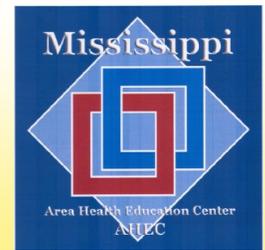




Mississippi Rural Health Association,
Mississippi Office of Rural Health, and
Mississippi Area Health Education Centers



Crossroads

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Administrative Assistant:
Cheryl Grubbs, MPH
mississippirural@bellsouth.net
601.898.3001
www.msaha.org

Website services:
Mississippi Online Ventures, LLC
Dwayne Walley - Owner
601.497.0845
<http://www.movllc.com>
dwalley@movllc.com

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From the MRHA president's pen

Happy Fall! I hope that each of you were able to celebrate the end of summer by participating in MRHA's 2011 annual conference. With over 100 registrants, 16 student posters in the competition, and one of the largest numbers of vendors that we've ever had, I am ready to call the conference a success. Actually, coupling all of this with our outstanding slate of speakers and the wonderful staff at the Muse Center, I truly believe that this was the best conference that we've ever had. A big thanks to all of the conference participants and especially all of the MRHA board members who worked so hard to make the conference an unqualified success.

During the annual meeting of the membership held at the conference, there were two changes made that I feel significantly affects MRHA operations and about which you need to be informed. First, there were a number of changes to the MRHA bylaws. While most of these changes involved cleanup or clarification of the bylaws language, a significant change was the addition of a section in the bylaws that deals with conflicts of interest encountered by your board members.

This was the end of a long journey to pass this bylaws addition, and the board's sincere thanks go out to board member Mark Garriga for his efforts in making the section



Alan Barefield, President
Mississippi Rural Health
Association 2011

meaningful and readable. The board is also actively working on the addition of several policies which deal with several operational issues required by the Internal Revenue Service. The revised set of bylaws is now posted on our Web site and any new policies passed by the board will be posted when they are approved.

One other major change approved by the board in its September 12 meeting was to approve the award of the MRHA Executive Director contract to Ryan Kelly and The University of Southern Mississippi College of Health. While this change offers MRHA some new and definite opportunities, it does come with some bittersweet aspects. After over three years of working with three different MRHA

presidents to increase the size and scope of the organization, Cheryl Grubbs will be leaving MRHA at the end of October.

Cheryl has been a tremendous asset to the organization and has been instrumental in finding new programs and grant opportunities to expand our horizons. She was instrumental in working with Joanie Perkins and Tim Thomas to initiate the Rural Health Clinic workshops and provided invaluable assistance for the Office of Tobacco Control and Wal-Mart Foundation contracts. Cheryl, many thanks from the entire board and organization for all you've done.

I would encourage each of you to contact Ryan and get to know his plans for enhancing MRHA operations. I think that his tenure with MRHA will serve to carry our organization to new heights. While some of the logistical details are still being worked out, I anticipate everything being finalized by the end of October.

In closing, I would like to say that it has been a privilege being the president of this organization over the past year. I think that we have accomplished a great deal over the past year, and I look forward with excitement to Danny McKay's term as your MRHA president. Take care and have a great fall.

From the State Office of Rural Health director's desk

by Rozelia Harris, MBA



National Advisory Committee On Rural Health and Human Services



The National Advisory Committee on Rural Health and Human Services held its 69th meeting September 26-28, 2011, at Forrest General Hospital in Hattiesburg, Mississippi. The Committee is a 21-member citizens panel of nationally recognized rural health and human service experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. The Committee was chartered in 1987. Committee members, including the chairman, serve overlapping four-year terms. Several members are involved in the planning and actual delivery of rural health and human services. Others are representatives of state government, provider associations, and other rural interest groups. Each year, the Committee selects one or more topics upon which to focus during the year and usually has three meetings per year. The three Subcommittee topics for this meeting were: 1) Health Disparities in Rural Communities; 2) The Physician Payment Value Modifier; and 3) Care Transition for the Aging and Disabled.

The National Advisory Committee on Rural Health and Human Services currently has three Committee members from the state of Mississippi. The Committee is chaired by Mississippi's former Governor, The Honorable Ronnie Musgrove. The Committee Vice-Chair is the former mayor

of Tupelo, The Honorable Larry Otis. Mr. Robert Pugh, Executive Director of the Mississippi Primary Health Care Association, serves on the Committee and was the Chair of the Health Disparities Subcommittee.

