National Center for Rural Health Works

December 2012

NEWSLETTER

The National Center for Rural Health Works will share the following activities:

- **2011-2012 projects**
  - Community Health Needs Assessment Template (CHNA Template)
  - The Economic Impact of a Critical Access Hospital on a Rural Community
  - Estimating the Need for a General Surgeon Based on the Demand for Primary Care Practitioners in the Medical Service Area
  - Economic Impact of Rural Health Care, report prepared for National Organization of State Offices of Rural Health for the National Rural Health Day in November 2012
- **2012-2013 New Work Plan**
  - Emergency Medical Services (EMS) Guidebook
  - Update the Economic Impact of a Primary Care Physician
- **2012-2013 RHW Workshops**

2011-2012 PROJECTS

Community Health Needs Assessment Template (CHNA Template)

The Patient Protection and Affordable Care Act (PPACA) is a United States federal statute signed into law on March 23, 2010. One requirement of the PPACA OR ('ACA') is that all 501(c)(3) not-for-profit hospitals conduct a community health needs assessment. These requirements are effective for tax years beginning after March 23, 2012, and the assessment must be conducted at least once every three years. In response to this, the **National Center for Rural Health Works,** with the advice and counsel of a National Advisory Team, created the CHNA Template to meet the new requirements.

Goal: The goal of **the National Center** is that either 1) hospitals will be able to use the CHNA Template to guide their own community health needs assessment process or 2) professionals from State Offices of Rural Health, State Hospital Associations, State Cooperative Extension

Services, consultants, or others will use the CHNA Template in their states to work with rural hospitals at no or minimal cost.

Website Availability: The text and appendices for the entire CHNA template are included on the website. Each of the CHNA activities and products are described in detail. The template is located under "The Products," then click on "Community Health Needs Assessment." Look on this page for the "Community Health Needs Assessment Template (CHNA Template) - "NEW" Health Assessment Template."

The CHNA Process: The CHNA process starts with a Facilitator and a Local Steering Committee designated by the Hospital administration. The Steering Committee invites local leadership to be members of the Community Advisory Committee and sends a letter of invitation. The process includes a minimum of three community meetings with additional meetings determined by the local hospital. During the CHNA process, four secondary data reports are presented:

- Demographic and Economic Data Report
- Economic Impact Report (optional)
- Community Input Tool Summary Results
- Health Indicator/Health Outcome Data Report

After the Community Advisory Committee meetings have been completed, a report is prepared to summarize the health needs identified with proposed implementation strategies and responsibilities. The Hospital Board will review the health needs report and determine an Action Plan, considering available resources and other organizations' possible participation in implementation. The Hospital administration publishes the Action Plan as specified by the Internal Revenue Service (IRS) and prepares the appropriate IRS Forms to meet all PPACA requirements. The CHNA process generates two final reports:

- The community health needs and proposed implementation strategies and responsibilities identified by the Community Advisory Committee's and
- The Hospital's final Action Plan with consideration for resource availability and for other organizations' possible participation in implementation strategies.

The Economic Impact of a Critical Access Hospital on a Rural Community

Critical access hospitals are a critical part of the health system for many rural communities. Without critical access hospitals, residents of these communities would lose access to health care. Research shows that once a community loses its hospital, other health services (i.e., physicians, pharmacies, etc.) will soon exit the community. Most residents are not aware of the fact that the health sector, anchored by a critical access hospital, is responsible for a number of jobs and payroll. The employment opportunities and the resulting wages, salaries, and benefits from the critical access hospital are extremely important to the local economy.

Objective of Study: The objective of the study is to estimate the economic impact of a typical critical access hospital. This information illustrates the need for rural and critical access hospitals

to share their economic impact with their communities. Sharing the economic impact of the hospital with the local residents can assist the hospital to gain the public's understanding and support of the need for the local hospital.

The Data and Approach: The National Center has measured the economic impact of many critical access hospitals over the years and provided studies to each community. The 73 CAH studies utilized for this research represent 21 states and have been completed since 2007. The data indicates the averages for the following: (1) employment was 141 employees; (2) wages, salaries and benefits were $6.8 million; and (3) annual construction costs were $4.2 million.

The Multiplier Effect: The data above reflect the direct impacts of a critical access hospital. The secondary and total economic impacts are measured from multipliers generated from an input-output model, utilizing data from IMPLAN.

