Rural Health Works:
Community Health Engagement for Local Elected Officials

NACO National Association of Counties
The Voice of America's Counties

National Center for Rural Health Works

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About the National Association of Counties

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation's 3,068 counties. NACo advances issues with a unified voice before the federal government, improves the public's understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACo, visit *www.naco.org*.

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Community Health Engagement Process

The National Association of Counties (NACo) Health and Human Services Programs are designed to help counties find solutions to the challenges they face in their communities including increasing access to health care, expansion of rural health systems, enhancing connections between workforce and economic development and advancing public health and wellness programs and policies. County commissioners are often the best officials to lead such a process. Through training, education and technical assistance opportunities, these programs mobilize county officials to take a leadership role in improving health and human services in their community and provide them with the tools needed to deliver more effective and higher quality services while containing costs.

Through NACo's Health and Human Services Program, the community health engagement process is a strategic planning process that assists counties in evaluating their health care systems with county-specific-data that demonstrate the importance of the health care sector to the local economy. This is a dynamic, interactive, data-driven process that enables local communities to understand and to improve their health care delivery system. More specifically, the process assists counties to:

- identify their health care needs,
- examine the social, economic and political realities affecting the local delivery of health care,
- determine what they want and realistically can achieve in a health care system to meet the county's needs, and
- develop and mobilize an action plan based on their analysis and planning.

The Community Health Engagement Process (CHEP) is about local people solving local problems. With county leadership, CHEP engages local community members in developing common goals toward maintaining and/or increasing local health services and improving the health and wellness of the community.

CHEP begins with an initiating group, generally a small group of community leaders (hospital administrator must be included), and the Resource Team to review the process. The Resource Team members are representatives from the National Center for Rural Health Works who provide group meeting facilitation, data, and analysis to the process. The community leaders are the decision makers. **The Resource Team makes no decisions or recommendations**.

After the process is discussed, the county commissioners and the community leaders decide if they wish to proceed with CHEP. If the decision is to proceed, the next step is to identify a Community Representative. The Community Representative position requires a minimum of work; i.e., sending meeting announcements, organizing the meeting place, etc. These activities must be conducted by a local person. Oftentimes the Community Representative is a person employed in the county commissioners' office or in the local hospital. Another responsibility of the initiating group is to select members for a broad-based Steering Committee. These members represent all community interests and must be willing to identify health concerns, evaluate data and reports, and assist in development of a health action plan. Suggested Steering Committee members are community leaders and may include:

- Farmers and ranchers
- Retirees
- City governments
- County government
- State government
- Tribal governments

- Health care providers
- Hospital administrator & other key personnel
- Hospital board
- Doctors
- Dentists
- Optometrists
- Chiropractors
- Mental health professionals
- Nurse practitioners
- Physician assistants
- Therapists - physical, massage, speech, rehabilitation, occupational
- Pharmacists
- Medical equipment suppliers
- Home health providers
- Nursing homes
- Chambers of Commerce
- Economic development organizations; i.e., coalitions, councils of government, substate planning districts
- Industries & businesses; i.e., manufacturing, banks, telephone companies, retail sales (Main St. businesses), groceries, realtors, insurance companies, etc.
- Public education; superintendents, principals
- Technology education
- Higher education and private education
- Volunteer organizations; food banks
- Religious leaders; i.e. ministerial alliances
- Minority groups or group leaders
- Service organizations; i.e. Kiwanis, Lions, Rotary, Toastmasters, etc.
- Social service organizations
- Other community leaders