The meeting was open to the public and convened on the first day with the first two presentations being overviews of rural Mississippi and the Mississippi State Office of Rural Health provided by Dr. Mary Carrier, Mississippi State Health Officer, and Rozelia Harris, Director, Mississippi Office of Rural Health and Primary Care. For the remainder of day one, the Committee heard presentations on the three subcommittee topics. Monday concluded with a call for public comment.

On Tuesday, September 27, 2011, two of the subcommittees visited sites around the Pine Belt area and held panel discussions. The Health Disparities Subcommittee visited New Augusta Family Health Center in New Augusta, the Physician Payment Value Modifier Subcommittee visited Covington County Hospital in Collins, and the Care Transition for the Aging and Disabled Subcommittee remained at Forrest General.

The final day of the meeting included working sessions for each subcommittee to develop their reports and report to the



Rozelia Harris, MBA
Director, MORH

full committee. The three-day meeting concluded with acknowledgement and recognition of nine departing Committee members and a final call for public comment.

Additional information on the National Advisory Committee, along with meeting agendas and summaries, white papers, and reports, is available on their Web site at <http://www.hrsa.gov/advisorycommittees/rural>.

Operation Bloom works to improve breast healthcare for women

Operation Bloom is a project by the Runnels Foundation to improve breast healthcare for women by providing free events where women can learn about their individual breast health. At these events, medical personnel help to identify those at risk of developing breast cancer and/or who may already be in early stages of the disease. Furthermore, the Runnels Foundation helps to find a pathway for these women to access the healthcare system and receive timely treatment in order to reduce breast cancer mortality.

At Operation Bloom events, partici-

pants receive a free clinical breast exam, self-exam training, and information on local free and/or discounted mammogram programs.

The Runnels Foundation was established in August of 2010 and held its first breast cancer screening in Jackson in October of that year. Since then, events have been held in Greenville, Greenwood, Magee, Mendenhall, Prentiss, and Collins.

On October 29, Operation Bloom will be in Flowood at the YMCA 5k run, an event that is open to everyone (not only YMCA members and 5k participants).

Events are being planned for other towns over the next few months. So far, over 450 people have been screened for breast cancer at Operation Bloom events. In addition to being free, everyone is welcome to attend regardless of age, gender, income, or insurance status.

To find out about upcoming events, please call 601.939.9778. You may also e-mail Kathryn@opbloom.org or look them up on the Web at www.opbloom.org or go to www.msra.org.

A vision to serve: the Delta Area Health Education Center

After recently graduating from Delta State University with a Bachelor of Science in Nursing degree and successfully passing the NCLEX examination, I am now able to write my credentials as a registered nurse (RN) after my signature. Achieving this goal is the fulfillment of a lifelong dream that was 40 years in the making. As I evaluated the job offers to begin my second career as a nurse, I searched for an employer that shared my personal and professional goals. Accepting the position as the director of the Delta Area Health Education Center (AHEC) on July 1 has provided me a service opportunity with an organization that also shares my personal vision of providing affordable, available, accessible, quality health care in the Mississippi Delta.

To efficiently utilize our grant funding, the Delta AHEC will focus its programs to provide health care activities in the elementary, middle, and secondary schools that will eventually lead to the recruitment of these individuals as primary health care providers. It is essential to invest in the youth of our communities so they can recognize the value of remaining in the state of Mississippi after completing professional training. This professional pool of primary health care providers will assist in eliminating health care disparities and serving medically underserved populations, specifically in the place of my birth, the Mississippi Delta.

As Director of the Delta AHEC and a product of the public school educational system of the Mississippi Delta, I realize the importance of providing cultural awareness and diverse training opportunities. These vital training opportunities will assist the primary health care providers in appreciating the Delta's rich cultural, political and spiritual heritage. Through the personal investment of these individuals in the rebirth of the Delta, more medical professionals will be available to invest in the reform of health care in the Mississippi Delta.

