National Center for Rural Health Works

May 2007

Rural Health Works - NEWSLETTER

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SPRING HAS ARRIVED

Spring has arrived!! April showers are supposed to bring May flowers. But May SHOWERS are drowning the flowers and vegetable gardens in Oklahoma. However, we never complain about rain in Oklahoma because we know that the drought will come later in the summer. When checking the weather, there is a 60% chance of rain every day next week at NRHA in Anchorage, Alaska! Hope everyone has a great trip and stays dry. Be sure to take your rain gear and jackets, lows are forecast in the forties and highs in the sixties.

This newsletter is 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 (RHW) is presenting two workshops during this contract year based on demand and location. The first workshop was hosted by the Oregon Health and Sciences University (OHSU) Office of Rural Health in Portland, Oregon, in March 2007. The Kentucky Workshop is the second regional workshop this year, Tuesday, August 21, 2007. We are excited that the Kentucky State Office of Rural Health and the University of Kentucky Cooperative Extension Service are hosting the workshop in Lexington, Kentucky. The workshop location is the Radisson Plaza Hotel Lexington at 369 W. Vine Street.

RHW invites any interested party to register and attend the Kentucky workshop (see attached detailed information brochure and registration form). 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 also has a website with additional information on the workshop topic areas:

www.ruralhealthworks.org

These are the ONLY planned RHW regional training workshops this grant year. Next year, two additional regional workshops are planned, again based on demand and location. RHW will be looking for two states to host the regional workshops in 2008. 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. Each participant will pay a small registration fee. Please feel free to share this information with anyone you think might be interested in hosting or attending a workshop. Workshops can also be requested to be presented on-site in a particular state; however, the state will incur some costs for the workshop. Anyone interested in MORE information on the workshops, attending, or hosting a workshop is requested to either call or send an email to Dr. Doeksen or Ms. St. Clair.

2006-2007 NEW PRODUCTS COMPLETED – NOW AVAILABLE

Last year 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.

These applications have been compressed into four one-page summaries. Each is described here.

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 (attached one-page summary).

The Oklahoma Medicaid program employs 50,176 employees and has a total employment impact of 111,590 employees. The program pays $1.6 billion in wages, salaries, proprietary income, and benefits (income), resulting in a total income impact of $3.0 billion. The total spending from the program (output) totaled $3.3 billion and the total business spending impact (output impact) of the Oklahoma Medicaid program was $8.0 billion.

In addition to the impacts of employment, income, and output, the impact of the Medicaid program on state taxes was calculated. The selected state taxes directly generated from the program totaled $159.6 million, with a total selected state tax impact of $354.9 million.

In conclusion, the state of Oklahoma invested $1.1 billion in state fund expenditures in FY 2006 for the Medicaid program. Federal funds matched $1.87 for every $1.00 in state funds, resulting in total federal funds of $2.1 billion. The state and federal funds combined created over 111,000 jobs and generated almost $3.0 billion income in the Oklahoma economy. The Medicaid program expenditures subsequently resulted in more than $354.9 million in state taxes. These state taxes offset the cost of the Oklahoma Medicaid state dollars by approximately 31%, as $1 out of every $3 of state funds invested in Medicaid are recovered through state taxes.

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.

The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-Migrating Health Care Services

The next three one-page summaries (attached) resulted from this one study: "The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-Migrating Health Care Services." This larger study has been condensed into these three sub-sections for clarification.

The Economic Contributions of a Rural Physician

Many people have little idea of the economic importance of the health care system to the local community. Primary care physicians are a major part of the health care system. In most rural communities, they are the principal provider of local health care services. Economically, primary care physicians hire and pay staff to operate a clinic and also contribute to the local hospital through inpatient admissions and outpatient services. A large portion of the revenues generated by a primary care physician practice will be returned to the local community. Local expenditures support jobs, create additional wages and salaries and provide tax revenues that are vital to the local economy. As these dollars continue to be spent in the community, the multiplier effect generated by the physician becomes clear.

A typical primary care physician practice employs 4 clinic employees and generates revenues of $394,275 and income (wages, salaries, proprietor's income, and benefits) of $286,925 from the 4.0 clinic employees. Revenues to the hospital from physician activity will also support employment and generate payroll. An additional 12.6 jobs and $434,627 in income will be created at the hospital from patient visits. Total hospital revenues are estimated at $751,949.

In summary, one typical primary care physician generates approximately $1.5 million in revenue, $0.9 million in payroll and creates 23 jobs in both the physician clinic and the hospital. Thus, the physician's *economic* contributions are as important to a community as their *medical* contributions. As our nation faces a growing physician shortage, it is absolutely critical that rural leadership across the United States understands that rural communities are at risk of losing much more than the opportunity to receive local medical care.

