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Dental Hygienists: Spreading the Health

By Augusta Callaway, MHS

Benton, Claiborne, Franklin, Humphreys, Issaquena, Tunica and Sharkey

What do these seven counties have in common? None of them have an active dentist. And, in Mississippi, that also means they don't have any active dental hygienists.

According to some dental health professionals, Mississippi's Dental Practice Act, which governs what a dental practitioner can and cannot do, is restrictive. The Act states that dental hygienists are required to work under the "direct" supervision of a dentist, meaning that a dentist must be in the same building for the hygienist to provide care. Mississippi is one of only five states that have this requirement.

To understand the implications of this regulation, it helps to understand the role dental hygienists play. Typically they do the following:

- Clean teeth to prevent disease, as well as the pain, suffering and expense that comes with it
- Teach their patients how to brush and floss
- Provide general education about dental health
- Observe whether proper dental care is being practiced

In short, hygienists are on the front lines of dental disease prevention.

Lets look back at our seven counties.

How could the oral health of their residents be improved without importing dentists—who, by the way, are in very short supply?

"The key is to increase the public's oral health literacy, provide preventive services like sealants and fluoride treatments that prevent cavities, and expand community water fluoridation," says Elizabeth Carr, RDH, MDH, president of the Mississippi Dental Hygienists' Association.

Oral health education can be taught in places like schools and nursing homes. Unfortunately, due to

Mississippi's restrictive Dental Practice Act, dental hygienists are unable to provide any preventive care during this type of outreach.

Similarly, even though hygienists apply sealants safely and effectively, they are unable to do so in health clinic settings where a dentist may not be present. Sealants are coverings that act as a microscopic barrier over your teeth. "They keep the biting surfaces of your teeth from staying orange after you eat Cheetos," says Carr. According to a survey conducted by the Pew Charitable Trusts, less than 25% of high-need schools in Mississippi have sealant programs; 75% or more is ideal.

Community water fluoridation is generally tackled by Regional Oral Health Consultants within the Mississippi Department of Health. There are currently seven consultants, all dental hygienists, working across the state. Some have up to 20 counties in their territories, making it quite difficult for them to give each county the attention it deserves.

Dental hygienists are generally typecast as clinicians; the reality is they are public health agents of change.

To learn more, contact the Mississippi Dental Hygienists' Association at mdha@live.com or Elizabeth Carr at 601.985.8384



Dental hygienists performing preventive care at the University of Mississippi Medical Center in Jackson, Miss.

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MRHA Upcoming Events and Programs

Rural Health Clinic Workshop

The Mississippi Rural Health Association will host a Rural Health Clinic Workshop on Friday, April 19, 2013, at the Vicksburg Hampton Inn and Suites, located at 3330 Clay Street in Vicksburg, 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.msaha.org/events.

Only 55 spots are open so be sure to register today!

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



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.msaha.org for a full listing of webinars available to members.

Association's 18th Annual Conference Date Announced

The Association will host its 18th annual conference once again at The Hilton, in Jackson, Miss., **Tuesday-Wednesday, Sept. 17-18**. Sponsorship information is currently available at www.msaha.org/events. Please mark your calendars for this great event! More information regarding topics and speakers will be made available soon.

Thank you FirstChoice Cooperative for supporting MRHA's upcoming 18th annual conference!



The Great Unknown of Exchanges

By Agusta Callaway, MHS

By now, most of us have heard the news that the U.S. Department of Health and Human Services (HHS) denied the Mississippi Insurance Department's (MID) application for a state-based insurance exchange. Many Mississippians and most health care professionals understand the Exchange to be an online marketplace to ease the consumer experience of purchasing insurance and encourage competition among insurance providers.

Open enrollment in the Exchange is set for October 1, 2013, which means you can start signing up for insurance plans at that point. Coverage will not begin until January 1, 2014.

Again, the Exchange is an online market place. "What if I'm not online?" That's a question many rural Mississippians face daily.

Federal regulations released in March 2012 address this issue; all exchanges (both

federal and state-based) must provide a call center and paper applications.

What has yet to be addressed is exactly how the call center will be advertised or how the paper applications will be distributed. Ideally, media outlets such as radio and television will be used to share these details, since individuals with low literacy rely heavily on those outlets.

