Autumn 2010

NRHA & VRHA Upcoming Events

September 28-29  
Rural Health Clinics Conference

September 29-October 1  
Critical Access Conference

December 1-3  
Rural Multiracial and Multicultural Conference

December 8-10  
VRHA Annual Conference

January 24-26  
Rural Health Policy Institute

May 3  
Rural Medical Educators Conference

May 3-6  
NRHA Annual Conference

Get Your Seat at the Table!

Conferences have a well-established, predictable format: the participants listen to a speaker for an hour then have fifteen minutes to ask questions. For the 2010 Virginia Rural Health Association annual conference, that format will be turned on its head!

The theme for the 2010 event is, Difficult Dialogues: Generating Ideas for Rural Health. The theme reflects VRHA’s desire to have people actively engaged in some tough discussions. Many of the issues plaguing rural health in Virginia are well-known, but agreement on how to address those issues does not come easily. Difficult Dialogues will give participants the opportunity to share their experiences, concerns and ideas about the policies that govern rural health.

First Patient Enters New Onley Community Health Center

The first patient walked through the doors of Eastern Shore Rural Health System, Inc.’s new Onley Community Health Center on Monday, July 26, 2010. Several of the patients who have used the new center have complimented it’s beauty and the up-to-date medical equipment (such as digital x-ray) it provides for the community. Smiles can be seen on the faces of patients and staff alike, who are thrilled with the efficiencies the new facility provides.

The new Onley Community Health Center (OCHC), located on Badger Lane in Onley, VA is approximately 20,000 square feet. There is space for 10 health care clinicians and each has access to 4 exam rooms. The building is designed around a central nursing station, with dedicated wings for specialized services such as pediatrics, internal medicine, family practice and corporate accounts. The centralized nursing station and increased number of exam rooms will enhance efficiency and effectiveness, reducing wait times and increasing patient satisfaction. The separate wings will enhance clinician efficiency as well as patient privacy.

The design allows for the future addition of an inpatient unit, and the building includes a kitchen and 10 bathrooms. The large entry lobby also has a small, patient waiting area.

For more information about these and other events, visit: www.vrha.org/events.html
The Pharmacy Connection

Question: What happens when an uninsured patient with chronic illness can't afford medications?

Answer: Typically that patient ends up sick, unable to work and, often, in the hospital.

According to recent estimates, there are approximately one million uninsured Virginians. Thousands of them go without medications every day because they can’t afford them. If a patient has to make a choice between eating, paying rent and filling a prescription, the prescription will most often be the first to go. Too many Virginians must make this choice. And without needed medications these patients may end up in an emergency room.

Question: Is there anything I can do to address this problem?

Answer: Yes! Help those patients obtain free medicines via The Pharmacy Connection (TPC). TPC is a software program developed by the Virginia Health Care Foundation (VHCF), which expedites applications for free medicines from the pharmaceutical companies’ Patient Assistance Programs (PAPs). TPC helps determine if the patient qualifies for the PAPs, completes the required application, and sets re-order dates to trigger reorders.

Online Doctor Visits Reality

Beginning Jan. 1, 2011, Virginia will require insurers to pay for telemedicine services, with some caveats.

Telemedicine service is defined as “the use of interactive audio, video, or other electronic media used for the purpose of consultation, diagnosis, or treatment.” It does not include “audio-only telephone, electronic mail message, or facsimile transmission.”

Insurers are expected to treat services rendered through telemedicine in the same manner as services rendered in traditional settings. While insurers are not required to pay for the technical cost of rendering telemedicine services, they must “reimburse the treating provider or the consulting provider for the diagnosis, consultation or treatment of the insured delivered through telemedicine services on the same basis that the insurer … is responsible for coverage for the provision of the same service through face-to-face consultation or contact.”

Insurers may require telemedicine preauthorization in the same manner as for services delivered in a traditional setting. However preauthorization is not permitted for “emergent telemedicine services.” For example, one could see an Emergency Department using telemedicine for consultations with specialists and no preauthorization would be required. Insurers are also prohibited from requiring co-payments, annual or lifetime limits on services provided by telemedicine that differ from those required for services delivered in face-to-face encounters.

Opportunities Abound

The law presents healthcare practitioners new opportunities for reimbursable patient care. For example, a late night interaction between a patient and a physician might be billable if the communication occurs through a video conference, an Internet-based messaging application such as Skype, or other interactive protocol that meets the law’s requirements. It is important to note the law focuses on payments by insurers, even if an inurer will pay for the service, if the Board of Medicine or other health regulatory board or agency prohibits the conduct, payment is a moot issue.