Having the Delta AHEC office housed at Delta State University in the Robert E. Smith School of Nursing in Cleveland, Mississippi provides a unique collaboration that will assist in achieving the goal of providing academic and community-based training activities. Thanks to the visionary attitude of Dr.



**Emily Newman, MEd, BSN, RN, Director
Delta Area Health Education Center**

Lizabeth Carlson, Dean of the School of Nursing, grant funding was obtained to complete a new building addition of open classroom space. The room can be configured into three different training areas or open into one area to be utilized for training of approximately 90 primary health care providers.

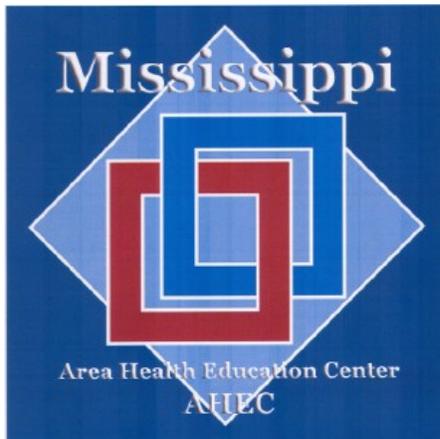
Under the direction of Mrs. Jeni Bond, Simulation Laboratory Coordinator, primary health care professionals are afforded the opportunity to actively participate in training in the recently completed Simulation Laboratory. Health Science high school students, nursing students from community colleges, and the Robert E. Smith School of Nursing students receive valuable training in the

simulated critical care environment or the simulated maternal/newborn delivery room. Scripted critical care scenarios offer hands-on training opportunities in providing care to the most fragile patients. Through the collaborative planning between the Director of the Delta AHEC and Dr. Vicki Bingham, Chair of Academic Programs, these valuable training facilities and opportunities are being made available to primary health care providers in an effort to provide trained health care professionals who serve the Mississippi Delta.

As the Director of the Delta AHEC, I am able to orchestrate the diverse educational and training opportunities needed to decrease health care disparities and increase the availability of affordable health care within the Mississippi Delta. To schedule an on-site tour, training, or to learn more about educational opportunities for primary health care providers, nurse practitioners, rural clinic staff, or Health Science students, please contact me at 662.846.4255. Working collaboratively as health care professionals, we can be a vital part of the shared vision to serve in addressing the health care needs of the citizens of the Mississippi Delta.

*Submitted by
Emily Newman, MEd, BSN, RN, Director
Delta Area Health Education Center*

The Delta Mississippi Area Health Education Center (Delta AHEC) is hosted by the School of Nursing at Delta State University and is an affiliate of the Mississippi Area Health Education Center Program (MS AHEC) at the University of Mississippi Medical Center. The MS AHEC Program is partially funded by a grant from the Health Resources and Services Administration (HRSA).



Would you prefer to receive Crossroads as an e-mail attachment?

If you would prefer to receive an electronic version of this newsletter, please send an e-mail message of your preference to mississippirural@bellsouth.net. Be sure to include your name, work address, telephone number, and most importantly, your e-mail address.

FirstChoice Cooperative offers new administrative services contract portfolio

FirstChoice Cooperative, MRHA's exclusively endorsed business partner for group purchasing services, has announced the development of a new suite of programs and contracts to assist its member hospitals and facilities in reducing their expenses and capturing lost revenue.

These programs and contracts are designed to assist administrators in reducing their costs for service on high-ticket equipment (CSAP program), and to assure that the supply pricing on their manufacturer invoices matches their contracted pricing (PVAP program). Both of these FirstChoice programs are performance-based, with no upfront fees.

Another performance-based contract will perform audits on your telecom, waste, and utility invoices, searching for erroneous or inappropriate charges. Contracts have also been developed with



consulting firms to look at your supply chain costs from a variety of perspectives (such as supply cost per adjusted patient day, purchases off contracts, etc.).

Do you have issues or questions about revenue cycling or your Charge Master? FirstChoice has a contract with a well-known national leader in these areas, PARA Financial Services, to assist you as well. Looking to increase your reimbursement or accelerate core measures? Our new Press Ganey contract should help out in those areas.

As many of you already know,

FirstChoice Cooperative has a full contract portfolio for all products and services you might need, "from the front door to the

back door, including the door!" If you are not currently using FirstChoice as your group purchasing organization, it is not too late! Membership is free – and you earn actual CASH patronage dollars on your contracted purchases!

