President Obama’s budget proposal, released earlier this morning, continues to be a source of concern for many rural health providers. While the non-binding budget proposal is unlikely to be adopted by Congress, the President again proposes cuts to the Critical Access Hospital (CAH) system and other members of the rural health safety net. As in years past, the President’s proposal suggests cutting all CAH reimbursement from 101% of cost to 100% while completely excluding current CAHs that are within 10 miles of another health care facility, regardless of the care that other facility offers or who it is intended to serve. Additionally, the budget proposal calls for additional cuts to bad debt reimbursement for all providers. Even discretionary programs designed to help CAHs are being cut; the Rural Health Flexibility Grant line is cut by 15 million dollars.

The President’s proposal is not all bad, though. As part of an effort to expand access to primary care providers, the President has proposed a significant investment in the National Health Service Corps (NHSC). In addition to nearly 310 million dollars in mandatory funding for the NHSC enacted as part of the Affordable Care Act (ACA), the budget asks for an additional 100 million dollars in FY 2015 to train more primary care providers to serve newly insured populations throughout rural America. Similarly, the Teaching Health Center program would continue to receive significant funding, as mandated by the ACA.

While NRHA is appreciative of this funding, a number of other programs are targeted for cuts in the President’s budget. Area Health Education Centers would see their federal funding completely eliminated. A grant program designed to help rural communities acquire emergency medical devices would also be left without funds. Taken in concert with the cuts proposed to CAHs, these sections of the President’s budget would severely damage the rural health safety net. NRHA will continue our efforts to ensure that these cuts are not enacted while working with the Administration and Congress to adequately train and retain a quality workforce in rural America. If you have any questions, please contact NRHA Government Affairs Staff at (202) 639-0550.
Rural Health Clinic Workshop

- Advanced Billing,
- RAC Audits,
- CMS Update,
- National Policy Review

- 4 hours AACP credit offered
- Friday, July 18, 2014
- William Carey University

Registration is $100 for members, $125 for non-members. Register online at www.msrha.org/events.
Secondhand Smoke is dangerous to children

Smoking around children can cause sudden infant death syndrome (SIDS), lung problems, ear infections, and more severe asthma.

Secondhand smoke
It hurts you. It doesn’t take much. It doesn’t take long.
Many Chronically Ill Americans Unable to Afford Food or Medicine

By Allison Bond, Reuters Health

One in three Americans with a chronic disease such as diabetes, arthritis or high blood pressure has difficulty paying for food, medications or both, according to a new study.

People who had trouble affording food were four times more likely to skip some of their medications due to cost than those who got plenty to eat, researchers found.

“This leads to an obvious tension between ‘milk’ or ‘med,’” said Dr. Niteesh Choudhry, who worked on the study at Brigham and Women’s Hospital in Boston. “If you have a fixed income, should you treat or should you eat?”

The findings are based on data collected by the 2011 National Health Interview Survey, a questionnaire that offers a snapshot of the U.S. population as a whole. Nearly 10,000 people age 20 and up filled out the survey and reported having one or more chronic illnesses like cancer, asthma, emphysema or a psychiatric illness.

Among those participants, 23 percent took their medication less often than prescribed because of the cost, 19 percent reported difficulty affording food and 11 percent said they were having trouble paying for both food and medications. In the end, about one in three had trouble affording food, medication or both.

These rates are high but are similar to figures found in previous studies, said lead author Dr. Seth Berkowitz, from Massachusetts General Hospital in Boston.

Yet the link between difficulty paying for food and for medications is a novel one.

“The idea of tradeoffs that people might make (between buying medications or food) is something we haven’t seen before,” said Berkowitz.

The researchers also found that patients who had difficulty paying for both food and meds were 58 percent more likely to be Hispanic or African American.

With each additional chronic illness the patients reported, their risk of having a tough time affording those items went up by 56 percent, according to the findings published in The American Journal of Medicine.

Finally, people having trouble affording medications and food were 30 percent less likely to have public, non-Medicare insurance like Medicaid, and about 60 percent less likely to participate in the Special Supplemental Nutrition Program for Women, Infants, and Children, known as WIC. This program provides supplemental food and healthcare referrals for certain women and children up to age five.

By removing some of the financial pressure from people struggling to afford food, assistance programs like WIC may also help them afford their medications, Berkowitz said.

For that reason, for people struggling to pay for either food or medications, the authors recommend looking into eligibility for food assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP) and WIC, along with community support services like food banks.

When it comes to medications, there may be cheaper alternatives or assistance programs for the medication a patient is already taking.

