



MISSISSIPPI  
**RURAL HEALTH**  
ASSOCIATION

# Crossroads

Vol. 10, No1, Spring 2014

**CROSSROADS  
NEWSLETTER  
CELEBRATES  
10 YEARS**

**SOME RURAL  
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**U.S. CHAMBER  
LOOKS TO FIX,  
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**THE IMPORTANCE  
OF CUSTOMER  
SERVICE IN THE  
WORKPLACE**

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## Production Team

### Production Leader

Ryan Kelly

### Graphic Designer

Lorie Hanson

*Crossroads* is published quarterly by the Mississippi Rural Health Association

## What is *Crossroads*?

*Crossroads* is a publication of the Mississippi Rural Health Association and aims to communicate up-to-date health care news and events through relevant and timely articles.

## How do I find more information about the Mississippi Rural Health Association?

You may find more information at [www.msrrha.org](http://www.msrrha.org)

## How do I contact the editors?

You may contact the editors by calling Ryan Kelly, Executive Director, (601) 898.3001

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# CROSSROADS NEWSLETTER CELEBRATES 10 YEARS

By Ryan Kelly, Executive Director

We at the Mississippi Rural Health Association are proud to have served you since 1993, and in this issue we celebrate the tenth year of our primary newsletter, Crossroads. You may notice that this issue of Crossroads is larger than ever before and in full color. We plan to continue to provide the highest quality material and news possible, relying on sources in the Association as well as in the health care profession at-large. We know how important quality news is, and we plan on delivering!

As the Mississippi Rural Health Association continues to grow its membership over 600 in 2014, the rural voice of Mississippians has never been stronger. We take this voice to Jackson for local policy development, and we communicate regularly with the National Rural Health Association's lobbyists in Washington for national policy influence. We provide professional development workshops across Mississippi and now provide webinars that allow each member to learn from the privacy and convenience of their own office. Overall, we are here to serve rural Mississippians and are proud to do so! Additionally, we plan to get even better!

In 2014, it is our plan to provide even more workshops and webinars to meet the needs that you reported to us in a recent membership survey. We will also host a Rural Health Clinic Conference in May 2014 as the beginning of an annual event to specifically serve the state's rural health clinics.

Crossroads is made possible by the generous support of the Association's sponsors and members, notably including the Mississippi State Department of Health (Office of Rural Health and Office of Tobacco Control) as well as the National Rural Health Association. We greatly appreciate the partnership that these organizations have participated in with the Association, and we look forward to a wonderful future together.

Thank you all for making this tenth anniversary of Crossroads special. Please enjoy the new layout!



# FROM THE STATE OFFICE OF RURAL HEALTH

By Rozelia Harris

The application cycle is now open for two National Health Service Corps (NHSC) Programs, the FY 2014 NHSC Loan Repayment Program and the NURSE Corps Loan Repayment Program.

The primary purpose of the NHSC Program is to increase access to primary care services to communities in need. The NHSC seeks primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and behavioral and mental health providers (health service psychologists, licensed clinical social workers, marriage and family therapists, psychiatric nurse specialists, and licensed professional counselors) to provide primary health care services to populations located in selected Health Professional Shortage Areas (HPSAs).

The NHSC Loan Repayment Program (LRP) provides loan repayment assistance to participants to assist in their repayment of outstanding qualifying educational loans in exchange for meeting a service obligation. NHSC Loan Repayment funds are exempt from Federal income and employment taxes. These funds are not included as wages when determining benefits under the Social Security

Act.

There are both full-time and half-time options for service commitment. Half-time practice is not available to those serving under the Private Practice Option. Providers practicing at an NHSC-approved site with a HPSA score of 14 or above can receive up to \$50,000 (full-time) or \$25,000 (half-time) for two years. Providers practicing at an NHSC-approved site with a HPSA score of 13 and below can receive up to \$30,000 (full-time) or \$15,000 (half-time) for two years.