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Immunization Requirements for Virginia’s college students: http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+23.7-5

Back to School Vaccinations Are Vitaly Important

Yes, it is that time of year again! The back to school season is upon us once more, and with it comes a whole check-list for parents and children to address. For parents, back to school means shopping for the supplies you’ll need for the upcoming school year. For children, back to school means new opportunities for reimbursable patient care services to new locations. In remote and hard-to-recruit locales, access to additional healthcare providers would stimulate market competition and place pressure on fees. At this time, neither the Department of Health nor the Virginia Bureau of Insurance has weighed in on whether telemedicine will satisfy network access requirements.

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be addressed, especially when telemedicine services are used at remote clinics. In addition, a determination needs to be made as to whether the remote clinic should bill, or if the physician who renders the care should bill. Payors face the interesting challenge of whether to classify a telemedicine encounter with a patient who is at home as a house call or an office visit.

There are also matters for federal and state officials to consider. These include whether insurers or healthcare providers should provide the technology, and which group should approach patients. A determination also needs to be made of whether offering the technology would be considered an illegal kickback for governmental plans or providers.

A New Landscape

Medicare has provided for limited telemedicine service coverage and Virginia Medicaid has doubled in it, but with this law, the “Old Dominion” has swung the door wide open for both payers and providers to enter a new age in the delivery of health care.

This article is provided as an informational service and does not constitute legal advice or guidance, which can only be rendered in the context of specific factual situations. If a legal issue should arise, please contact the attorney listed in this article, or retain the assistance of other competent legal counsel.
Women, Infants, and Children

Since its inception in 1972, WIC has continued to provide nutrition education, health care referrals and breastfeeding support and supplemental food for low-income pregnant women, infants and children up to their 5th birthday. The current economic downturn alongside growing health disparities has qualified more Virginia residents for the WIC program. Families with household income at or below 185% of poverty and have a nutritional need are eligible for the WIC program. Anyone who receives Medicaid, TANF or food stamps automatically meet income guidelines. However, many families may not be aware of their eligibility for the program or the benefits of being a WIC participant.

Research has shown that participation in WIC reduces infant mortality, low birth weight and premature births. Children participating in WIC are more likely to receive necessary immunizations and consistent medical care. Numerous studies indicate that pregnant participants have longer pregnancies resulting in fewer premature births and fewer low birth weight babies.

Registered Dietitians work with participants to educate them about the nutritional needs of their bodies before and after pregnancy as well as their infants and children. A variety of nutrition education methods are offered to meet the needs of diverse populations across Virginia’s thirty-five health districts. They are screened every six months and appropriate medical and social service referrals are made to meet the individual needs of each participant. Our nutrition teams are dedicated to providing quality education and support to ensure the health of the families that we serve.

Pregnant women in the WIC program are more likely to receive early entry into prenatal care thereby reducing the number of low birth weight babies and infant mortality rates. WIC also encourages breastfeeding by providing peer support and education about the numerous health benefits to both mother and baby. Our clinics and outreach efforts include materials, educational activities and opportunities that support and promote breastfeeding.

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- radius of OCHC.

OCHC serves this diverse population six days a week by providing routine primary health care and lab work. It also provides care for sports injuries and on-the-job accidents. These patients are triaged by OCHC’s nursing staff and can often be x-rayed or otherwise treated at the center, thereby eliminating unnecessary visits to the nearby Shore Memorial Hospital’s emergency room. Otherwise, patients are stabilized at OCHC prior to transport to Riverside Shore Memorial Hospital.

OCHC staff also performs post-accident breathalyzers.

OCHC staff offers specialized events every year, including days for flu shots, sports physicals for athletes and educational events for pediatric asthma patients. By serving the community on a day-to-day basis for primary and emergency care and providing outreach in these special ways, OCHC has made itself an integral part of our community. It seeks to be more responsive to local needs and to better serve the community in which it resides by improving its physical plant with a new OCHC.

Congressional Health

Historically, the church has been a source not only of spiritual healing, but of physical well-being. Clergy and their congregations have long practiced the ministry of health across the continuum of life. Only in recent years has the term “congregational health” emerged, defined as the focus of a congregation— an assembly of people who meet for worship and religious instruction in a designated locale— dedicated to being bound in soul, body, and spirit and to experiencing freedom from physical disease or pain. Today, congregational health has an even more succinct mission: to unite the best practices of public health with faith-based principles and organizations. In so doing, as health inequities are identified and root causes addressed, we can begin to close the health gaps in our communities.