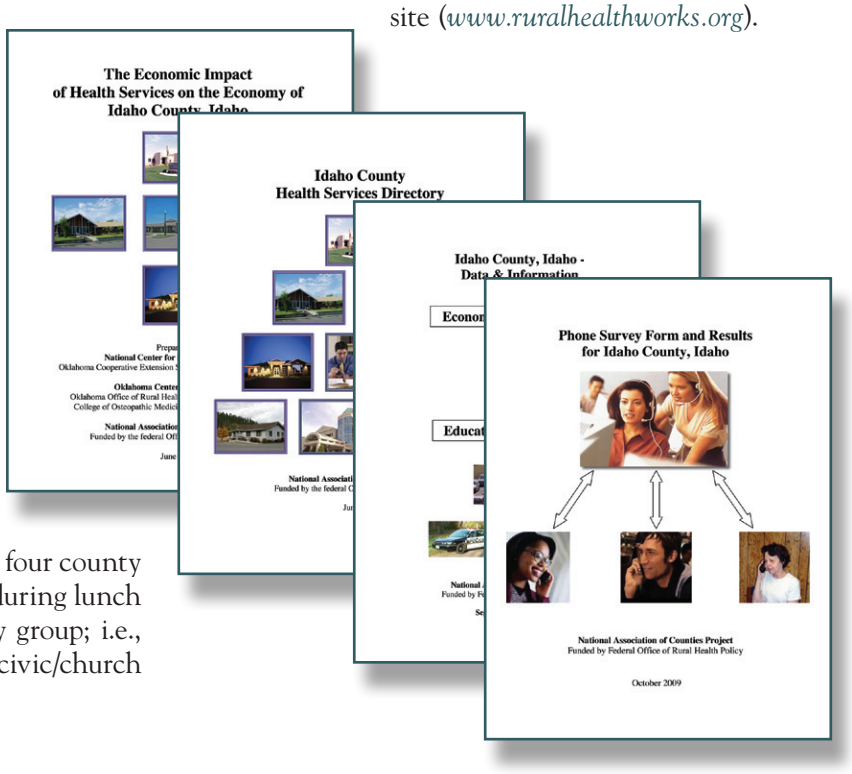
The Rural Health Works process entails four county meetings. The meetings are conducted during lunch with a light meal provided by a county group; i.e., the local hospital, a local business, or civic/church group. The Resource Team starts the meetings at noon, conducts the meeting while participants are having lunch, and ends the meeting after one hour. This time frame ensures that Steering Committee members are able to participate in the process and still be back to work in a timely manner.

The Steering Committee meets four times and assists with the development of four products. These include:

1. Economic impact of health services;
2. Health services directory;
3. Data and information report; and
4. Survey and report on health services utilization.

At the end of the fourth meeting, a county health action plan is developed. If the action plan involves additional analyses, the Resource Team assists and may conduct health feasibility studies. Each of these products is explained in detail in the following sections.

As each product relates to and builds upon the others, the remainder of this report will outline the creation of the four products using Idaho County, Idaho, as the example. The four products from Idaho County, Idaho, as well as examples from other counties that have completed the Rural Health Works process, are available from NACo's Health and Human Services webpage (*www.naco.org*) or the National Center for Rural Health Works website (*www.ruralhealthworks.org*).



The Economic Impact of Health Services

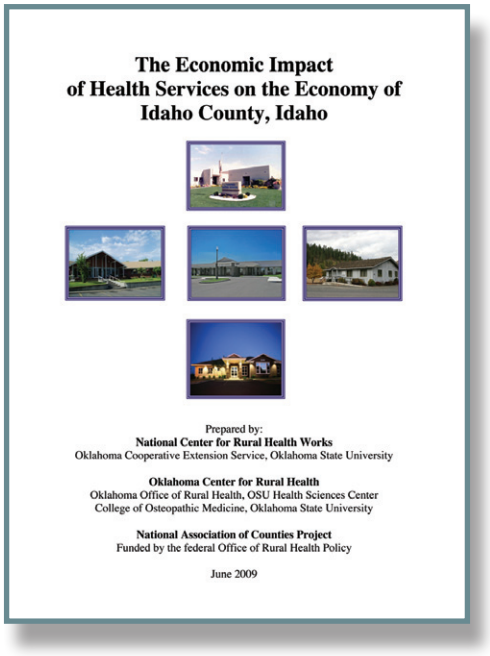
At the first meeting, the product entitled, "The Economic Impact of Health Services," is presented to the Steering Committee. The Steering Committee members know the medical contribution that health care services provide their local county residents, yet few know the economic contribution that health care services have on the local economy. This important relationship between health care services and rural development is often overlooked. At least three primary areas of commonality exist. A strong health care system can: 1) help attract and maintain business and industry growth, 2) attract and retain retirees, and 3) generate quality health care jobs in the local area.