Applications for the FY 2014 NHSC Loan Repayment Program must be submitted by March 20, 2014.

The NURSE Corps Loan Repayment Program provides loan repayment assistance to registered nurses and advanced practice registered nurses, such as nurse practitioners, working in a public or private nonprofit Critical Shortage Facility or nurse faculty employed by an accredited school of nursing. A Critical Shortage Facility is a health care facility located in, designated as, or serving a primary medical care or mental health Health Professional Shortage Area (HPSA). Please refer to the following website for information on eligible facility types for the program:

[www.hrsa.gov/loanscholarships/repayment/nursing/](http://www.hrsa.gov/loanscholarships/repayment/nursing/).

Participants receive loan repayment for 60 percent of their total outstanding qualifying educational loan balance incurred while pursuing an education in nursing in exchange for a two year service commitment. They may qualify to receive an additional 25 percent of their original loan balance for a third year of service.

Applications for the NURSE Corps Loan Repayment Program must be submitted by 7:30 pm ET on February 27.

The applications are required to be submitted on line via the NHSC portals. For more information and a listing of approved NHSC sites, please visit the NHSC website at: <http://nhsc.hrsa.gov/>.

For information on HPSA scores, please visit <http://bhpr.hrsa.gov/shortage/shortageareas/> or contact the Mississippi Office of Rural Health and Primary Care at 601-576-7216.



## SCHEDULE OF EVENTS

**HCAHPS Webinar Series** (12 sessions)  
Begins March 18, 2014

**Rural Health Clinic Workshop**  
Advanced Billing, RAC Audits, CMS Update,  
and National Policy Review | 4 hours AACP credit offered  
Friday, April 25, 2014 – Stoneville, MS

**Rural Health Clinic Conference**  
Friday, May 2, 2014 – Jackson, MS

**Rural Health Clinic Workshop**  
Advanced Billing, RAC Audits, CMS Update,  
and National Policy Review | 4 hours AACP credit offered  
Friday, July 18, 2014 – Hattiesburg, MS

**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.msrrha.org/events](http://www.msrrha.org/events) or call **601.898.3001**



# MISSISSIPPI, NATION SEE SURGE IN HEALTH CARE ENROLLMENTS

By Deborah Barfield Berry, *Hattiesburg American*

More than 8,000 Mississippians have selected a health care insurance plan under the Affordable Health Care Act, up from 802 at the end of November, according to federal officials. By the end of December, 35,611 Mississippians had applied for coverage, with 8,054 selecting a plan through the federal HealthCare.gov online exchange, according to figures released recently by the Department of Health and Human Services. Nationally, federal health officials said 7.7 million people have signed up for private health insurance or Medicaid coverage through either HealthCare.gov or a state-based online exchange.

Nearly 2.1 million had selected a plan by the end of December. "We're seeing a very strong response to the marketplace,"

Health and Human Services Secretary Kathleen Sebelius told reporters Monday. "It is a brand new day for health care for millions of Americans and for the millions of families who finally have the security and peace of mind of health coverage."

People faced a Dec. 31 deadline if they wanted to get coverage that would start by Jan. 1. Families and individuals have until March 31 to sign up for coverage under the Affordable Care Act or face a fine. The exchanges will re-open in the fall. Federal officials credit aggressive outreach for much of the surge in enrollment.

Many new enrollees are between 18 and 34, Sebelius said. But Republicans said the figures fall short of the administration's goals.

"The administration's perpetual-

ly rosy outlook on the Affordable Care Act makes its enrollment reports suspect," said Sen. Thad Cochran. "The administration needs to fully account for the next wave of people expected to lose their health insurance from small business employers."

Republican leaders say the figures are particularly low among young people.

"There's no way to spin it — youth enrollment has been a bust so far," said Brendan Buck, a spokesman for House Speaker John Boehner, R-Ohio. "When you see that Obamacare offers high costs for limited access to doctors — if the enrollment goes through at all — it's no surprise that young people aren't rushing to sign up."