“The most important thing people can do is talk with their doctors about it,” said Berkowitz.

It’s also important for people to be honest with their doctor if they are unable to afford enough food, since that may affect which medications and dosages are best.

“If you are eating very irregularly, a medication that might be perfectly safe when you are eating regularly could cause low blood sugar,” or other complications, Berkowitz told Reuters Health.

If patients don’t bring up the fact that they are struggling to afford medications or food, Berkowitz said, the doctor won’t know to adjust medications accordingly.

He said people should “not be embarrassed or ashamed” to bring up the topic with their doctor.
Young people who tried electronic cigarettes had a greater likelihood of smoking conventional cigarettes, according to a new study, further raising concerns over whether the devices serve as a gateway to teen tobacco use.

The study, published online Thursday in the Journal of the American Medical Association Pediatrics, found that middle-school and high-school students who said they had smoked tobacco were less likely to stop, compared to non-e-cig users, if they were also using e-cigarettes.

The study raises doubts over user claims that e-cigarettes, which emit a vapor that is inhaled when a battery heats nicotine solution, can be used to help curb the rate of tobacco use among young people.

“In relation to the idea of smoking cessation, it didn’t look like e-cigarettes were discouraging [tobacco] cigarette smoking in adolescents,” said study co-author Lauren Dutra, a post-doctoral scholar at the University of California, San Francisco School of Medicine. “What we saw was that the adolescents who had used e-cigarettes were more likely to be cigarette smokers, and they are more likely to transition from experimenting with cigarettes to actually becoming regular smokers.”

The findings did not definitively say that e-cigarette use led young people to start smoking, according to Dutra, but suggested rather that a causal link is possible.

Youth e-cigarette use has increased steadily in recent years. A report released last September by the Centers for Disease Control and Prevention found that the number of middle-school and high-school students who reported using an electronic cigarette had doubled between 2011 and 2012, from 3.3% to 6.8%.

Sales of the devices have exploded in recent years, thanks in part to a major TV and radio advertising campaigns, reminiscent of tobacco advertising during the 1960s.

“This study’s findings are cause for concern and provide another reason why the FDA must act quickly to regulate e-cigarettes and stop their marketing and sale to kids,” said Vince Willmore, vice president of communications for the Campaign for Tobacco-Free Kids. “E-cigarettes are being irresponsibly marketed using the same slick tactics long used to market regular cigarettes to kids, including celebrity endorsements, glossy magazine ads that portray e-cigarettes as fun and sexy, race car sponsorships and sweet flavors.”
Chantix (varenicline) and Zyban (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 on $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 7 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:
• 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
  • 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 quit using tobacco.
Despite opposition from doctors’ groups, on a voice vote Thursday, the House of Representatives passed a one-year patch for Medicare’s unpopular sustainable growth-rate formula for physician payments and, in the same bill, extended the implementation deadline for ICD-10 diagnostic and procedural codes for at least a year.

The American Medical Association and its allies had come out strongly against the deal, which was brokered by House Speaker John Boehner (R-Ohio) and Senate Majority Leader Harry Reid (D-Nev.) earlier this week. Attention will now turn to the Senate, where influential Senate Finance Chair Ron Wyden (D-Ore.) also has expressed opposition to the deal.

The bill went far beyond a temporary doc fix patch and elicited opposition from a range of healthcare organizations and individuals upset by the temporary patch and by other provisions.

Included is an extension of the deadline to implement ICD-10 diagnostic and procedural codes for at last a year past their planned Oct. 1, 2014 target. The bill also calls for a six-month extension to comply with a controversial new inpatient payment rule for hospitals, the so-called two-midnight rule.

Also included is a one-year delay in cuts to hospitals that serve poor people. The cuts were part of the Patient Protection and Affordable Care Act. The temporary reprieve for Disproportionate Share Hospital payments is particularly welcome news for hospitals in states that have not moved forward with Medicaid expansion.

The AMA, the largest trade group for physicians, had called for House members to vote against the bill. “By extending the Medicare provider sequester and ‘cherry picking’ a number of cost-savings provisions included in the bipartisan, bicameral framework, the (bill) actually undermines future passage of the permanent repeal framework,” said AMA president Dr. Ardis Dee Hoven, in a statement. “Further, it would perpetuate the program instability that now impedes the development and adoption of healthcare delivery and payment innovation that can improve healthcare and strengthen the Medicare program.”