Research shows that if a community wants to attract business and industry, it needs good health and education services.[1] Research also shows that if a community wants to attract and retain retirees, a healthy and safe environment is needed.[1] Finally, data indicate that the national population aged 65 and over is projected to increase more rapidly than any other age group; thus, health care demand and health care workforce needs are correspondingly forecasted to increase. In fact, the health care sector is one of the few sectors in the current recession where employment is increasing.[2]

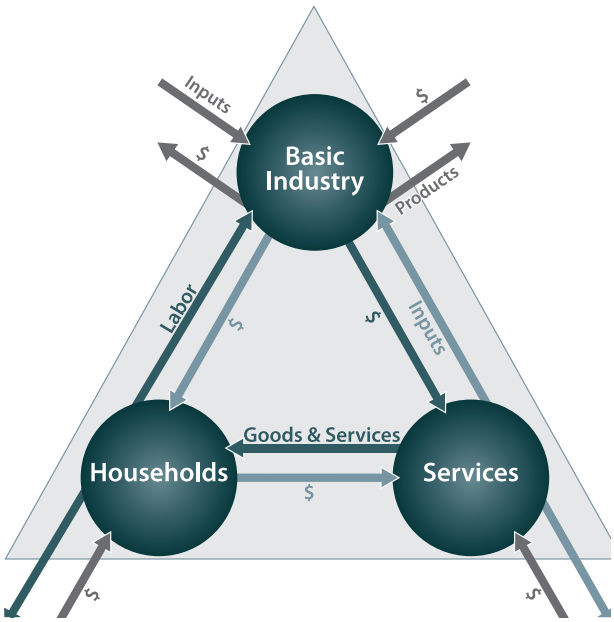
To demonstrate the importance of health care services on the local economy, the Resource Team prepares "The Economic Impact of Health Services" report.[3] This report is created by gathering and analyzing local employment and wage data from the local health businesses. To show an example of an economic impact report, one economic impact table from the Idaho study is presented.[4] The health care services were divided into five sectors. For the hospital sector, Idaho County had two hospitals with 369 employees. The physicians, dentists, and other professionals' sector (including their office staff) had 46 employees. For all five sectors, 687 employees worked in health care services in Idaho County.

The number of jobs in health care services only tell a portion of the economic impact. As the health care businesses and their employees purchase goods and services in the county, jobs are created in other businesses in the county. These secondary impacts are estimated using employment multipliers.

A model is available[5] that develops multipliers for the specific medical service area. In this case, the medical service area is Idaho County. A medical service area could be a zip code area, group of zip code areas, a county, or multiple counties. Whatever the case, each medical service area has its own unique multipliers.



Overview of County Economic System



Applying the employment multipliers to the employment for each health sector yields an estimate of each sector's employment impact on Idaho County. For example, the hospital sector has employment of 369 employees. Applying the employment multiplier of 1.50 to the employment of 369 brings the total employment impact of the hospital sector to 554 employees (369 x 1.50 = 554). The secondary impact of the hospital sector is 185 employees (369 x 0.50 = 185); these are the jobs created in other industry sectors in the Idaho County economy as a result of the spending of the hospital and the spending of the hospital employees.

A similar analysis is completed to measure the economic impact on wages, salaries, and benefits. This analysis generates income multipliers which measure how income moves through a medical service area.

Research results[6] indicate that in rural counties:

- 10 to 15 percent of a rural county's employment directly work in health care services;
- 15 to 20 percent of the rural county's employment work directly in health care services or are generated (secondary) from health care services; and
- Hospitals are often the largest or second largest employer in the county.

In summary, the "Economic Impact of Health Services" report demonstrates the economic importance of health care services to the county economy. The Steering Committee should now realize the need to support and evaluate their county health care services; this evaluation may include the need to enhance and/or expand health care services. Additional health services would further promote economic development in the county.