# HINDS CC OPENS NEW NURSING, ALLIED HEALTH SIMULATION CENTER

By Ruth Ingram, *Clarion Ledger*

Hinds Community College showcased its new Nursing and Allied Health Simulation Center recently during a ribbon-cutting and open house.

The center is at 1820 Hospital Drive in Jackson, near the college's Jackson Campus-Nursing/Allied Health Center on Chadwick Drive.

"This new Nursing and Allied Health Simulation Center offers four simulation labs that will help our nursing and allied health students develop important clinical skills as they are being prepared to care for patients in local health care agencies. Simulation provides an opportunity to enhance professional competencies, experience specific clinical situations, and implement interdisciplinary care," Libby Mahaffey, Nursing and Allied Health dean, said in a news release.

The building was donated to the college by brothers and physicians Dr. Christopher Ball and Dr. Kyle Ball. The building formerly housed their obstetrics and gynecology practice. The renovation and equipping of the Nursing Simulation Center was made possible by a \$2.5 million U.S. Department of Labor Trade Adjustment Assistance Community College and Career Training grant.

The Nursing/Allied Health Center enrolls about 900 students each semester. While most of the simulation activities will focus on patient care experiences, all nursing and allied health programs are expected to use the Nursing and Allied Health Simulation Center for some simulated activities.

These programs include associate degree nursing, dental assisting technology, diagnostic medical sonography, emergency medical sciences, health care assistant, health information technology, medical laboratory technology, physical therapy assistant, practical nursing, radiologic technology, respiratory care technology and surgical technology.

Article Note: Dr. Mahaffey is a board member of the Mississippi Rural Health Association.

# GOVERNOR'S PLAN TO RESTORE LOST DSH FUNDS FROM ACA

By Ryan Kelly, Executive Director

One method of paying for the Affordable Care Act (ACA) is to eventually eliminate the Disproportionate Share Hospital (DSH) payments. These payments follow an established formula to distribute federal funds to state hospitals to reimburse them for providing care for citizens with no ability to pay. These funds reimburse hospitals for both Medicaid and Medicare expenses, therefore creating two important sources of revenue for hospitals, Medicaid DSH and Medicare DSH.

Under the ACA, or ObamaCare as it is colloquially referred to, payment reductions were scheduled to begin in October 2013. However, Section 1204 of the federal budget agreement, HJ.Res.59, delays the Medicaid DSH payment reductions included in the ACA for two years. Instead, the budget agreement delays the reductions until October 1, 2015, but doubles the reduction that would otherwise have applied in that year.

To implement these annual reductions, the statute requires the Secretary of HHS to develop a methodology to allocate the reductions that must take into account five factors: impose a smaller percentage reduction on low DSH states; impose larger percentage reductions on states that have the lowest percentages of uninsured individuals; impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid in-patients or with high levels of uncompensated care, and the methodology must take into ac-

count whether the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

So here is the question - what are Mississippi lawmakers to do to assist hospitals that will face substantial and very costly cuts? Since Mississippi leadership including Governor Phil Bryant has decided to not pursue the federal government push for Medicaid expansion (the original reason and justification for Medicaid DSH cuts), Republican leadership has offered an alternative to supplement these cuts. House Public Health Chair Sam Mims, R-McComb, is advocating legislation that would replace with state money a portion of federal funds that hospitals are losing by ACA cuts. This supports Governor Bryant's new plan to support hospitals in wake of these cuts and provide a Mississippi-based solution to the economic problem.

"We need our small-town hospitals and large hospitals to succeed," Mims said, explaining the reason for the proposed state funding help.

In his budget, Bryant proposes to offset the cut in federal funds by providing an additional \$4.4 million to state hospitals. Mims' bill would appropriate \$4.5 million from reserves for that effort.

