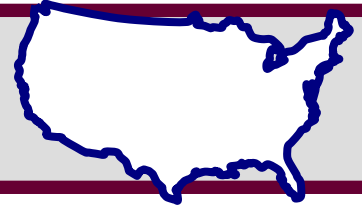


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National Center for Rural Health Works



NEWSLETTER

December 2006

HOLIDAY WISHES

The staff of the National Center for Rural Health Works (RHW) wishes everyone a safe and joyous Christmas and New Year season. The past year has been great and we look forward to working with each of you in the New Year.

In this newsletter we want to update you on RHW activities. You may wish to add some of the new RHW products to your State RHW program tool chest. We welcome and encourage your ideas and suggestions as to new tools or other activities which may enhance RHW in your state.

2007 REGIONAL TRAINING SESSIONS

The National Center for Rural Health Works is planning two regional workshops in 2007. The first regional workshop will be held in Portland, Oregon on Tuesday, March 27, 2007. A brochure and registration form with the complete details will be sent out this week! Based on demand and location, a second workshop may be scheduled in the East or the South in late summer or early fall. These workshops are open to anyone interested in learning about the Rural Health Works program tool chest. The workshop teaches professionals how to conduct economic impact studies, as well as learn about the community health engagement process and health feasibility (budget) studies.

RHW workshops are also available to individual states. However, since regional workshops are now being provided, individual state workshops will require that the state pay for the trainers' travel expenses. Anyone interested in more information on the workshops is encouraged to contact Dr. Doeksen or Ms. St. Clair by phone or email.

NEED HOST FOR REGIONAL RHW WORKSHOP

RHW is looking for a state to host the second workshop in late summer or early fall. The host state provides a meeting room and has the workshop available locally to their participants; no out-of-pocket cost is incurred by hosting a workshop. Anyone interested in MORE information on the workshops, OR attending, OR hosting a workshop is requested to either call or send an email to Dr. Doeksen or Ms. St. Clair. Please feel free to share this information with anyone you think might be interested in hosting or attending a workshop.

NEW PRODUCTS - SOON AVAILABLE IN TOOL CHEST

Last year two new applications were included in the RHW work plan. These included:

- Measuring the Economic Impact of the Oklahoma Medicaid Program on the State Economy and
- Measuring the Economic Impact of a Rural Primary Care Physician, Measuring the Potential Health Dollars Lost to Out-Migrating Primary Health Services, and Quantifying the Need for Specialty Physician Services.

The Economic Impact of Oklahoma's Medicaid Program on the State's Economy

The objective of this report was to estimate the economic impact of the Medicaid program on the economy of the state of Oklahoma. Although there is a tremendous amount of information about the program services, providers, and recipients, the economic impact is not well known. The summary will present selected economic impact highlights.

The 509 Medicaid administrative employees created 387 additional jobs in Oklahoma's economy for a total employment impact of 896 jobs. The \$29.8 million in wages and salaries plus benefits (income) generated \$13.1 million additional wages and salaries plus benefits (income) in Oklahoma's economy, for a total income impact of \$42.9 million.

As a result of the Medicaid health care services expenditures, 26,677 jobs were created in the health sector and 32,813 jobs were created in other businesses in Oklahoma's economy. The total jobs generated in the State of Oklahoma as a result of the Medicaid health care services expenditures were 59,490. The Medicaid health care services expenditures generated \$957.7 million in income in the health sector and \$833.2 in income was generated in other businesses in Oklahoma's economy. The total income from Medicaid health care services expenditures was \$1.8 billion.

Combining the administrative employment and health care services employment, the total employment impact of the Medicaid program on Oklahoma's economy was 60,386 jobs. Combining the administrative income and the health care services income, the total income impact of the Medicaid program on Oklahoma's economy was \$1.8 billion.