The Idaho County study, "The Economic Impact of Health Services on the Economy of Idaho County, Idaho," as well as Economic Impact reports from other counties, are available from NACo's Health and Human Services webpage (*www.naco.org*) or the National Center for Rural Health Works website (*www.ruralhealthworks.org*).

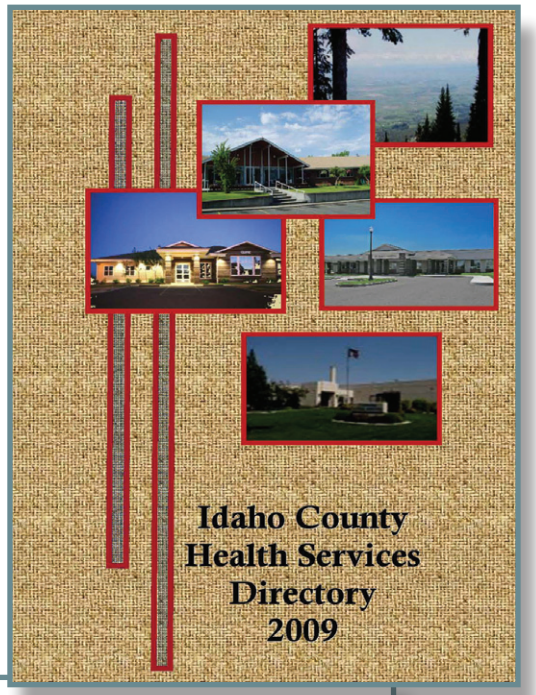
Employment Impact of Health Services on the Economy of Idaho County, Idaho

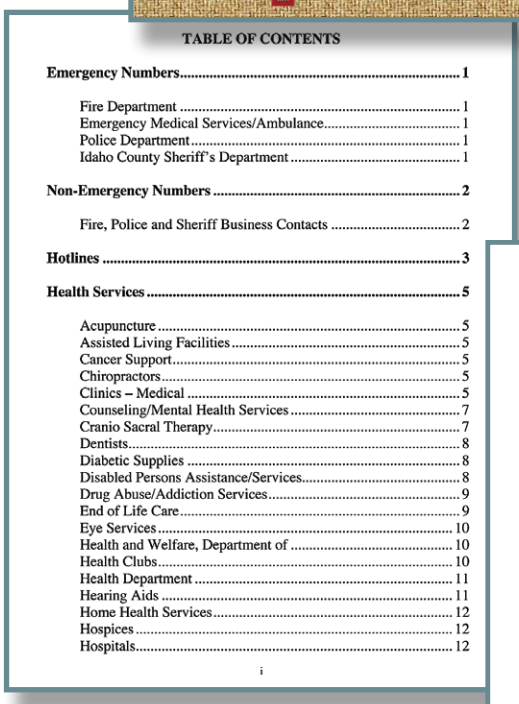
Health Sectors	Number of Employees	Employment Multiplier	Secondary Impact	Total Impact
Hospital				
Syringa Hospital & Clinics	149	1.50	75	224
St. Mary's Hospital & Clinics	220	1.50	110	330
Combined Hospitals	369	1.50	185	554
Physicians, Dentists, & Other Health Professionals	46	1.35	16	62
Home Health Services	84	1.17	14	98
Pharmacies	34	1.40	14	48
Other Health & Medical Services	154	1.13	20	174
TOTALS	**687**		**249**	**936**

SOURCE: Local employment data for all health services; multipliers from IMPLAN 2007 data, Minnesota IMPLAN Group, Inc. [*www.implan.com*].

Health Services Directory

The second product is a "Health Services Directory." The health services directory for Idaho County is used for illustration.[7] This product is popular since many residents do not know what services are available in their county. The goal is to list every health service available in the county so residents are aware of what is available locally. Hopefully, knowledge of the services available will increase local utilization of health services. If a resident travels out of town for health services, they will also spend money on gas, shopping, dining, etc. out of town and these dollars are lost to the local economy.