Mims states that \$4.5 million will not cover all federal cuts to DSH. There is no plan at this time from the federal or state government to replenish Medicare DSH funds. For that matter, there has yet to be a stated rationale from the federal

government on why Medicare DSH funds were cut in the first place other than to help fund the ACA. Simply put, there is no plan at this time to restore these funds.

The loss of Medicare DSH funds is estimated by the Mississippi Hospital Association to cost the state \$146.5 million per year.

State Democrats acknowledge that the \$4.5 million is a small amount compared to the huge losses that hospitals are expected to face in wake of the ACA, and instead push for complete Medicaid expansion as a method of providing the necessary funds. Republicans counter that Medicaid reimbursement rates are too low to provide the impact truly needed by state hospitals and are an unaffordable solution for Mississippi.

For now, a plan is in place to assist hospitals with immediate federal cuts. The big question is, what does the future hold and can Mississippi sustain the long-term cost of federal hospital requirements to treat all patients regardless of their ability to pay?



## HEALTH TIP



### Don't Skip Breakfast!

Many have heard that breakfast is "the most important meal of the day." Beginning each day with a healthy meal helps to provide essential glycogen for your muscles and brain and keeps you sharper longer. In addition, a healthy breakfast will increase your metabolism and actually help you to burn more calories throughout the day. Healthy grains, fruits and proteins help to make up a balanced breakfast. Low-sugar cereals, juices, and lean muffins are preferred. Bacon, sausage, and highly buttered biscuits should be avoided. If you are in a rush, low fat and highly nutritioise options are available.



### Rural Medical Scholars

This summer, 19 talented high school students from across the state graduated from the Rural Medical Scholars program directed by Mississippi State University Extension Service. The program's objective is to "grow local docs" for the state - a state with the second-lowest number of physicians per capita in the country.

During the program, the Scholars enroll in two pre-medicine courses, shadow local physicians and participate in a variety of activities related to the life of a physician. Two hundred and ninety-four students have graduated from the program since its beginning in 1998. Funded by Mississippi State University Extension Service with additional support from the State Office of Rural Health, the program is producing dividends for the state of Mississippi. Thirty-four former Scholars have gone on to medical school and 21 have graduated and are practicing physicians. In addition to doctors, numerous others have gone into nursing, pharmacy, counseling, physical or occupational therapy and medical research.

For more information, contact Bonnie Carew, MSU Department of Food Science, Nutrition and Health Promotion, at 662-325-1321 or [bcarew@ext.msstate.edu](mailto:bcarew@ext.msstate.edu), or go to [www.RMS.msucare.com](http://www.RMS.msucare.com)



### Rural Health Champion

Freddie White-Johnson, program director of the Mississippi Network for Cancer Control and Prevention at the University of Southern Mississippi, has been recognized as a 2013 Rural Health Champion by the University of Mississippi Medical Center. White-Johnson also serves as founder and president of the Fannie Lou Hamer Cancer Foundation, a non-profit organization that offers financial support and other resources to bolster the Network's efforts.



## SOME RURAL HOSPITALS FACE CUTS UNDER ACA

By Cristina Janney, *GateHouse Media*

The roll-out of the Affordable Care Act has already set off significant change and uproar around individual insurance plans. As the ACA settles into place in 2014, more change and concerns are coming to small rural hospitals.

Under the ACA, small rural hospitals will see significant reductions in traditional Medicare payments, and some will see new payment requirements for patient care. Rural hospitals rely on Medicare payments — which primarily cover older people — for almost 45 percent of their annual income.

The changes in how Medicare money reaches rural hospitals — and all hospitals around the country — are an attempt by federal lawmakers to improve health care and reduce costs.

Among the goals is to measure and reward quality of care and reduce expensive uninsured visits to hospital emergency rooms. By having more people covered by insurance, the theory goes, there will be higher numbers of paying patients and less unpaid debt.

Hospital administrators say they will have to change services and

staffing to become more efficient and put more resources into primary care to reduce unnecessary hospital admissions.

