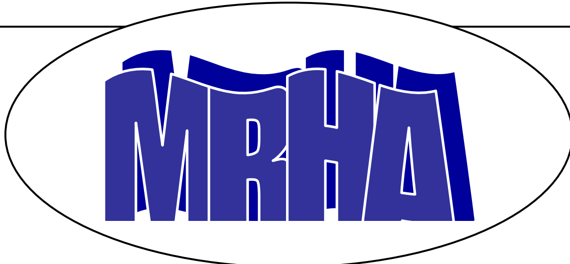
Maryland Rural Health Association

Issue 20 Fall (December 2005-January-February) 2006



For more information on MRHA call 410.226.5527
Or visit our web site at:
WWW.MDRURALHEALTH.ORG

2006 Rural Health Conferences—Save the Dates!

• Rural Health Policy Institute; Grand Hyatt Washington, D.C.; Feb 27-March 1, 2006

• ***Maryland Rural Health Association Seminar: How Legislation Works***; MDA Offices, Annapolis, MD; March 3, 2006; Contact MRHA Offices 410.226.5527 for more information.

• NRHA Annual Conference and Minority and Multicultural Health Conference; May 15-19, 2006; Reno, NV

• State Rural Health Association Skill-building Workshop, June 2006, Date/Location TBA

• Rural Clinicians and Quality Conferences, July 2006, Date and Location TBA

• Rural Health Clinics and Critical Access Hospital Conferences, October 2006; Date and Location -TBA

•***2006 Maryland Rural Summit***, October 25-27, 2006; Cecil County-Sandy Cove-North East, MD. Contact MRHA Offices 410.226.5527 for more information.

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Presidents Message:

As the calendar year 2006 unfolds MRHA looks ahead with increased enthusiasm and excitement in service to its Members and rural Maryland. New programs and activities are planned which will enable us to better serve our members and constituents. Here is a listing of some of these events. Lead by Marita Novicky a Policy Institute is planned for March 3 in Annapolis to discuss how State legislation is made and how advocacy can contribute to this process. Also, an update on present health care legislation before the General Assembly will be discussed by Mr. Cas Taylor. More information on this can't-miss session is a feature article of this Newsletter.

Doug Wilson Ph.D is leading the committee preparing the Association's Strategic Plan. This plan, soon to be shared with Members, will provide us with future growth and direction. An update will follow in a later issue.

Tom McLoughlin is leading the committee investigating opportunities to enhance our Executive Leadership Services. As the MRHA grows also grows our need for increased staff involvement and services. You will be keep posted on this issue.

This years Rural Summit will be held on the Shore in Cecil County October 25, 26, and 27. Our theme, still being detailed out, will deal with the changing face of rural Maryland as population pressures continue to demand more rural land for urban uses. Mark your calendars now for this important
event.

As these activities unfold we need your assistance two ways: first, to attend, participate, spread the word, and support these activities: second, the MRHA needs, and welcomes, all support and involvement from all its Members. Volunteer today, we need your help and by working together we will continue to bring service to rural Maryland.

Jacob F. Frego
President

2006 Board of Directors:

Jacob F. Frego-President
Executive Director, Eastern Shore AHEC

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Peninsula Regional Medical Ctr.

Agency Liaison Representatives:

Steve McHenry
Executive Director
Rural Maryland Council

Stacy Kidd, MPH
Administrator, Rural Health Projects
Office of Rural Health and Primary Care Services
DHMH

For information on the 2006 Maryland General Assembly

OR TO REVIEW BILLS IN THEIR ENTIRETY, GO TO http://mlis.state.md.us/#bill AND TYPE IN THE APPROPRIATE BILL NUMBER, OR MAKE YOUR QUERY BASED ON SPONSOR, FILE, CODE OR SUBJECT.

Please feel free to submit information to be included in this newsletter and on the Calendar of Events.

You may reach our Executive Offices at the following address:
Phone 410.226.5527 or Fax 410.226.0177
PO Box 400 Oxford, MD 21654
Or via email at:
aoc@shore.intercom.net

SPOTLIGHT ARTICLE ON:

Maryland State Office of Rural Health

The big news is that the Maryland State Office of Rural Health (SORH) is moving out of the office formerly known as the Office of Rural Health and Primary Care Services and will be moving under the Supervision of Jeanette Jenkins in the Office of Health Policy and Planning. The SORH will officially become part of Executive Direction in the Family Health Administration. This move will provide the SORH with more visibility and greater opportunity to work with other programs in FHA. Stacy Kidd will remain the Administrator for the SORH, while Grace Zaczek moves on to her new and exciting role in Medicaid.