In conclusion, the state of Oklahoma invested \$918.6 million in State General Fund expenditures in FY 2006 for the Medicaid program. The State General Funds were matched \$1.86 in federal funds for every \$1.00 in state funds, resulting in federal funds of \$2,130 million. The state and federal funds combined created over 60,000 jobs and generated more than \$1.8 billion income in the Oklahoma economy. The Medicaid Program expenditures subsequently resulted in more than \$192.0 million in state sales, state income, and selected "other" state taxes, thus, offsetting over 20% or \$1 out of every \$5 of the original investment of \$918.6 million from the State General Fund.

This study provides valuable information to state leaders on the tremendous economic benefit of the Oklahoma Medicaid Program. This study can be duplicated in other states to utilize in support of their state Medicaid programs. The additional contribution of the study is that it

provides a methodology for estimating the state taxes generated by a state's Medicaid investment.

Measuring the Economic Impact of a Rural Primary Care Physician, Measuring the Potential Health Dollars Lost to Out-Migrating Primary Health Services, and Quantifying the Need for Specialty Physician Services

The medical importance of quality local health care services might be apparent to most community residents. However, many people have little idea of the economic importance of the health care system to local communities. Primary care physicians are a major part of the health care system. If primary care services are not available locally to meet the need for services, residents have to purchase their services in nearby communities. These out-migrated dollars are missed opportunities that can significantly impact the local economic base.

A large portion of the revenues to a primary care physician practice will be returned to the local community. These primary care dollars will generate employment of medical staff and income from wages, salaries, benefits (staff) and proprietor compensation (physicians) that will be spent locally. Employee spending along with physician office purchases will stimulate economic growth in many other parts of the economy resulting in a multiplier effect from the inter-industry activity. A local primary care physician also significantly impacts the hospital by admitting patients and generating outpatient activity, resulting in increased revenues for the hospital.

The first objective of this study is to estimate the economic impact of a primary care physician on a rural community. This report clearly documents that a rural physician practice creates four staff jobs that results in \$287,000 in wages, salaries, and benefits (income). The physician impacts the hospital with 12 jobs and an estimated \$430,000 in income. The total direct impact of a rural primary care physician totals more than 16 jobs and \$700,000 in income. After secondary impacts are included, the impact of a rural physician totals approximately \$1.5 million in revenue, \$0.9 million in wages, salaries and benefits, and 22 jobs. This estimate is low, as the impact measures only the impacts from the clinic and hospital and does not include the impact on pharmacies, nursing homes, etc. The economic contributions of a primary care physician are as important to a community as the medical contributions.

A second objective of this study is to introduce a methodology to estimate the potential to recapture health expenditures for physicians and hospitals that a community loses when primary health services are not purchased locally. This illustrates to local decision makers how the community may increase their economic base by maximizing the local utilization of primary care health services.

The last objective is to provide a methodology to quantify the potential specialty physician services needed in a medical service area. Additional dollars may be captured in the community if patients have specialty physician services available locally and purchase subsequent laboratory services locally, rather than purchasing these services at the specialist's office location.

In conclusion, this study is designed to provide templates to local communities to enhance their capability to provide primary care and specialty care physician services locally. Communities may be able to increase their economic base as well as provide additional and more accessible health care services to their local residents.

2005-2006 EVALUATION OF RURAL HEALTH WORKS

The National Center for Rural Health Works was evaluated by Peter House and Amy Hagopian from the School of Medicine at the University of Washington for 2005-2006. Two evaluation reports resulted: 1) the first evaluated the National Center for Rural Health Works, and 2) the second evaluated the RHW project with the National Association of Counties (NACo).

Evaluation of National Center for Rural Health Works

States with active RHW programs were surveyed, resulting in 45 respondents from 36 states. The complete detailed 2005-2006 RHW Program Evaluation results are available on the RHW website. Highlights of the evaluation report are included here:

How important is RHW? The majority of respondents said RHW had been either very important (42%) or somewhat important (36%) to their states.

Future project interest. Twenty-one states said they were interested in an impact analysis of Rural Health Clinics (RHCs), while 17 states said they would like to conduct an impact analysis of J-1 physicians on the local economy.