Administrators also say the changes will be difficult at a time when rural hospitals already face tough economics. Rural hospitals work on a much smaller scale than their urban counterparts and so have a history of operating on small margins. The recent recession, sequestration cuts in Medicare, and drops in patient volume as rural populations shrink have all left rural hospitals financially vulnerable.

About 40 percent of rural hospitals operate at a loss, said Maggie Elehwany, government affairs and policy vice president of the National Rural Health Association.

Under the Affordable Care Act, there will be a \$196 billion reduction in annual increases in Medicare payments to hospitals, skilled nursing facilities and ambulatory surgical centers over 10 years.

No matter how they receive federal funds for Medicare, all rural hospitals face significant cuts in coming years.

Rural hospitals' response to the

new system likely will change how patients receive care and what services the hospitals provide.

A major thrust of the Affordable Care Act is to improve the quality of health care and raise the overall health of Americans. So the ACA will tie millions in federal funds to quality of care, basing payments on positive outcomes.

Hospitals traditionally have received Medicare payments based on the number of procedures they perform. The industry calls this volume-based purchasing. Starting this year under the ACA and expanding in fiscal years 2014 and 2015, Medicare payments will be based on the quality of treatment patients receive. A payment system based on quality of care is known as value-based purchasing.

In order to reward quality, there will have to be measures of quality. Hospitals will gain or lose 1 percent of Medicare funding depending on 20 factors that gauge quality of care. Quality of care will be measured via checklists on specific actions hospitals are expected to take and data collected from patient surveys.

## U.S. CHAMBER LOOKS TO FIX, NOT REPEAL ACA

By Jessica Zigmond, *Modern Healthcare*

The U.S. Chamber of Commerce has accepted that the Patient Protection and Affordable Care Act is here to stay and, rather than continue calling for its complete repeal, will work this year to change what it sees as flaws in the 2010 law, the business group's president and CEO said recently.

Outlining the chamber's 2014 priorities, Thomas Donohue, the group's president and CEO, sounded realistic about the statute that his organization had once wanted Congress to repeal and that Donohue said posed the single greatest threat to the future of American enterprise.

"The administration is obviously committed to keeping the law in place, so the chamber has been working pragmatically to fix those parts of Obamacare that can be fixed—while doing everything we can to make regulations and mandates as manageable as possible for businesses," Donohue said in his annual State of American Business address in Washington. "In 2014, we will work to repeal onerous healthcare taxes; repeal, delay or change the employer mandate; and give companies and their employees more flexibility in the choice of health insurance plans."

Donohue also highlighted the need for entitlement reform, as he has in this address in previous years. In 10 years, he noted, the

cost for Social Security, Medicare and Medicaid will reach \$3 trillion a year, while the share of the budget to pay for those programs—plus interest on the debt—will expand to 76% in 2023 from 65% last year.

"Demographics are destiny and there's no way around it," Donohue said. "Americans are living longer. Each and every day another 10,000 baby boomers retire—and that will add up to 77 million new retirees over the next 17 years."

In a news conference after his remarks, Donohue said he believes entitlement reform will not happen for a few more years.

Katie Mahoney, executive director of health policy at the chamber, told *Modern Healthcare* that the chamber would like to see the Affordable Care Act's health insurance tax and medical device tax repealed, and it also will explore how the law's transitional reinsurance fee might be financed in a different way.

Mahoney also said the chamber—which represents the interests of more than 3 million businesses of all sizes in all sectors—would also like Congress to repeal the ACA's already-delayed employer mandate. But she acknowledged that in the current political environment, the chamber will take a pragmatic approach and will work to modify the mandate in a way that provides more certainty

to businesses.

"Under the statute, applicable large employers—those with 50 or more full-time equivalents—have to offer affordable minimum value coverage to full-time employees, full-time employees being those that work 30 hours or more a week," Mahoney said. "Historically, full time has been defined as 40 hours a week, and we would like to see that definition be restored."