For more information on these new Administrative services contracts, please contact your FirstChoice Cooperative Region Director, or contact Jeff Nellis, Vice President of Marketing for FirstChoice Cooperative at janellis@fccoop.org or call (936)-447-4497.



Coding Tip Corner

RHC's are not subject to the Quality Reporting incentives or penalties. Please see CMS's description of an eligible provider:

Eligible But Not Able to Participate

The following professionals are eligible to participate but are not able to participate for one or more reasons:

1. Professionals paid under, or based upon, the PFS billing Medicare Carriers/ Medicare Administrative Contractors (MACs) who do not bill directly.
2. Professionals paid under the PFS billing Medicare fiscal intermediaries (FIs) or MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level:
 - Critical access hospital (CAH), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI for the professional services provided by the physician or practitioner.
 - All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

Services payable under fee schedules or methodologies other than the PFS are not included in Physician Quality Reporting (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, independent laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

Eligible professionals participating in the eRx Incentive Program should familiarize themselves and their office staff with the eRx Incentive Program requirements for the relevant program year.

For more information, contact Joanie Perkins, CPC, at Joanie.perkins@northsunflower.com, or (662) 756-1703.

MRHA applauds these 100% smoke-free communities in Mississippi!

<u>City/Town</u>	<u>Date Implemented</u>	<u>City/Town</u>	<u>Date Implemented</u>
Metcalfe	9/3/2002	Clinton	8/14/2008
Mayersville	9/17/2005	Laurel	12/4/2009
Starkville	5/20/2006	Grenada	1/8/2009
Tupelo	10/5/2006	Hollandale	12/3/2010
Mantachie	11/5/2006	Meridian	2/19/2010
Oxford	11/17/2006	Batesville	3/4/2010
Hattiesburg	1/1/2007	Bassfield	3/10/2010
Hernando	3/8/2007	Prentiss	4/17/2010
Aberdeen	3/22/2007	Lumberton	6/1/2010
Mathison	4/15/2007	Madison	6/1/2010
Ridgeland	7/9/2007	Sumrall	6/1/2010
Greenwood	8/17/2007	Crystal Springs	6/15/2010
Kosciusko	11/2/2007	Jackson	7/1/2010
Amory	11/2/2007	Wesson	7/1/2010
Corinth	11/9/2007	Belzoni	7/1/2010
Flora	12/13/2007	Pearl	9/1/2010
Petal	12/20/2008	Jonestown	10/11/2010
Ecru	3/12/2008	Rienzi	1/1/2011
Pontotoc	5/1/2008	Flowood	5/4/2011
Collins	6/8/2008	Marks	7/14/2011
		Calhoun City	9/2/2011

Behavioral health and primary care integration

It is well documented that mentally ill children, adolescents, and adults do not receive consistent, or have no, primary care services. Extensive research of this population has identified the scope of the problem due to the lack of primary health care services.

- 75% of adults who suffer from schizophrenia also suffer from a chronic metabolic disorder for which they receive no treatment.
- People with serious mental illness die an average of 25 years earlier than their age cohorts in the general population.
- 60% of premature deaths in persons with mental illness are due to medical conditions such as cardiovascular, pulmonary, and infectious disease.
- 50% of severely mentally ill patients have at least one chronic illness severe enough to limit daily functioning.
- Psychiatric medications for children and adolescents contribute to obesity, risk of diabetes, and cardiovascular disease.

The barriers to care are also well documented:

- Separate health and mental health service delivery systems and funding sources.



Northeast Mental Health Mental Retardation Commission Region III's mobile clinic that helps deliver primary care services to all county offices.

- Long history of this separation has left providers unfamiliar with issues in the other's field.
- Severely mentally ill adults do not seek primary care due to isolation, cognitive impairment, attention difficulties, and/or poor social/family support systems.

Northeast Mental Health Mental Retardation Commission Region III is a Community Mental Health Center providing behavioral health services to seven counties in Northeast Mississippi (Benton, Union, Pontotoc, Lee, Monroe, Chickasaw, and Itawamba). Our primary mission is to

provide services to adults who suffer from a severe/persistent mental illness and children/adolescents who are severely emotionally disturbed. Our primary treatment objective is to assist patients in functioning independently in their communities and avoiding psychiatric hospital admission or long-term institutional placement.