Key Finding: A typical critical access hospital:

- Employs 141 employees, generates $6.8 million in wages, salaries and benefits (income), has an average annual construction investment of $4.2 million, and has a medical service area population of 14,600.
- Generates a total annual impact of 195 jobs and $8.4 million in wages, salaries, and benefits (income) from hospital operations.
- Generates a total annual impact of 53 jobs and $1.9 million in wages, salaries, and benefits (income) from construction investments.
- Generates a total annual impact of 248 jobs and $10.3 million in wages, salaries, and benefits (income) from both operations and construction.

A complete copy of the report, "The Economic Impact of a Critical Access Hospital on a Rural Economy," is available on the website.

Estimating the Need for a General Surgeon Based on the Demand for Primary Care Practitioners in the Medical Service Area

Converging forces are contributing to declines in the availability of rural general surgery services. A developing crisis will have profound impacts on many rural residents, hospitals, physicians and communities. Previous research indicates that the scope of urban and rural general surgical procedures is often markedly different. Research in North Carolina found that the scope of practice for rural general surgeons is significantly diverse and procedure volumes performed by rural general surgeons vary dramatically.

Objective of Study: With the variability among surgeons, it is challenging to estimate the amount of general surgery services that a specific medical service area (MSA) could support. There is a strong relationship between primary care services and other specialty physician services. Visits to specialists are typically generated from primary care practitioner referrals. Therefore, the local percent of utilization of primary care practitioner services will be utilized as the basis for estimating the need for general surgeons.

The Data and Approach: A methodology has been developed to estimate the need for general surgery based on available primary care practitioner services. This methodology can be used to estimate the need for other specialty services as well. The methodology is designed to assist local decision-makers in assessing the need and potential for general surgery services in the local MSA.

Case Study: For illustration purposes, a case study was conducted, utilizing data for a typical rural hospital MSA. Local decision-makers will need to specify the percent of the population that utilizes local primary health care services.

The number of annual physician office visits was estimated based on the population of the MSA; this was accomplished through the application of physician office visit rates from the National Ambulatory Medical Care Survey (NAMCS) applied to age and gender population groups. NAMCS reports that 60.6 percent of total physician office visits are to practitioners active in patient primary care while the remaining physician office visits are to specialists.

The methodology is designed to provide a basis for estimating the need for general surgery based on the demographics of the MSA, the general surgery procedures identified as viable for the MSA, and the local utilization rates for primary care practitioners and general surgeons in the MSA. A national database of surgical procedures is available and allows the construction of coefficients (rates of utilization per population) for each general surgery procedure. For the case study, potential general surgery procedures were identified to represent "typical" rural general surgery procedures. The coefficients for the identified "typical" general surgery procedures for the case study were applied to the population of the case study MSA. The results of the case study provided the hospital administrator an analysis of the need for general surgery and the number of full-time equivalent general surgeons necessary to meet the need.

The methodology can be applied to any rural MSA to estimate the need for a general surgeon based on the demographics of the MSA and the general surgeon scope of practice. The list of procedures can be adapted to represent a particular general surgeon or hospital scenario.

Key Findings: The study resulted in the following findings:

- The relationship between primary care and specialty physician services can be the basis for estimating the need for specialty services.
- The number of visits and type of general surgery procedures can be significantly different from hospital to hospital.
- The need for a general surgeon is impacted by the demographics of the population base, the scope of practice for the local general surgeon, the number of primary care practitioners, and the general surgery referral patterns of the primary care practitioners.
- The medical service area, percent of local utilization of local primary care practitioners, and the referral rates for local general surgeons are determined by the local decision-makers.

A complete copy of the report is available on **the National Center** website.

Economic Impact of Rural Health Care, report prepared for National Organization of State Offices of Rural Health for the National Rural Health Day in November 2012

This report was made available to all the State Offices of Rural Health to illustrate the economic impacts of health. Included in the report are bulleted items for each area of health care with bar charts. Impact bullets are included for national health sector employment, national per capita health care expenditures, and national health care expenditures as a percent of gross domestic product. Bullets are included for general rural health with emphasis on the relationship of health care to business and industry and to retirement recruitment and retention. Bullets are included for rural hospital and rural hospital construction impacts, rural primary care physician and general surgeon impacts, and rural pharmacy impact.