The existing “two-midnights” rule requires admitting physicians to have good reason to believe that a patient will need two nights in the hospital before Medicare will pay full inpatient rates under Part A for the stay. Lacking such documentation, Medicare auditors will generally classify the stay as outpatient observation, which pays hospitals much less under Part B and sticks the patient with a 20% copayment. That rule went into effect Oct. 1. But it was modified so that Medicare’s aggressive recovery auditing companies could not overturn claims under the new policy until Sept. 30, 2014.

The new bill requires Medicare to extend that recovery-auditing moratorium until March 31, 2015. It also would give Medicare officials the discretion to extend what’s known as the “probe and educate” process until the same date next year. Under that process, a different set of companies, known as Medicare administrative contractors, can audit a small number of short-stay inpatient claims and train hospitals on how to submit more accurate bills.

Postponing ICD-10 implementation, a month after CMS Administrator Marilyn Tavenner had said there would be no extension, angered providers who had invested heavily in meeting the Oct. 1 deadline. At the same time, others concerned about that deadline expressed relief over the extension.

Buzz surfaced early today on Twitter and across media channels that opposition to the measure could derail House passage but such speculation proved to be unfounded.

In the Senate, Finance Chair Wyden has his own plan to pay for a permanent doc fix and has opposed the temporary approach.

“We have a choice. We can either continue on with the status quo in Medicare by enacting a 17th patch undefined reinforcing a flawed payment formula that jeopardizes seniors’ access to their doctors, pits provider groups against each other, and fails to actually improve the Medicare program,” Wyden said. “Or, we can end the budget fiction that is the SGR, provide certainty to seniors and their doctors, and get the ball moving on bipartisan Medicare reforms undefined paying for value, managing chronic illness, increasing data transparency, and finally moving away from fee-for-service payment that got us into this mess.”

Wyden added, “My choice is to end the status quo in Medicare by permanently repealing and replacing the SGR. There is no reason to wait.” While some assume he will go along with the temporary patch, Wyden has yet to publicly stake out a position on the measure.
SCHEDULE OF EVENTS

Rural Health Clinic Workshop
Advanced Billing, RAC Audits, CMS Update, and National Policy Review
4 hours AACP credit offered
Friday, July 18, 2014 – William Carey University

Rural Health Clinic Workshop
Grant Writing, Leadership, and Community Engagement
August, 2014 (Exact Date TBD)
Starkville, MS

Rural Health Clinic Workshop
Advanced Billing, RAC Audits, CMS Update, and National Policy Review
4 hours AACP credit offered
Thursday, September 25, 2014
Jackson, MS

19th Annual Conference
Thursday, September 25 – Friday, September 26, 2014
Jackson, MS

For more information or to register, visit
www.msrha.org/events or call 601.898.3001

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Quitting Will Save Your Patients’ Lives
Tobacco use remains the leading preventable cause of death and disease in the United States. Recent studies show that brief advice from a clinician about smoking cessation yielded a 66% increase in successful quit rates. Talk to your patients. Tell them that quitting smoking is the most important step they can take to improve their health. They will listen to you.

How to Help Patients Quit*

Assist the tobacco user to:
• Set a quit date, ideally within 2 weeks.
• Remove tobacco products from the environment.
• Get support from family, friends, and coworkers.
• Review past quit attempts—what helped, what led to relapse.
• Anticipate challenges, particularly during the critical first few weeks, including nicotine withdrawal.
• Identify reasons for quitting and benefits of quitting.

Give advice on successful quitting:
• Total abstinence is essential—not even a single puff.
• Drinking alcohol is strongly associated with relapse.
• Allowing others to smoke in the household hinders successful quitting.

Encourage use of medication:
• Recommend use of over-the-counter nicotine patch, gum, or lozenge; or give prescription for varenicline, bupropion SR, nicotine inhaler, or nasal spray, unless contraindicated.

Provide resources:
• Recommend 1-800-QUIT NOW (784-8669), the national access number to state-based quitline services.
• Refer to Web sites for free materials (www.smokefree.gov and www.ahrq.gov/path/tobacco.htm).


Summary of Findings from the 2010 Report of the Surgeon General

1. There is no safe level of exposure to tobacco smoke. Any exposure to tobacco smoke—even an occasional cigarette or exposure to secondhand smoke—is harmful.

2. Damage from tobacco smoke is immediate. Tobacco smoke contains more than 7,000 chemicals and chemical compounds, which reach your lungs every time you inhale. Your blood then carries the poisons to all parts of your body. These poisons damage DNA, which can lead to cancer; damage blood vessels and cause clotting, which can cause heart attacks and strokes; and damage the lungs, which can cause asthma attacks, emphysema, and chronic bronchitis.

