high-quality health care services, ensure continuity of care, and decrease fragmentation of care among the homebound elderly and

disabled by providing the availability of home visits by NPs and placing a strong focus on a collaborative team approach to the coordination of patient care. This coordination includes NPs, primary care providers, registered dietitians, pharmacists, and other agencies providing skilled services, in addition to family members and caregivers. The GTPDD Senior Medical Services program utilizes a collaborative practice model that focuses on keeping primary care providers involved in the plan of care and medical management of their elderly and disabled patients, who have become homebound. Care coordination and collaboration are

both key components of health care that encourage continuity of care and decrease fragmentation of care among these two vulnerable populations.

GTPDD Senior Medical Services utilizes the most efficient and effective means to ensure the physical, social, emotional and spiritual needs of the homebound elderly and disabled by meeting the total care needs of these vulnerable patients who are unable to access primary care in the traditional primary care office setting due to limited mobility, disability, or lack of transportation. GTPDD Senior Medical Services promotes health maintenance, restorative care, illness prevention, management of chronic illnesses, and functional/self-care independence to prevent unnecessary admissions to nursing homes, reduce the length and recurrence of hospitalization, and diminish unnecessary utilization of emergency room services. The transitional care program provides services to the homebound elderly and disabled who have been discharged from the acute or skilled setting, with the overall goals of ensuring care coordination and continuity of care in the post-discharge setting and minimizing the incidence of hospital or nursing home readmission.

The number of Americans over the age of 65 is expected to increase from 40.2 million in 2010 to 88.5 million in 2050. In addition, the population 85 and older is expected to increase more than 21 percent.<sup>5</sup> How are we preparing to care for this increasing aging population, especially the oldest of the old, who are over 85 years of age? This population is often extremely frail and requires additional medical care and support due to multiple chronic illnesses and other comorbidities. Advanced medical care has led to an increase in life expectancy; therefore, people are living longer, and the development of acute and chronic illnesses is inevitable. Currently, 90 percent of individuals who are age 65 and older have one chronic illness, and 77 percent have two or more chronic illnesses.<sup>6</sup> Due to these facts, the medical and social aspects of caring of the aging population is going to become increasingly complex, and care coordination along with collaboration will be essential to ensure the delivery of patient-centered, high-quality and cost-effective care.

The elderly who are 85 years of age and older are often homebound due to complete immobility, limited mobility, impaired cognition or vision limitations that interfere with their ability to transport themselves to and from their health care provider's clinic. This specific population may lack transportation all together. This is especially true in the rural areas. If seniors do have access to transportation, it may be unreliable. Only 50% of elderly Americans have access

to public transportation; among the elderly, access to public transportation is more limited for the rural poor than the urban poor.<sup>7</sup> Lack of access to transportation is yet another barrier to accessing health care in the rural population, but it is particularly problematic for impoverished elderly rural dwellers, who may not own a vehicle or who cannot drive long distances.<sup>8</sup> These are very common reasons why elderly forego or lack access to health care services, which leads to a decreased quality of life, lack of care coordination, ineffective and lack of timely management of acute and chronic illnesses, increased incidence of emergency room visits, hospitalizations and rehospitalizations.

As the aging population continues to grow, along with an increased life expectancy, home call visits by NPs will play a key role in improving the quality of life, ensuring access to timely and comprehensive health care, in addition to prompt and effective management of acute and chronic illnesses, among the homebound elderly and disabled in rural locations. A comprehensive program such as GTPDD Senior Medical Services is able to provide this much-needed care and support to these vulnerable populations by bringing health care access and coordination to their places of residence. With health care reform and introduction of the Affordable Care Act, programs such as those provided by GTPDD Senior Medical Services will become a major source of health care delivery among the rural elderly and disabled populations.

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## RHC Listserv and Question/Answer Forum

Do you have billing and coding questions or other issues related to regular operation of your rural health clinic? The Mississippi Rural Health Association is here to help! Visit the Association's Q/A Forum at [www.msrrha.org](http://www.msrrha.org) to view the answers to common questions asked of the Association. To gain access to the Association's rural health clinic listserv, email us at [president@mississippirural.org](mailto:president@mississippirural.org) for inclusion.



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