The FY 07 application for SORH funding has been submitted to the Federal Office of Rural Health Policy for approval. Level funding is expected for the program. In FY 07, as long as level funding is awarded, the SORH will grant funding to Garrett, Frederick, Caroline, Worcester, and Allegany counties for exciting projects ranging from medical Spanish training to obesity and diabetes prevention programs.

The FY 07 Small Rural Hospital Improvement (SHIP) grant has also been submitted to ORHP for approval. The three eligible hospitals - Garrett County Memorial, McCready, and Atlantic General – are slated to receive up to $10,000 each (amount based on available funding) to assist in improving QI, HIPPA, and POS activities.

DID YOU KNOW….

During a Alcohol & Drug Addiction Administration briefing before the House Health & Government Operations Committee's Health Insurance Subcommittee, Dr. Pete Luongo, ADAA Director, gave a state-of-the-state overview on drug treatment in Maryland. The ADAA has been focusing on how to improve data collection and access to data so that the State can determine how to make the best use of its resources. The data shows that in the areas of the State where treatment programs are available individuals are taking advantage of the programs and where treatment behind the walls is being implemented, it is successful. Other studies show a reduction in crime due to treatment.

According to Dr. Luongo, 80% of uncompensated care costs in the State can be attributed to addiction treatment and suggestions indicate that the percentage is actually higher. For example, when a gun shot victim is rushed to the ER, the treatment costs are classified as "gun shot wound" when addiction may have played a significant role in the individual being shot in the first place. Based upon this discussion, Chairmen Hammen commented that it might be appropriate for hospitals to begin collecting data to indicate whether certain injuries/treatments may be related to addictions.

Please remember to send in your 2006 MRHA Membership Dues

Please contact our offices at 410.226.5527 if you have any questions regarding your membership status.

National Rural Health Association Awarded CyberAlert PR Grant

The National Rural Health Association (NRHA) announced that is was selected to receive a public relations grant from CyberAlert, Inc., a worldwide media monitoring and press clipping service. The NRHA was one of 17 not-for-profits selected to receive this award from more than 250 grant applications.

The NRHA will use this award to electronically monitor and track worldwide rural health media coverage and to improve the speed with which it stays informed of events around the Nation. The Association's goal with this new service is to provide additional value to membership, and increase the level of national brand recognition. It will also bring previously unknown activities, groups and individuals to the attention of the NRHA consequently offering new recruitment opportunities.

The NRHA is a national nonprofit organization, with approximately 10,000 members that provides leadership on rural health issues. The Association's mission is to improve the health and well being of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

CyberAlert, Inc., (www.cyberalert.com) is a worldwide media monitoring and press clipping service serving corporations, government agencies, and not-for-profit organizations for public relations, marketing, and competitive intelligence. Contact Julie Cockley at National Rural Health Association, 904.268-6191 or at Cockley@nrharural.org .

A MESSAGE FROM: Alan Morgan, CEO, NRHA

Dear Member of the National Rural Health Association,

This will be a critical year for rural health support at the federal level. While NRHA will offer multiple educational opportunities in 2006, perhaps none is more important than the Annual Rural Health Policy Institute in Washington, DC.

In 2005, rural Americans made sure their voices were heard on Capitol Hill. Thanks to your hard work we were able to help stall the massive Health and Human Services appropriations bill in November that threatened to gut rural health care funding. It is clear that Congressional leadership never expected that rural America would stand together with a unified voice and a strong message. Together we have proved that there is a voice for rural America, and that eliminating federal support for rural health is not an option.

Ultimately, while the rural health safety net was not eliminated, it was severely damaged, with many outstanding rural programs drastically cut. 2006 is the year to turn the tide in Congress. With your voice, we can shift the debate towards increasing funding for rural health. I hope you will join me at the 2006 Rural Health Policy Institute, February 27 through March 1, to prepare for the battle ahead.