In validating the connection between spiritual and physical health, evidence-based scientific research has been ongoing. Dr. Harold Koenig, MD, Professor of Psychiatry at the Center for Spirituality, Theology and Health at the Duke University Medical Center, addressed the issue in his testimony to the Subcommittee on Research and Science Education to the US Senate Committee on Appropriations in 2008. “If the religious congregations in America all had health programs, then two-thirds of the US population would be exposed to disease detection, disease prevention, and health promotion efforts,” he noted. “Since persons of all ages participate regularly in religious congregations...health education efforts would occur at all ages, from the young (focused on substance abuse prevention and character development) to the middle aged (focused on healthy eating, exercise, stress reduction, etc.) to the elderly (focused on volunteering, mentoring and generative types of activities).”

With the growing visibility of this emerging field, many organizations and institutions have worked to develop congregational health programs, ministrations, and models — as well as underscore the need to collaborate, educate, and provide assistance to local congregations. Pockets of activity have been observed throughout Virginia, but until recently, nothing has been developed on a community-wide level. Much work remains.

To answer the call, the Congressional Health Resource, LLC (CHR) provided an opportunity to collaborate with the Virginia Department of Health, Office of Minority Health and Health Equity (OMHHE, formerly known of the Office of Minority Health and Public Health Policy). With the mission of uniting the promise of medicine with the power of faith, CHR is devoted to lessening the gap between the secular and the sacred, increasing synergies, and building healthier communities. This mission is relevant because over half of Virginia’s population attends church. By leveraging the Commonwealth’s 7,000+ congregations (excluding African American congregations) as a force multiplier, the reach of public health can be much more extensive and its impact, more profound.

The collaboration was formalized, and CHR was commissioned to conduct a pilot including five congregational health assessments for five sectors of the community (health, faith-based, education, government, and civic) in four Commonwealth counties—Page, Shenandoah, Essex, and Bath. The purpose of this pilot program was three-fold, to 1) identify community-based leaders as targets for promoting a health/faith relationship, 2) identify community-based assets that currently exist, and 3) develop a congregational current needs assessment for health programs. The goal was to use this study as a framework that can be replicated in other

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the delivery of health care services in rural Virginia. VRHA intends for the event to be the first step in developing a policy agenda, a platform VRHA would present to our Governor and General Assembly.

Each session will start with a panel overview of one of the six topic areas: Aging in Place, Oral Health, Behavioral Health, Veteran’s Health, Care Coordination, and Maternal Health. The panels will have fifteen minutes to provide their views and then the moderator will lead the participants in a discussion to identify potential policy solutions to the issues.

- Should women be able to choose their birth experience based on their medical risk factor criteria?
- Should Home Health Aides be paid mileage to encourage them to travel outside of town?
- Should Master’s-level behavioral health providers be eligible to receive reimbursement from Medicaid?
- Should there be a timeline requirement for hospitals and home health agencies to share data?
- Should the Dental Practice Act be modified to develop a Community Dental Health Coordinator position?
- How can we better serve our Veterans?
- And more importantly - what other questions should we be asking? Help us find the answers.

Get your seat at the table! Attend the VRHA annual conference December 8-10, 2010.
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Challenges
This new technological freedom, however, raises legal issues for both health care providers and insurers. For example, Virginia’s General Assembly (1998) directed the Department of Health Professions through its individual boards. And while, general, physician licensing through telemedicine platforms is permissible for Virginia licensed physicians, the Commonwealth has not yet adopted reciprocity provisions for providing telemedicine services across state lines. Also worth noting, prescribing via telemedicine is governed by federal DEA regulations at 21 CFR Part 1300 et seq., which place parameters around such encounters.

Healthcare providers need to carefully examine current liability insurance to ensure this type of patient interaction is covered. Providers also need to determine coverage carried by the telemedicine vendors, technology vendors and remote location providers, and terms of contracts with these vendors will require careful legal review. In addition, as providers have a duty towards patient confidentiality, all involved in the process must comply with applicable confidentiality laws and regulations.

Issues such as patient care documentation and medical records overlap must be considered.

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 salud communities throughout Virginia.**

Surveys for all four counties were completed in December 2009. Executive Summaries can be accessed on the VDH OMMHHE website (www.vdh.state.va.us/ healthpolicy/primarycare/ruralhealth/health-assessment.htm). An overview of survey results reveals that faith-based organizations and their clergy strongly believe in the connection between physical, emotional, and spiritual health. And, their institutions should play a role in helping congregations to be physically healthy. Despite these findings, few churches have a defined and active health ministry for a number of reasons – from uncertainty about how to start such a program to a lack of finances, resources, volunteers, health care expertise, and community partners. Most secular organizations surveyed indicated that they had a variety of resources that they could lend to congregations to promote health – for example, funding, program/leadership training, partners, teachers, and, if churches could identify the need and show the value of the contribution, volunteers.