The Economic Impact of a Physician Shortage

This study is designed to illustrate the impact of a physician shortage in a rural area. In addition to the impact on the health status of the local population, a shortage can significantly impact the local economic activity. A physician shortage in a community leads to residents purchasing their primary care health services in nearby communities. In addition, out-of-town trips to obtain health care naturally offer opportunities to spend dollars out-of-town that may have been spent

locally. With this out-migration of health services, businesses and the overall local economy lose these primary care dollars.

The goal of a rural community should be to capture as much of the primary care services locally as possible. Local decision makers and health care providers should be involved in determining the usage rate appropriate for the service area.

An additional physician and/or part time physician would increase the number of local visits and recapture the dollars leaving the area. It was estimated that an example Oklahoma rural community would require an additional 0.6 full time equivalent physician to achieve a target rate of 75 percent of total patient visits from the community. The additional 0.6 FTE physician will generate $687,734 in revenue in the clinic and the hospital, for a total impact of $919,637 throughout the economy of the rural community. The recaptured activity will generate a total impact of 13.8 jobs and $533,493 in income including the physician net earnings and medical staff wages, salaries and benefits at the clinic and hospital.

The results presented show that even a part time physician can have a significant impact on the economy of a rural community. For many rural communities, this impact will make a noticeable difference through increased services and the opportunity to keep their hospital from closing. The lost income from this physician shortage also has a negative impact on potential sales tax collections which affects a community's ability to fund other important services.

All recaptured dollars can be regarded as new revenue that comes into the community. New revenues stimulate growth and economic development and are further amplified by the multiplier effect that comes with them. Local decision makers should exercise caution when estimating local spending, particularly when utilizing national coefficients. Spending patterns and income levels vary across regions and from state to state. In addition to the impact on health status, a physician shortage has a dramatic economic effect on a community by reducing employment and income in several sectors. These impacts should be considered when assessing local health services.

Specialty Physician Services

Primary care physician services are fundamental to quality rural health care systems, but there is still a need for some access to specialty physician services. Typically, most visits to a specialist will be to the larger urban facilities in the metropolitan areas. Specialty services are often technology driven and the necessary infrastructure is cost prohibitive for a smaller rural hospital. Furthermore, the demands for specialty services do not support full-time specialists in the rural areas that have sparse populations. However, rural residents could and do receive a range of specialty services in the local community.

To illustrate the need for specialists for a specific medical service area population, data were obtained from several sources. Ratios of population to specialty physicians were calculated to show the average population needed to support one full time specialist. For example, on average, a population of 93,782 would support one allergist. These ratios can be applied to the

population of an example rural medical service area to estimate the need for a specialist in some of the more common medical and surgical specialties.

An example rural population of 9,138 was illustrated. For example, the average need shown for a cardiology specialist is 0.36 FTE (9,138/25,501); this is based on an average population of 25,501 to support one full-time cardiologist. This can be compared to a specialist visiting the hospital on a basis of one to two times per week. If the average specialist spends five days per week and 47 weeks per year in practice, a 0.2 FTE specialist would practice 47 days per year or average one day per week. Likewise, a 0.4 FTE specialist would practice 94 days or average two days per week.

The economic impact of a specialist on the local community is difficult to ascertain. The average cost per visit is going to vary significantly among different diagnoses and specialists. An additional economic benefit of having a specialist practice in the local community is capturing dollars from laboratory services. A rural community could capture revenues from the addition of selected specialty physician services and from subsequent laboratory services maintained in the local community. This study quantifies the potential specialty physician services needed in a rural medical service area population.

2007 NEW PRODUCTS IN PROGRESS

The National Center for Rural Health Works will provide templates for three new economic impact studies:

- The economic impact of a rural pharmacy on a rural community's economy;
- The economic impact of a state medical school on a state's economy; and
- The economic impact of telemedicine on a rural community's economy.

These three new products will be completed during 2007 and will be available to our RHW partners as completed. If you have a particular interest in any of these new products or know of any relevant information, literature, or articles concerning these areas, please contact the National Center to contribute to the development of these products.

The 2006-2007 work plan was determined from recommendations from the RHW Managing Committee and the RHW National Consulting Council. The objective of these new studies is to develop the methodology such that others employing RHW tools in their states can duplicate these studies. Again, 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 National Center. The team is very open to future work plan suggestions. Please be sure to contact Dr. Doeksen with additional suggestions on new RHW tools and products.

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