We are excited about our agenda for the Policy Institute, and we certainly expect a successful meeting not only for NRHA membership, but also for the promotion of rural health in our nation's capital. A complete agenda is available on our website, www.NRHArural.org/conferences. Register online and reserve your hotel room today.

Your care and interest in the wellbeing of more than 60 million rural Americans is greatly appreciated. Please seriously consider participation in the Policy Institute this year. In 2005 we made great strides toward saving the rural health safety net and we must continue the pressure. And this begins at the 2006 NRHA Policy Institute.

Thank you again for your help and support.

OTHER HEALTH NEWS IN MARYLAND

Hospital Urges Lawmakers to OK Open-Heart Surgery

By Pamela Wood, Staff Writer

Anne Arundel Medical Center officials met with county delegates yesterday to pump up interest in allowing the Parole hospital to perform open-heart surgery.

Currently, the Maryland Health Care Commission oversees when and where open-heart surgery programs are established. The commission hasn't approved a new open-heart program in the Baltimore region in more than a decade. The hospital is working on legislation that would allow for a one-time exception for Anne Arundel Medical Center, said hospital President Martin L. Doordan. "We just made a decision to see if there would be an alternative," Mr. Doordan said in an interview. "Legislation is the only avenue we see."

Mr. Doordan said AAMC is in a unique situation, attracting patients from Central and Southern Maryland as well as the Eastern Shore. Each year, the hospital transfers more than 400 cardiac patients to other hospitals for bypasses and elective angioplasties. Most patients needing open-heart surgery are sent to hospitals in Baltimore or Washington, D.C. Doctors at AAMC already annually perform more than 100 emergency angioplasties, which involves opening a clogged artery with a balloon and often reinforcing it with a mesh stent.

Open-heart surgery is one of the most hotly contested issues in health care circles, with hospitals vying to open new programs. Every three years, the health care commission updates its "state health plan" that evaluates whether certain programs, such as open-heart, are needed in different parts of the state. When the state cited a need for a new open-heart center in the Washington suburbs a few years ago, it led to court battles as hospitals competed for the right to open the center. No need for additional open-heart services in the Baltimore area - which includes both county hospitals - was identified in the latest version of the report in 2004.

Currently, nine hospitals in the state offer open-heart surgery, and Suburban Hospital in Bethesda will open its open-heart unit later this year, said Pamela Barclay, deputy director of the Maryland Health Care Commission. She declined to comment on the bill since she hadn't seen it. Though the bill wouldn't affect Baltimore Washington Medical Center in Glen Burnie, officials there said they'd like to offer open-heart surgery, too. Twenty percent of admissions are cardiac patients. "We have not yet seen the legislation, but community hospitals have been facing this issue for years," said Karen Oldscamp, BWMC's senior vice president and chief operating officer.

Mr. Doordan said the bill is being drafted and should be finalized next week. Del. Mary Ann Love, D-Glen Burnie, said there seems to be strong interest among the county's delegates. "I can't speak for everybody, but they presented a very good case. It's been an ongoing issue with the hospitals," said Mrs. Love, chairman of the county House delegation. And while getting local lawmakers on board is one thing, AAMC's bill could face opposition from lawmakers who represent areas with other hospitals.

Generally, lawmakers extend "local courtesy," agreeing to support bills from other counties if the county's delegation is in agreement on the matter. But hot issues can sometimes supersede local courtesy.

Published February 04, 2006, The Capital, Annapolis, Md.
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MRHA to Host Policy Institute

By Marita Novicky, MRHA Board Secretary

The MRHA will host a special Policy Institute on Friday, March 3, 2006 from 10:00 a.m. – 2:00 p.m. in room 101 of the Maryland Department of Agriculture, 50 Truman Highway, Annapolis, Maryland 21401. The Policy Institute: Making Health Policy—How it Works in Maryland features Annie Kronk, retired State Lobbyist for Johns Hopkins University, and first Vice Chair of the Rural Maryland Council and Chair of its Health Care Working Committee. Also featured is Cas Taylor, former Speaker of the Maryland House of Delegates, now an active lobbyist with Alexander & Cleaver and a member of the MRHA's Board of Directors.

The four-hour institute will give participants an understanding of how health policy and funding decisions are made in Maryland, how a bill becomes a law, and the role the MRHA and its members play in helping shape health policy for rural areas in Maryland. The Institute will cover health-related legislation the Maryland General Assembly is considering during its 2006 session. This Institute is the first in a planned series of informational sessions for MRHA members and rural advocates.