Although barriers to making the appropriate linkages are many, they can be overcome.

CHR believes that the church is uniquely equipped to assist in reducing minority health disparities and influencing healthy life choices. This role is strengthened when faith communities collaborate with each other and with other local, state, and national community service organizations to disseminate quality health information and provide core health-related services.

“Churches are clearly utilized as community health partners and lack health expertise and resources,” notes CHR’s Rev. Andrea Lomboy. “Congregational health achieves this fusion by emphasizing wellness, wholeness, prevention, and education. When considering public health, it cannot be ignored.”

Understanding best practices can help improve the health of individuals and, consequently, the community at large. The Health and Wellness Ministries, General Board of Global Ministries (The United Methodist Church, New York) observes that the church is the only community-based organization found in virtually every American community. It can “reach people of all ages, races, and economic backgrounds and it can strongly influence people’s values and personal life choices,” the Board maintains. “Because the church is generally more integrated into the life of individuals and communities than our modern medical establishment, it can better enable people to assume responsibility for their own health.”

The road before us is clear. Because of the ongoing imperative for equal access to health care resources, we must draw upon every resource available to help Virginians with their health needs. By reaching out to the faith community and providing resources to local congregations from the public health system, we can include churches as primary partners to ease the stress and recently known disparities – right in our own backyard.

*Some denominations choose not to participate while others simply do not have the data required to participate. For more information, see the Religious Congregations and Membership Study, Association of Statisticians of American Religious Bodies (www.thearda.com/ factfarms/gprc/us/2000.asp).

**To date, the pilot study has launched additional initiatives, including a secondary program in Essex County, development of a Community Health Ambassador Program, and an online knowledge portal to identify existing resources for leveraging by local congregations.

If any other counties where some of Virginia’s small rural hospitals are located, have an interest in pursuing this initiative, especially those that have the Critical Access Hospital (CAH) or Small Hospital Improvement Program (SHIP) designations, please contact Ms. Susan Triggs at 804-660-8842 or susan_triggs@vdh.virginia.gov for more information.

Fax Referral

What is the Quit Now Virginia Fax Referral?
The Fax Referral is the patient’s direct link to the state tobacco user quitter. Quit Now Virginia provides free information and coaching by telephone to residents who want to quit smoking or chewing tobacco. The counseling offered by the specially trained Quit Coaches, combined with medication prescribed by healthcare providers, gives the patient the best chance of quitting successfully.

With the Fax Referral, tobacco users no longer have to take the first step in calling the quitline--a Quit Coach will proactively contact the tobacco user to provide assistance after the fax referral.

After the provider gives informed consent, the signed form is faxed to the Quitline. A Quit Coach then contacts the tobacco user, within 48 hours of receiving the form, to begin the intervention. The quitline has Spanish-speaking Coaches, combined with medication prescribed by healthcare providers, gives the patient the best chance of quitting successfully.

With the Fax Referral, tobacco users no longer have to take the first step in calling the quitline--a Quit Coach will proactively contact the tobacco user to provide assistance after the fax referral.

Details about the quitline service can be found on the VDH Telephonic Use Control Project website (http://www.vhcf.org/medication/training.php) and for additional information about the Fax Referral (or to request a registration form), contact Janis Dauer at 757-888-9934 or jdauer@aptna.org.

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The 161 organizations (free clinics, CHGs, hospitals, medical practices) in the Commonwealth which currently use the software are quite pleased with it. The coordinator of the Medication Assistance Program at Westmoreland Medical Center recognizes the value of The Pharmacy Connection for its patients. “The Pharmacy Connection has everything I need to get free meds for my indigent patients. I can keep excellent tracking on all my meds—what they are, when the refills are due, what pharmacy generated more than $162 million in prescription medications (average wholesale price) for over $40,074 Virginians. TPC software is available to hospitals and other providers in Virginia through a licensing agreement with the Virginia Health Care Foundation. A free demonstration is available on-line (www.vhcf.org) and training and technical assistance are provided by expert TPC staff.

If you would like more information about the software and how it could benefit your facility, contact Juliet Tinsley at the VHCF website (www.vhcf.org). VHCF provides free training to anyone interested in learning more. You can register for training by visiting: http://www.vhcf.org/medication/training.php.