We do know that information HHS releases to the public should be written in plain language and be easy to understand... at least as easily as insurance can be explained. The government's website dedicated to explaining health care reform, www.healthcare.gov, is an example of simplified language.

Furthermore, the Affordable Care Act has provisions to establish a Navigator Program.

"Navigators will disseminate information regarding the Exchange and ultimately help individuals enroll

in plans on the Exchange," says Aaron Sisk, senior attorney at the Mississippi Insurance Department.

Navigators are organizations that provide services similar to consumer assistant programs, such as Health Help Mississippi. The main difference is that Navigators will focus on helping individuals use the Exchange. In addition, since Mississippi has a federally facilitated exchange, HHS is responsible for administering the state's Navigator Program.

"It is still very unclear what role Navigators will play in Mississippi," says Sisk.

If one of the main tenants of the Affordable Care Act is to expand coverage, then it is of utmost importance that health care professionals do the best they can to help individuals find the care that they need.

Stay informed at www.healthcare.gov.

Physician Compliance Change for RHCs, CAHs and FQHCs

The U.S. Department of Health and Human Services released a proposed rule the first week of February that would eliminate the requirement that a physician be physically present at least once in a two-week period at critical access hospitals (CAHs), rural health clinics (RHCs) and federally qualified health centers (FQHCs).

This proposed regulatory change to promote program efficiency, transparency and burden reduction for rural health providers is HHS's second package to achieve regulatory reforms under Executive Order 13563.

Watch for updates to this proposed rule on the Mississippi Rural Health Association's RHC listserv, msrha_rhc@googlegroups.com.

National Rural Health Association's 36th Annual Rural Health Conference

NRHA's 36th annual Rural Health Conference, the nation's largest gathering of rural health professionals, comes May 7-10, on the heels of the Kentucky Derby in Louisville.

This event is a sure bet with more than 50 innovative, practical and cost-saving sessions addressing workforce, telehealth, primary care collaborations, federal funding and programs, disease prevention and treatment, and much more.

Exclusive tracks are planned for the following:

- policy
- hospital and clinic management
- clinical
- state health resources
- rural education
- rural community

Go for the rural health Triple Crown. Arrive early for the 139th Kentucky Derby on May 4, and for the Rural Medical Educators Conference, focusing on linking rural curricula to outcomes, on May 7.

Register now to save \$100. Register at www.ruralhealthweb.org/annual.



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Benefits of Tobacco Cessation

By Cindy Widdig,
MRHA Tobacco Project Director

Both the risk and the severity of many diseases caused by smoking are directly related to the length of time that a smoker has smoked and the number of cigarettes smoked per day.

However, all individuals who smoke can substantially reduce their risk of disease and disability by quitting. There are both immediate and long-term benefits of quitting smoking. According to The National Cancer Institute (NCI), the immediate health benefits of quitting smoking are substantial:

- Heart rate and blood pressure, which are abnormally high while smoking, begin to return to normal.
- Senses of smell and taste improve.
- Within a few hours, the level of carbon monoxide (a poisonous gas which reduces the blood's ability to carry oxygen) in the blood begins to decline.
- Within a few weeks, circulation improves, less phlegm is produced, and coughing and wheezing subsides.
- Within several months of quitting, there are substantial improvements in lung function.

Long-term improvements in health after



quitting include the following:

- One year after quitting, the excess risk of coronary heart disease is half that of a continuing smoker.
- Two to five years after quitting, stroke risk can fall to that of a non-smoker.
- Five years after quitting, an individual's risks of developing cancer of the mouth, throat, esophagus and bladder are cut in half. Cervical cancer risk falls to that of a non-smoker.
- Ten years after quitting, the risk of dying

from lung cancer is about half that of a person who is still smoking. The risk of cancer of the larynx (voice box) and pancreas decreases.

- Fifteen years after quitting, the risk of coronary heart disease is that of a non-smoker.

For more information on the Tobacco Cessation Project, contact Cindy Widdig, Tobacco Project director for the Mississippi Rural Health Association, at 601.842.1359 or cindywiddig.mrha@gmail.com.