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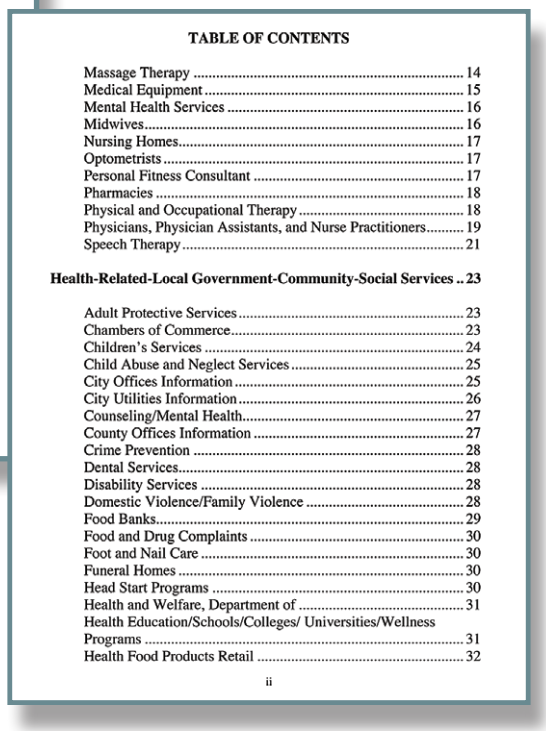

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A portion of the Directory's Table of Contents is presented below to give readers an idea of the depth and comprehensiveness of the "Health Services Directory." In addition to local health services and health-related local government, community, and social services, the Directory also contains State and National information Services, Support Groups, and Help Lines. An example is the Alzheimer's Association National information line. These are typically 1-800 numbers.

The back page of the directory is left blank for the Steering Committee to seek a sponsoring business to advertise and print copies for distribution. Some communities mail a copy of the directory to all residents, while other communities hand them out to new residents at health fairs or at the of-

At the first meeting, the Resource Team collects phone books from the local county.[3] The Resource Team uses the phone books to prepare a directory of health services. At the second meeting, the Steering Committee either (1) reviews the draft health services directory and makes necessary changes/ updates or (2) assigns Steering Committee members to review and update specific sections of the draft directory. Any changes and corrections are incorporated into the directory and the Steering Committee makes a final review at the third meeting. Generally, this is an easy process and is completed by the third county meeting.

fices of the health care providers. In addition, many communities post the directory on various community websites; i.e., county, city, hospital and/or other health care providers.

The Steering Committee identifies a volunteer to be responsible for updating the directory at least once a year. Upon completion of the "Health Services Directory," distribution of the directory is important to make it available to local residents either in hard copy or online. The expected outcome of the Directory is that local residents utilize local health care services and keep dollars local, which in turn promotes economic development.

The Idaho County study, "Idaho County Health Services Directory 2009," as well as Health Services Directories from other counties, are available from NACo's Health and Human Services webpage (*www.naco.org*) or the National Center for Rural Health Works website (*www.ruralhealthworks.org*).

Data and Information Report

The third product consists of all available secondary data for the medical service area. The product is compiled by the Resource Team and presented at the third community meeting. The data are collected for five distinct sectors: economic and demographic, health, education, traffic safety, and crime[3]. The data clearly describe the conditions in the medical service area. The example used to exemplify this report will be Idaho County, Idaho.[8] The complete report consists of 46 tables. A few select tables will be presented to illustrate the data and their usefulness.

Example Table 1 indicates that the population age 18 years and younger are becoming a smaller percentage of the total population as well as smaller in magnitude.

Example Table 2 shows that the population age 65 years and older is increasing as a percentage of the total population as well as in absolute numbers. This county will need additional health care services for the increasing elderly population and will need less for the younger population (i.e., school age children).