The cost of the Institute, including lunch, is $30.00. If you would like to attend, send a check for $30.00 to the MRHA, P.O. Box 400, Oxford, Maryland 21654. If you have questions or need more information, call Dottie at 410.226.5527.

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Issue 14 February 2006
RURAL AMERICANS

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Access to Health Care for Rural America: Why It Matters

By: Mary Wakefield, Ph.D., R.N.
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Grand Forks, North Dakota
Some may wonder why maintaining access to high quality health care in rural America is important. After all, there are parts of the country where livestock vastly outnumber people and making health care available is expensive. In fact, states like North Dakota have considerable land mass designated as frontier- commonly defined as less than seven people per square mile. Ensuring access to health care in remote areas can be daunting. However, policymakers and others too often look at rural health care as 'either/or' rather than the harder work of determining "what and how." New technology for example, offers some rural communities the opportunity to continue providing the complement of health care services that existed historically. This may mean having a home health nurse attend a patient's needs in their home. In another rural area a 'virtual' visit (the 'what') through the application of health information technology (the 'how') may achieve the same outcome. In other words, viewing rural communities, as with viewing rural health care systems, as all the same is both simplistic and simply inaccurate. Solutions to ensuring access may be as varied as interpreting the notion of 'rural' itself.
Embedded within the concept 'rural' are shades of gray, ranging from very low population density frontier areas with people living and working in that same location, to areas with fairly large numbers of people living in rural communities and commuting daily to large urban centers. For example, it is not uncommon to find people living in rural West Virginia and commuting daily to the nation's capitol, Washington D.C. Across this "rural continuum", a relatively large number of people can be counted. Surprising to some is the fact that about 20 percent of Americans live in the various dimensions of "rural America". This constitutes a population roughly equivalent to that of France.
The health care infrastructure that services rural dwellers is as varied as the population itself, with perhaps one exception. Some of the redundancy in availability of health services that exists in many large metropolitan areas is typically missing across rural areas. This isn't necessarily a bad thing. For example, the large volume of specialists and services available and provided to Medicare beneficiaries in Dade County, Florida-as well as in other high population density areas-is not generally found in rural America. Given recent studies that indicate that high cost, supply-induced care is not always tied to high quality patient outcomes, this is one difference between rural and urban health care that should not be troubling to rural Americans. However, there are services that are important to be able to access with relative ease-particularly given the health status of rural populations. Contrary to popular myth, rural Americans are not necessarily healthier than their city counterparts. Rural populations tend to exhibit higher rates of alcohol consumption, smoking and obesity than urban populations-all of which, left unaddressed, serves as a trip wire for serious chronic illnesses. In general, rural areas can be characterized as older and poorer than urban areas, according to the Institute of Medicine's 2004 Quality Through Collaboration report. An older population, with more chronic conditions, accesses health care more and impacts the health system directly. This also impacts provider payment as rural health providers tend to rely more heavily on the adequacy of Medicare payment.
Rural areas must also contend with income disparity. Typically, household income is lower in rural areas as compared to urban. Poverty is a factor as well. In 2000, about 85 percent of poor counties in the U.S. were rural. Again, more health problems are associated with people with lower incomes. According to a 2003 study published by the Kaiser Commission, uninsured rates are much higher in rural than in urban populations (24 percent versus 18 percent). These economic challenges compound the difficulty in ensuring geographic access.
Another set of problems facing rural areas relates to the rural health system itself. For example, rural communities tend to have significantly greater difficulty recruiting health care providers. In 2000, rural areas had more than 100 fewer physicians per 100,000 people than did urban areas. Nurses represent an emerging shortage area as there are nearly 70 fewer nurses per 100,000 people in rural areas than in urban. Rural areas consistently deal with shortages of mental, dental and emergency health care providers. An urban dwelling heart attack victim can often count on highly trained, salaried paramedics and emergency medical technicians to respond relatively rapidly. Alternatively, rural Americans often depend on emergency medical service volunteers who struggle to maintain basic credentialing and avoid burnout as they watch their numbers thin; all while managing their day jobs.
Rural health care providers and consumers aren't looking for hand-outs conveyed