Sixteen states said they would like an analysis of federally-qualified health centers (FQHCs). Fourteen states said they were interested in an impact analysis of Medicare on the state economy. Nine states said they were interested in the impact of converting from a critical access hospital to an FQHC or an RHC, and another nine states expressed interest in an impact analysis of the 340b Discount Drug Program on the local economy.

One-Day RHW Conference with RHW Participating States. Respondents were asked if they would be interested in a one-day RHW conference with participants from active state RHW programs. A little over one third gave an unconditional yes, with about half saying maybe. Forty percent of respondents did not know if they could pay their way to such a conference, but 43% thought they could. Five respondents said they could not get their way paid to such a conference. The Midwest was the most popular destination for a conference, with Kansas City and Chicago leading the way.

Recommendations. Recommendations were received on methods to better "market" the National Center for Rural Health Works to agencies or states that may not be aware of RHW. Included are a few of the recommendations that were suggested:

- Articles in state rural health association newsletters, primary care association newsletters, etc.
- Contact each State Office of Rural Health Director, especially new directors to explain the program.
- Develop a brief newsletter with completed reports, feasibility assessments, etc. to serve as models for what other states could be doing.
- Disseminate information and products through various conferences (both academic and non-academic; rural-specific and general health services research).
- Have more representation at national conferences.

Recommendations were also made on how to improve the National Center for Rural Health Works. A few of these recommendations are included:

- Centralized service for IMPLAN data analysis; not sure service will always be available here in our state.
- Facilitate the exchange of rural health works experiences and products among states.
- Provide travel/lodging scholarships.
- Show an overview of benefits and return on investment and give specifics on how to set up a similar program in a state - how much it costs in terms of overhead, equipment, supplies, and personnel.
- Website needs to include success stories; state contact listing needs to be included and kept updated.

Again, the complete detailed 2005-2006 RHW program evaluation results are included on the RHW website.

Evaluation of the RHW Project with NACo

Background. In the spring and summer of 2005, the Federal Office of Rural Health Policy funded the National Association of Counties (NACo) to sponsor RHW projects in three western counties: Grand County, Colorado; Pondera County, Montana; and Mason County, Washington. Consultants (Gerald Doeksen, Cheryl St. Clair, and Val Schott) from Oklahoma State University (OSU) worked with county officials to undertake fairly standard RHW projects. The distinguishing characteristic for these projects (contrasting with much of RHW's previous work) is that the local leadership was linked most closely with county government as opposed to the more common health care system-sponsored projects.

The NACo website contains detailed descriptions of the projects and their findings: (http://www.naco.org/Template.cfm?Section=New_Technical_Assistance&template=/ContentManagement/ContentDisplay.cfm&ContentID=18457).

Methods. The evaluators contacted representatives from each county and talked about the RHW project. The evaluators were more interested in unique aspects of each project and whether or not the county-based strategy was a good one to develop for further RHW projects. Calls were made to county officials in January and February 2006.

Conclusions. The National Center for Rural Health Works succeeded in the NACo projects. As outlined above, each of the counties was able to list several benefits of the work. The economic impact studies were the most uniformly appreciated, but informants saw value in the other pieces of the projects although to a lesser degree. The respondents appreciated the skill, experience, and knowledge of the OSU consultants. Dr. Doeksen, Ms. St. Clair, and Mr. Val Schott were seen as approachable and knowledgeable. "They did not talk down to us" was a common refrain. In that vein, a common comment was that the sessions to present data were frustratingly short but, at the same time, most meeting attendees left the sessions with new knowledge and a new appreciation of the importance of the health system to their communities.

The main power of the data generated by RHW is that it is specific to the county. The locals want to see their numbers and they are not impressed by generalized presentations concerning

economic impact. It also helps to have the numbers presented by outsiders with no vested interest in the local community.