Another change would be to simplify the calculation that businesses must complete to determine if they are an applicable large employer. As Mahoney explained, that term is defined as an organization with 50 or more full-time employees, but how to determine that figure—which takes into account part-time hours, for instance—is often confusing for small businesses.

Mahoney echoed Donohue's approach to the law and offered the reasons why the chamber has laid to rest its efforts to overturn the Affordable Care Act in its entirety.

"The landscape's very different," Mahoney said. "We've been through the Supreme Court decision, we've been through another election, and the president is going to be in office for another three years and this is his signature domestic policy," she added. "So I think to say otherwise would be irrational."



**AFFORDABLE CARE ACT**

# CMS DELAYS “TWO MIDNIGHT” RULE

By Joe Carlson, *Modern Healthcare*

Under growing pressure from hospitals and physicians, the CMS is delaying the most punitive aspects of the new “two midnight” rule for Medicare hospital admissions until after September 30.

The “two midnight” policy, included in Medicare’s inpatient payment rule for 2014, directs the agency’s auditors to assume that hospital admissions with proper documentation are reasonable and necessary in cases where the patient stays in the hospital for more than a day—defined legally as spanning two midnights in a hospital bed.

The change was intended to address widespread complaints that Medicare’s rules are too vague about when a moderately sick patient should be admitted for expensive inpatient care instead of outpatient observation. Hospitals have faced aggressive auditing over short inpatient stays, even though they say the rules didn’t set clear standards.

But hospitals aren’t happy with the new rules, either. That’s because they are presumed to have made an error and provided medically unneeded care if an inpatient doesn’t spend two midnights in a hospital bed.

Medicare’s recovery auditors were set to begin enforcing the rule Oct. 1, 2013, but that was pushed back to March 31 after providers complained. Only recently, the agency punted again and said recovery auditors—who employ sophisticated data-mining to locate questionable claims—will now have to wait until after Sept. 30 to start auditing claims under the “two-midnights” rule.

The agency will still allow Medicare’s administrative contractors, who process claims for payment, to review short stays and deny payment if the patient record doesn’t support medical necessity. But those reviews are intended to be instructional, and will be limited to a sample of between 10 and 25 claims per hospital.

“This is welcome news,” said Ken Raske, president and CEO of the Greater New York Hospital Association, in a letter to members. “The concerns expressed by all of you and our staunch collective advocacy on this issue have clearly influenced this delay.”



# HEALTH PROMOTION AND PREVENTATIVE CANCER SCREENINGS IN THE RURAL ELDERLY

By Mary Atkinson Smith, Nurse Practitioner, Starkville Orthopedic Clinic

Cancer remains the second leading cause of death in the United States following heart disease (Centers for Disease Control and Prevention [CDC], 2013). The aspects of health promotion play an important role in the prevention and early detection of cancer. Early detection of cancer allows for successful treatment and greater likelihood of survival. Disparities pertaining to the access of and exposure to evidence-based health promotion and preventive screening for cancer are common among the rural elderly aged 65 and older. A large percentage of cancers among the elderly are highly curable if detected early. The implementation of health promotion measures by utilizing screening recommendations from the U.S. Preventive Services Task Force (USPSTF) may assist healthcare providers in rural areas with pro-

viding effective and appropriate cancer screening to elderly over the age of 65. World Health Organization (WHO) (2013) defines health promotion as encouraging individuals to play a more proactive role in controlling and improving their health. The focus of health promotion goes beyond the behavior of individuals to a broader range of interventions from social and environmental standpoints. The elderly residing in rural areas often lack adequate exposure to concepts pertaining to health promotion, and with healthcare reform leading to various changes in Medicare, it is even more challenging. Therefore, it is vital for healthcare providers to play a proactive role in insuring the necessary support exists to encourage healthy behaviors among the elderly residing in rural areas. The USPSTF was created and

authorized by Congress in 1984 to improve the health status of all Americans (Agency for Healthcare Quality and Research, 2013). The USPSTF screening recommendations pertaining to various cancers serve as effective preventive clinical practice guidelines for the healthcare provider in rural areas caring for the elderly population. The recommended guidelines for cancer screening may be easily accessed online at [www.uspreventiveservicestaskforce.org/adultrec.htm](http://www.uspreventiveservicestaskforce.org/adultrec.htm).