In an effort to provide comprehensive health care, Region III began to develop non-traditional services two years ago. Presently, Region III offers behavioral health services, substance abuse programs, pharmacy, and lab services. In addition to these services, Region III has established a program to provide primary health care services to our patients. Region III Mental Health Center, in essence, will become their medical home. We have purchased a 40 foot, two exam room, mobile clinic which will allow us the ability to deliver primary care services to all county offices. This current service model provides our patients instant access to primary care services and medical staff that has experience providing care to the chronically mentally ill, thus, eliminating barriers to care.

MSDH adopts Life Course Concept in order to address high infant mortality

Perhaps you have heard the adage, "Think Globally but Act Locally" or "Your Biography Becomes Your Biology." For Mississippi, the intersection of these two statements can be summed up in a public health program that uses the Life-course Concept. A new Mississippi State Department of Health (MSDH) group is identifying how MSDH programs and services integrate across the course of life. The group is called Mississippi Lifecourse Network (LifeNet), and the first tasks include assessing current MSDH programs through an inventory of health outcomes, associated risk factors, services, and programs that address the risk factors framed by life stages of infancy, preschool, elementary school age, teenage, reproductive age, and adult. Once the MSDH inventory is complete for any life stage, community partners will be sought to enhance the understanding of statewide expertise and activities for that life stage.

Looking at health by life stage is not a new idea. In fact, it is what "country doctors" or "family doctors" have done for years. I was born in 1957 and Dr. Eckert was my family's doctor. He was also my grandparents, my parents, an aunt and uncle, my cousins, and my brother's doctor. When he told my family that we all needed to watch our weight, his matter-of-fact military trained style shocked me, but he had drawn this recommendation from the knowledge that my grandmother had hypertension, my grandfather was diabetic, and excess weight put my brother and me at risk of these conditions. Clinical specialties (e.g., cardiology, endocrinology, pediatrics) have led to many medical advances over the years, but there is still much value in family history and a focus on what these country doctors knew about the intergenerational health issues of the population.

The impetus behind the MSDH LifeNet group is the high infant mortality (IM) rate in Mississippi (2010 rate of 9.6 deaths of infants before their first birthday/1000 live births). For many years, Mississippi has the highest IM rate of the 50 United States. Reviewing causes of IM by life stage offers insight into the intergenerational risk factors that may contribute to infant deaths.

Several fundamental principles

characterize the life course approach. They include: (1) socio-historical and geographical location; (2) timing of lives; (3) variability; (4) "linked lives" and social ties to others; (5) personal control; and (6) how the past shapes the future.

logical innovations (e.g., information access through the Internet).

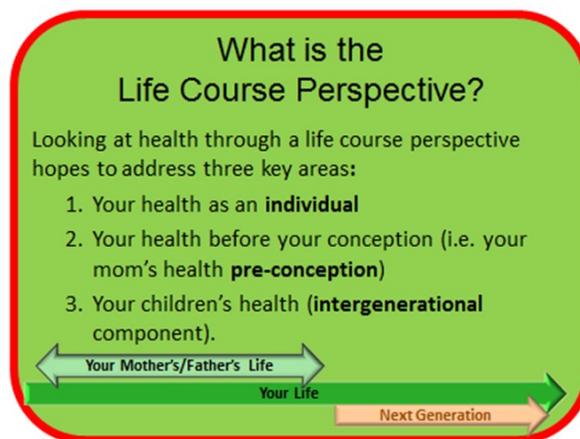
Time can also be envisioned as a sequence of transitions enacted over time. A *transition* is a discrete life change or event within a trajectory (e.g., from a single to married state).

Transitions typically result in a change in status, social identity, and role involvement. An off-age transition might be leaving home at a very young age or becoming a teenage parent. The timing of transitions can decrease the chance of success in a particular trajectory, such as the diminished likelihood of completing school for a teenage mom.

Variability or diversity in structures or processes is another life course principle. Generations or cohorts are not homo-geneous collections of people. Rather, they differ in terms of influential dimensions such as gender, social class, family structure, ethnicity, and religion. The ability to adapt to life course change can vary with resources or support. For example, young adults with weak family ties may not have the option to return home during difficult economic times, and their health may be affected by life in less than optimal conditions.