MRHA Hosts Mississippi Coalition for the Prevention of Agricultural Injury Among Youth



The Mississippi Rural Health Association hosted the first meeting of a coalition designed to prevent injuries among children on rural farms in Mississippi. Led by MRHA staff member Traci Breland, the coalition discussed the programs currently in place in Mississippi and how the coalition's work can advance those programs while providing guidance and cooperation among groups.

If you have a vested interest in preventing injuries among Mississippi's youth on small farms, contact the MRHA to learn how to join this coalition.



CDC and CMS Sound Alarm on “Nightmare” Bacteria



From CMS Medicare FFS Provider e-News

The Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) are asking for your assistance in tackling what may be one of the most pressing patient safety threats of our time—carbapenem-resistant enterobacteriaceae (CRE).

CDC recently released a report on the presence of CRE in U.S. inpatient medical facilities, demonstrating that action is needed now to halt the spread of these deadly bacteria. We are asking for rapid action from health care leaders to ensure that infection prevention

measures are aggressively implemented in your facilities and those around you.

Enterobacteriaceae are a family of more than 70 bacteria, including *klebsiella pneumoniae* and *E. coli*, that normally live in the digestive system. Over time, some of these bacteria have become resistant to a group of antibiotics known as carbapenems, often referred to as last-resort antibiotics. During the last decade, CDC has tracked one type of CRE from a single health care facility to facilities in at least 42 states. In some health care facilities, these bacteria already pose a routine threat to patients.

CDC has released a concise, practical CRE

prevention toolkit with recommendations for controlling CRE transmission in hospitals, long-term acute care facilities, nursing homes and health departments. Key recommendations follow CDC’s “Detect and Protect” strategy, including the following:

- Enforcing use of infection control precautions (standard and contact precautions)
- Grouping patients with CRE together
- Dedicating rooms, staff and equipment to the care of patients with CRE whenever possible
- Having facilities alert each other when patients with CRE transfer back and forth
- Asking patients whether they have recently received care somewhere else (including another country)
- Using antibiotics wisely

When fully implemented, CDC recommendations have been proven to work. Medical facilities in several states have reduced CRE infection rates by following CDC’s prevention guidelines.

The United States is at a critical point in our ability to stop the spread of CRE. If we do not act quickly, we will miss our window of opportunity, and CRE could become widespread across the country.

Data: Primary Care Shortage Will Be More Pronounced in Certain Regions

By Marty Stempniak,
Hospitals and Health Networks

Some 7 million Americans live in areas where demand could exceed supply by more than 10 percent.

Demand for primary care will swell in the near future, thanks to millions of uninsured patients flooding insurance exchanges. But physician shortages will be especially pronounced in certain parts of the country, according to a recently released study.

The upswing in primary care demand will translate to the need for about 7,200 new primary care providers, a 2.5 percent uptick from the current supply, according to a study by researchers at the University of Chicago and HHS' Office of the Assistant Secretary for Planning and Evaluation. But the demand is expected to be much greater in specific regions, as about 7 million Americans live in areas where primary care demand may exceed supply by more than 10 percent.

Variations exist throughout the country because some regions have greater populations of uninsured as well as smaller primary care capacity. Those with the biggest projected shortages have large

immigrant populations, including Texas (with about 900, or 5 percent, more primary care providers needed), Florida (590 or 3.5 percent) and California (1,100 or 3.4 percent), according to the study.

Policymakers must find ways to loosen policies to allow doctors to see more patients or to use more physician assistants and nurse practitioners to relieve the burden.

"The results of this study suggest that promoting and refining policies related to the distribution of primary care providers and community health centers may be as important as policies aimed at increasing the overall supply of primary care providers," researchers wrote.

Here are some other highlights:

- About 29 million newly insured people are expected to need care in 2014, according to the study, translating to about 25.7 million additional primary care visits per year.
- Some 235 primary care service areas will have a demand for PCPs more than 10 percent greater than the 2010 supply. In total, that area has a population of 6.95 million, about 2.2 percent of the entire U.S. population.
- Communities with the greatest projected need for more primary care providers include Pahokee, Fla. (46.8 percent), Shepherd, Texas (64.1 percent), and Los Fresnos, Texas (75.5 percent).



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Crossroads

Mississippi Rural Health Association