3. Smoking longer means more damage. Both the risk and the severity of many diseases caused by smoking are directly related to how long the smoker has smoked and the number of cigarettes smoked per day.

4. Cigarettes are designed for addiction. The design and contents of tobacco products make them more attractive and addictive than ever before. Nicotine addiction keeps people smoking even when they want to quit.

5. Even low levels of exposure, including exposure to secondhand tobacco smoke, are dangerous. You don't have to be a heavy smoker or a long-time smoker to get a smoking-related disease or have a heart attack or asthma attack triggered by smoke.

6. There is no safe cigarette.
What to Tell Your Patients About Smoking and Chronic Diseases

High Blood Pressure and Heart Disease
Smoking causes dangerous plaque buildup inside your arteries. Plaque clogs and narrows your arteries. Poisons from tobacco smoke also quickly damage blood vessels and make blood more likely to clot. This can block blood flow and lead to heart attack, stroke, or even sudden death.

Quitting smoking will improve your heart health. After just one year your risk for a heart attack drops sharply, and even if you've already had a heart attack, you cut your risk of having another one by a third to a half if you quit smoking. Two to five years after you quit, your risk for stroke falls to about the same as a nonsmoker's.

Diabetes
If you have diabetes and smoke, your risk for kidney disease is 2 to 3 times higher than if you don't smoke. Smokers with diabetes also have higher risk for heart disease and eye disease that can cause blindness; nerve damage that causes numbness, pain, weakness, and poor circulation; and amputations. You will also have more difficulty recovering from surgery.

After you quit smoking, you will have better control over your blood sugar levels. When you quit, you will be less likely to have heart or kidney disease, blindness, or amputations.

Cancer
Tobacco smoke contains toxic chemicals that can damage your DNA and lead to cancer. Nearly one-third of all cancer deaths are directly linked to smoking. Continuing to smoke weakens the cancer-fighting systems of your body. It can also interfere with your cancer treatment.

Fertility and Pregnancy
Smoking reduces a woman's chance of getting pregnant and damages DNA in sperm. Damage to sperm could decrease fertility and lead to miscarriage or birth defects. Women who smoke during pregnancy have a higher risk for pregnancy complications, delivering their babies early, and stillbirth. Their babies are more likely to have low birth weight or to die from sudden infant death syndrome, or SIDS. Tobacco smoke also damages the tissues of your unborn baby's growing brain and lungs and could interfere with the growth of the placenta, the organ that feeds the baby in the womb. This could lead to miscarriage, premature delivery, or low birth weight.

Men and women who are planning to have children should not smoke. Pregnant women should avoid exposure to secondhand smoke.

Resources for Quitting
- Call 1-800-QUIT-NOW
- Nicotine replacement or prescription drugs (www.fda.gov/ForConsumers/ConsumerUpdates/ucm198176.htm)
- www.smokefree.gov
- www.women.smokefree.gov

Most people find a combination of resources works best. Many people do not quit on their first attempt. Many smokers need several tries to successfully quit. But the benefits are well worth it. Keep trying.
Healthcare Provider Options

Any healthcare provider can offer their patients the services of the Tobacco Quitline as the next step in helping them quit tobacco. The Consent/Referral form is HIPAA approved and allows the Tobacco Quitline to make a proactive contact with the patient instead of waiting for the patient to call us. The form also specifies that the patient will allow follow up and progress information to be given to the healthcare provider that will become part of their chart and can be reviewed on each visit.

Working together, we can help patients take advantage of professional, trained staff who will help with a quit plan, quit date and support to be as successful as they can be. Healthcare providers can rely on the Tobacco Quitline to engage the patient and provide the behavior change support that has been proven to succeed.

A Medical Clearance Form is sent to the callers healthcare provider when a caller reports any conditions that may inhibit or question the use of nicotine replacement products or medications. In these cases, no products will be distributed without a medical clearance form signed and returned.

Healthcare providers may request quarterly reports on referrals to the Tobacco Quitline. A list of patients referred by Consent/Referral form will be provided with the contact, progress and follow up information.

Pregnant callers who request the use of nicotine replacement products would be required to provide the name and contact information of their primary care physician. A special form is faxed to the provider to include the approval/denial of use of nicotine replacement. In the case of approval, the Tobacco Quitline requires the form to be completed as a prescription for the specific product and dosage approved for use by the pregnant caller. No nicotine replacement products will be distributed to any pregnant caller without receipt of this approval.

Go to http://quitlinems.com/providers_options.php to download the Fax Referral Form and the Medical Clearance Form. Providers can also complete the Online Referral Form and become a registered healthcare provider by going to this website.