Social ties to others. A fourth construct emphasizes that lives are interdependent and connected on several levels. Societal and individual experiences are linked through the family and its network of shared relationships. As a result, macro-level events, such as war, could affect individual behaviors (e.g., enrolling in military service), and this can significantly affect other familial relationships. Stressful events, such as the death of a family member, can also affect family relationships because these occurrences can trigger patterns of stress and vulnerability or, conversely, promote adaptive behaviors and family resilience. Moreover, personality attributes of individual family members can also affect family coping

(continued on page 7)



Sociohistorical and geographic location. An individual's developmental path is transformed by conditions and events occurring during the historical period and geographical location in which the person lives. For example, geopolitical events (e.g., war), economic cycles (e.g., recessions), and social and cultural ideologies (e.g., patriarchy) can shape people's perceptions and choices and alter the course of human development and health. Thus, behavior and decisions do not occur in a vacuum, because people and families interact.

Timing of lives. Three types of time are central to a life course perspective: *individual* time, *generational* time, and *historical* time. *Individual* time refers to chronological age. It is assumed that periods of life, such as childhood, adolescence, and old age, influence health, roles, and rights in society, and that these may be based on culturally shared age definitions. *Generational* time refers to the age groups or cohorts in which people are grouped, based upon their age. People born between 1946 and 1964, for example, are often referred to as the *baby boom* generation. Finally, *historical* time refers to societal or large-scale changes or events and how these affect individuals and families, such as political and economic changes, war, and techno-

(continued from page 6)

styles, functioning, and well-being.

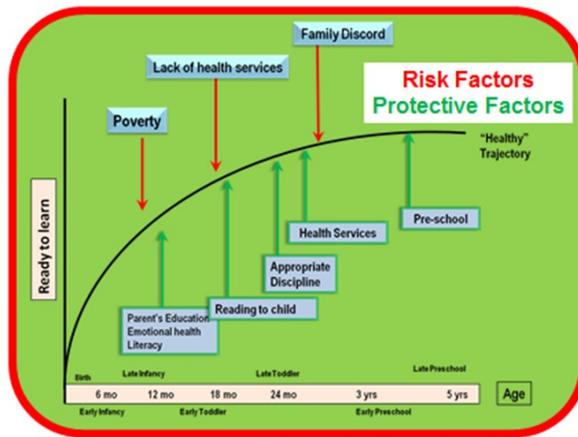
Personal control. According to the life course perspective, individuals are active agents who not only mediate the effect of social structure but also make decisions and set goals that shape social structure. However, it should be recognized that the ability to make specific choices depends on opportunities and constraints. For example, advice to eat fresh fruits and vegetables may go unheeded in areas known as “food deserts” where access to these foods is limited or too expensive.

How the past shapes the future. Finally, another hallmark of this perspective is that early life course decisions, opportunities, and conditions affect later outcomes. The past, therefore, has the potential to shape the present and the future, which can be envisioned as a ripple or domino effect. This can occur at various levels: the cohort/generational level and the individual/familial level. For example, one generation can transmit to the next the reverberations of the historical circumstances that shaped its life history (living through the feminist movement, for example). The timing and conditions under which earlier life events and behaviors occur (e.g., dropping out of school, witnessing domestic abuse) can also set up a chain reaction of experiences for individuals and their families (e.g., reproduction of poverty, a cycle of family violence). The past, therefore, can significantly affect later life outcomes such as socio-economic status, health, physical functioning. This

long-term view, with its recognition of cumulative advantage or disadvantage, is particularly valuable for understanding social inequality in later life and for creating effective social policy and programs.

Let’s consider again that timing and conditions under which earlier life events and behaviors occur can set up a chain reaction of experiences for individuals and their families. This diagram depicts risk and protective factors for readiness to learn from birth to five years of age. Protective factors push the person higher while risk factors push the trajectory back down and diminish learning readiness.