# THE IMPORTANCE OF CUSTOMER SERVICE IN THE WORK-PLACE

By Susan Campbell, Director of Clinic Operations at Rush Health Systems

What comes to your mind when you think of customer service? Is it just being kind and nice to our patients and those around us? No, customer service goes far beyond that point. It is a vital part of our everyday life. Today, everyone is always in a hurry to accomplish a task just to mark it off their list, but we don't take the time to acknowledge those around us. Whatever setting you work in, whether it is a clinic, hospital or other healthcare facility, our patients are what make us succeed. Do you call your patients by name and thank them for choosing you for their health care needs? It is a blessing to serve others. As you read the Ten Commandments of Customer Service, think about how you perform and how your staff or co-workers perform around customer service. Could you use a fresh reminder that God has allowed us to be in a position to take care of patients? How do you measure up?

## The Ten Commandments of Customer Service:

1. Know what your patients want.
2. Be a good listener.
3. Identify and anticipate needs.
4. Make patients feel important and appreciated.
5. Help patients understand your systems.
6. Appreciate the power of YES. Always look for ways to help your patients.
7. Know how to apologize when something goes wrong.
8. Get regular feedback.
9. Give more than expected.
10. Treat employees well.

Employees are your internal customers and need a regular dose of appreciation. Thank them and find ways to let them know how important they are to your facility.

Remember to keep these tips in mind as you start your day in your workplace. Remember that customer satisfaction is one of the most important parts of your job. And lastly, remember to treat others as you would want to be treated.



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# CHS-HMA DEAL HIKES PRESSURE ON SMALLER SYSTEMS, HOSPITALS

By Beth Kutscher, *Modern Healthcare*

Community Health Systems completed its \$3.9 billion acquisition of Health Management Associates, raising the stakes for hospitals and smaller systems across the U.S. that can't achieve the same economies of scale.

The Franklin, Tennessee based group is now the largest chain in the country by hospital count, unseating HCA. The deal, coming on the heels of other big plays such as Tenet Healthcare Corp.'s acquisition of Vanguard Health Systems and the merger of Trinity Health and Catholic Health East, speaks to the growth of the hospital mega-system and the mounting pressures on smaller systems and standalone facilities that have to compete against well-capitalized Goliaths.

The companies finished the transaction just days after the Federal Trade Commission signed off on a settlement that requires Community to divest two hospitals and outpatient assets in Alabama and South Carolina.

The takeover received overwhelming support from shareholders this month, despite earlier discontent from investors, who had voted less than six months earlier to replace the entire HMA board.

As Community works to digest its purchase, providers that compete with Community's hospitals will be looking at how they can achieve the similar efficiencies without the size. Some, which might need capital and balance sheet help, will likely look for a buyer or merger partner, said Jeff Hoffman, senior partner at Kurt Salmon, a consulting firm. But others may pursue non-ownership affiliations to build the same skill set necessary for population health management.

Small hospitals may not be able to compete on balance sheet efficiencies, but they have opportunities to compete on physician alignment and integration. "The real significant improvement is improving the cost of clinical care," he said. "They really need to ask what is their clinical integration and value strategy for the future."

Community has already announced a number of promotions among its top leadership team to prepare for the HMA integration. Larry Cash will serve as president of financial services in addition to holding his CFO position. David Miller, formerly president of Division 1 operations, will expand his role to oversee all six divisions and the integration of HMA's hospitals as chief operating officer. And Dr. Lynn Simon, chief quality officer, will be president of clinical services.

# SAVE the DATE

LearnTelehealth's  
**South Central Telehealth Forum**  
**May 9, 2014**  
Downtown Little Rock