The report is indicative of the scope of economic impact studies available from **the National Center** and is available on **the National Center** website.

2012-2013 NEW WORK ACTIVITIES

Emergency Medical Services (EMS) Guidebook

Many systems around the nation are facing serious financial stress. A guidebook is needed that discusses options for additional revenues and/or cost savings. The end result will be an EMS guidebook which will enable decision-makers to estimate costs and revenues for alternative EMS systems. This will be an update of an earlier guidebook. **The National Center** will be working with several RHW Advisory Council Members on this project:

- ✓ Tom Harris, Professor, State Extension Specialist, and Director of the University Center for Economic Development at the University of Nevada, Reno,
- ✓ John Packham, Nevada Office of Rural Health at the University of Nevada School of Medicine,
- ✓ Karlene Andreola, EMS Coordinator, Nevada, UNSOM Outreach Center, and
- ✓ Larry Allen, Director, Kentucky SORH and member of NASEMSO/NOSORH Joint Committee on Rural Emergency Care (JCREC).

Other EMS officials have been invited to provide counsel and assistance on the guidebook. The guidebook was planned for the 2011-2012 work plan; however, the CHNA Template dominated the work activities during 2011-2012 and this study was postponed until 2012-2013. The first five chapters have been drafted and the design of the budget spreadsheet has been initiated.

Update the Economic Impact of a Primary Care Physician

Primary care physicians are a major part of the health care system. In most rural communities, primary care physicians are the principal provider of local health care services, contribute to their communities through educational programs promoting healthy lifestyles, and often serve as medical director for the local hospital and/or the local emergency medical services.

Economically, they hire and pay staff to operate a clinic and also contribute to the local hospital through inpatient admissions and outpatient services. A key to achieving a sustainable economy is capturing local revenues. Local revenues support jobs, create additional wages and salaries and provide tax revenues that are vital to the local economy. If primary care services are not available locally to meet the need for services, rural residents have to purchase their services in other communities. In addition, out of town trips to obtain healthcare naturally offer opportunities to spend dollars out of town that may have been spent locally. These out-migrated dollars are missed opportunities and can significantly impact the local economic base. As America faces a growing physician shortage, it is absolutely critical that rural leadership across America understand that rural communities are at risk of losing much more than the opportunity to receive local medical care.

The objective of this study is provide an updated estimate of the economic impact of a primary care physician on a rural community and to provide a methodology for estimating the economic potential of health care services for a rural community. The economic importance of a rural primary care physician was originally prepared in 2007.

2012-2013 RURAL HEALTH WORKS WORKSHOPS

The National Center is planning three regional training workshops in 2013:

- March 12, 2013 in St. George, Utah. Hosted by the Utah Office of Primary Care and Rural Health, Utah Department of Health.
- Tentative for the week of June 4, 2013, in Orlando, Florida. Hosted by the Florida State Office of Rural Health, Florida Department of Health.

Anyone interested in hosting a third workshop in 2013 should contact **the National Center**. Workshop hosts are on a first to offer, first to host basis. The host state assists with locating a training facility and inviting state participants; they ***incur no financial costs***. The benefit to a host state is having the workshop available for state participation (with a nominal registration fee per participant). Please share this information with anyone interested in hosting or attending a workshop.

The National Center invites any interested parties to register and attend these workshops. The workshops teach professionals how to conduct economic impact studies, how to fulfill CHNA requirements with the CHNA Template, and how to develop health feasibility (budget) studies. **The National Center** also has additional information on the workshop topic areas on their website: **www.ruralhealthworks.org.**

Workshops can also be requested to be presented on-site in a particular state; however, the state will incur some costs for the workshop. Contact the National Center for further information.

Staff for the National Center

Gerald A. Doeksen, Director
Email: gad@okstate.edu

Cheryl F. St. Clair, Associate Director
Email: cheryl@okstate.edu
Direct Phone Line: 405-744-9824

National Center for Rural Health Works
Oklahoma State University
Oklahoma Cooperative Extension Service
513 Ag Hall
Stillwater, OK 74078
Main Phone: 405-744-6083
Fax: 405-744-9835

Funding Support

Bridget Ware, Project Officer
Office of Rural Health Policy
HRSA, USDHHS
Phone: 301-443-3822
Email: BWare@hrsa.gov

National Center for Rural Health Works - National Advisory Council

Website: www.ruralhealthworks.org