MSDH started LifeNet in June 2011 and there have been two meetings. The first was to introduce the concept of life course, and the second was to focus on an issue paramount to infant mortality in Mississippi – safe sleep. From reviewing infant deaths, MSDH has identified that many deaths are associated with the infant being in an unsafe sleep environment such as an adult bed, a crib filled with blankets and stuffed animals, or co-sleeping in a chair, sofa, or bed with an adult. We are currently working on updating literature and Web sites to increase awareness of the ABCs of infant safe sleep: Alone, on the



Graphic Concept Adapted from Neal Halfon, UCLA

Back, in an uncluttered Crib, in a smoke free environment.

In the future, we will be seeking input from partners outside the health department to mobilize a statewide appreciation for the connectedness of health. If you are interested in this activity, please contact Dr. Connie L. Bish at connie.bish@msdh.state.ms.us.

References:
Life Course Theory - Key Principles And Concepts - Single Parent, Gender, Poverty, Family, History, Development, Family, Social, Age, Time, and Individual <http://family.jrank.org/pages/1072/Life-Course-Theory-Key-Principles-Concepts.html#ixzz1Xp2g5B48>

Submitted by
Connie L. Bish, MS, PhD, MPH
State MCH Epidemiologist

Free prescription assistance program for all Mississippi residents

The Mississippi Drug Card is a free statewide prescription assistance program that offers free drug cards to all Mississippi residents. The program will provide discounts on both brand and generic medications with an average savings of around 30%. The program has no restrictions to membership, no income requirements, no age limitations, and there are no applications to fill out. Everyone is eligible to receive savings!

The Mississippi Drug Card was launched to help uninsured and under-insured residents afford their prescription medications. However, the program can also be used by people who have health insurance coverage with no prescription

benefits, which is common in many health savings accounts and high deductible health plans. Additionally, people with prescription coverage can use the program to get a discount on prescription drugs that are not covered by insurance.

There are currently more than 56,000 pharmacy locations across the country participating in the program, including all major pharmacy chains. To locate participating pharmacies and search medication pricing, go to www.MississippiDrugCard.com. There you can also learn more about the program and print customized cards for your friends, family, employees, etc. No personal information is required to print a card, and all prescriptions

processed through the program are completely confidential.

A new feature for businesses, employers, or anyone else needing to order hard cards in bulk, can be found by visiting www.campaignprint.com/una, login using Group# MSRXX, and follow the instructions to order your hard cards online. This site will allow you to design and place your own logo on the cards!

If you have any questions or would like more information on private labeling the program, contact Lila Cedotal, Program Director for Mississippi Drug Card, at lila@mississippidrugcard.com or call 877.507.5445.

MISSISSIPPI RURAL HEALTH ASSOCIATION

31 Woodgreen Place
Madison, MS 39110
Telephone/Fax: (601) 898-3001
E-mail: mississippirural@bellsouth.net



*A voice for health
in rural Mississippi*

We're on the Web!
<http://www.msaha.org>

Free tobacco cessation training workshops for rural health clinic staff

The Mississippi Rural Health Association can provide a training workshop on tobacco cessation counseling for rural health clinics. The workshop will provide a health overview and cover a range of topics including local and national tobacco statistics, effective intervention strategies, medications review, motivational enhancements, and systems change procedures for the clinic environment. There is **no cost** to the clinic for staff to attend this workshop.

The three-hour workshop has been approved for 3.5 continuing education (CE) hours. CE hours are restricted to the following categories: AMA Category I, pharmacists, nurses, dentists and general CEUs. However, professionals from other disciplines are welcome to attend the workshop. The Mississippi Rural Health Association can also provide a one and one-half hour training. This workshop does not provide CE hours.

The goal of both workshops is to equip clinical staff to counsel all tobacco-using patients to quit and to refer tobacco-using patients to the Mississippi Tobacco Quitline for continued counseling and assistance with nicotine replacement therapy products.

Each rural health clinic that sends clinic staff to a workshop will receive the following incentives:

- At least one carbon monoxide monitor with accompanying supplies
- A financial incentive for each patient referred to the Mississippi Tobacco Quitline
- Fax referral forms for the Mississippi Tobacco Quitline
- Display materials for each exam room in the clinic
- Continued technical assistance from the Mississippi Rural Health Association

For more information, contact mississippirural@bellsouth.net or call Cindy Widdig at 601.842.1359.