The central criticism was that the OSU team was not flexible enough in allowing the counties to customize this work based on local needs and interests. A number of informants saw the projects as being "canned." The evaluator, however, has to point out that one of the reasons that the OSU consultants are able to do such a high volume of quality work in a short time is that they have standardized a lot of their tools. This produces remarkable economies of scale that out-weigh the desire for more highly tailored projects. In the end, very small communities are able to benefit from the years of experience of the consultant team.

If there is an opportunity for follow-up visits/projects by the RHW team, the highest benefit would be to lead the communities through a planning process whereby they could make decisions on how to aim economic development efforts.

2006-2007 WORK PLAN - NEW PRODUCTS TO CONSIDER

The 2006-2007 work plan will be determined from recommendations from both the RHW Managing Committee and the RHW National Consulting Council. Both groups will have conference calls in January 2007 to discuss the following possible program options and additional program suggestions can be added to the list:

1. Measuring the impact of a pharmacy on a rural community.
2. Measuring the impact of rural hospital converting to an FQHC or RHC.
3. Measuring the impact of the 340b discount drug program on the local economy.
4. Measuring the impact of Medicare on a State's Economy.
5. Measuring the impact of a FQHC or RHC coming into a community with a Critical Access Hospital.
6. Measuring the impact of technology including telemedicine on the local economy.
7. Measuring the impact of J-1 physicians on local economy.
8. Measuring the impact of Medical Schools.

The objective of any new study is to develop the methodology such that others employing RHW tools in their states can duplicate these studies. Please feel free to share any questions or ideas relative to any of the above suggested study areas for the 2006-2007 work plan with the RHW's team. The team is very open to new work plan suggestions. Please be sure to contact Dr. Doeksen with additional suggestions on new RHW tools and products.

RHW STAFF MEMBERS:

Gerald Doeksen
Cheryl St. Clair
Fred Eilrich

gad@okstate.edu
cheryl@okstate.edu
eilrich@okstate.edu

National Center for Rural Health Works
513 Ag Hall, Stillwater, OK 74078
Phone: 405-744-6083

RHW Managing Committee

Gerald A. Doeksen, Oklahoma Cooperative Extension Service, Oklahoma State University
Val Schott, Oklahoma Center for Rural Health and Office of Rural Health, College of Osteopathic Medicine, Oklahoma State University
Rick Maurer, Extension, University of Kentucky
Larry Allen, KY Office of Rural Health, University of Kentucky Center for Rural Health
Woody Dunn, University of Kentucky Center for Rural Health
Tom Harris, Department of Applied Economics, University of Nevada
Gerald Ackerman, Nevada Office of Rural Health
John Packham, Nevada Office of Rural Health
Caroline Ford, Nevada Office of Rural Health
Lisa Davis, Pennsylvania Office of Rural Health
Heather Reed, Ohio Office of Rural Health
Susan W. Isaac, The Institute for Local Government Administration and Rural Development at Ohio University
Jerry Coopey, Health Resources and Services Administration, Federal Office of Rural Health Policy
Peter House, School of Medicine, University of Washington
Amy Hagopian, School of Medicine, University of Washington
Jonathan C. Sprague, Rocky Coast Consulting, Maine
Alison Reum, University of Kentucky Center for Rural Health

RHW National Consulting Council

Terry Hill, Rural Health Resource Center
Chuck Fluharty, Rural Policy Research Institute, University of Missouri
Jonathan Sprague, Rocky Coast Consultant
Caroline Steinberg, American Hospital Association
Keith Mueller, University of Nebraska
Stephanie Osborn, National Association of Counties
Mary Wakefield, Rural Assistance Center, University of North Dakota
Peter House, University of Washington School of Medicine
Val Schott, Oklahoma Office of Rural Health, Oklahoma State University
Ray Stowers, College of Osteopathic Medicine, Lincoln Memorial University, TN
Carol Miller, Frontier Education Center

Funding Support

Federal Office of Rural Health Policy
HRSA, USDHHS
Jerry Coopey, Project Officer
Email: JCoopey@hrsa.gov

Website: www.ruralhealthworks.org