The health services section of this report is the largest section. This section contains all available

Example Table 1

Persons ≤ 18 Years of Age Population and Percent of Total Population for Idaho County and the State of Idaho

	Idaho County	State of Idaho
1990		
Population ≤ 18 Years	3,845	308,405
Percent of Total Population	27.9%	30.6%
2000		
Population ≤ 18 Years	3,873	369,030
Percent of Total Population	25.0%	28.5%
2008		
Population ≤ 18 Years	3,089	3,339,224
Percent of Total Population	20.0%	28.0%

SOURCE: U.S. Census Bureau (*www.census.gov* [July 2009]).

Example Table 2

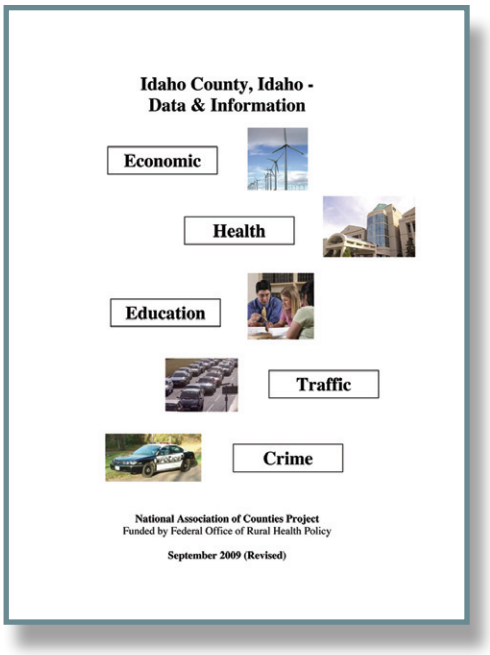
Persons ≥ 65 Years of Age Population and Percent of Total Population for Idaho County and the State of Idaho

	Idaho County	State of Idaho
1990		
Population ≤ 18 Years	2,150	121,265
Percent of Total Population	15.6%	12.0%
2000		
Population ≤ 18 Years	2,644	145,916
Percent of Total Population	17.0%	11.3%
2008		
Population ≤ 18 Years	3,066	1,440,476
Percent of Total Population	19.8%	12.1%

SOURCE: U.S. Census Bureau (*www.census.gov* [July 2009]).

data related to public assistance programs, birth data (by size, race, single mother, etc.), health behavioral data (smoking during pregnancy, obesity, smoking, drinking, etc.) and leading causes of death.

The Data and Information Report is extremely useful for grant writing as it essentially contains all available data in one document. This product is also useful for developing new health services or starting a new business or business line. The data reflect local conditions. From these data, the Steering Committee members will be able to identify county health issues that need to be addressed. Recently in one county, it was documented that 70 percent of the births were to single mothers. In another county, obesity was clearly identified as a problem. The Steering Committee was able to develop an action plan to address their identified issues.



The Idaho County study, "Idaho County, Idaho – Data and Informaton," as well as Data and Information Reports from other counties, are available from NACo's Health and Human Services webpage (*www.naco.org*) or the National Center for Rural Health Works website (*www.ruralhealthworks.org*).

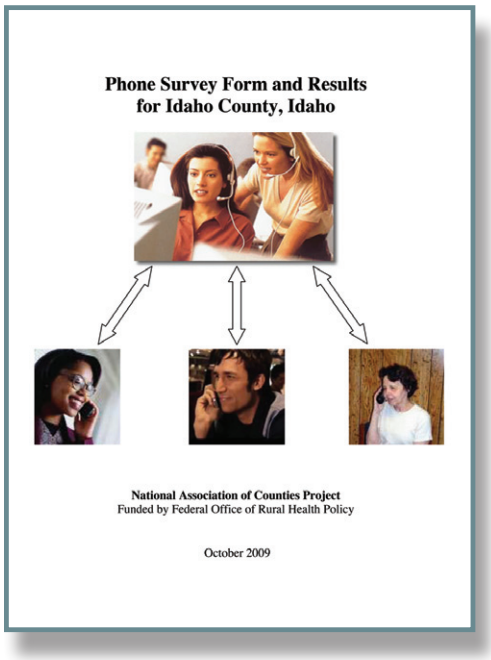
Health Services Utilization Survey

The fourth product is the "Health Services Utilization Survey," illustrated with the Idaho County study.[9] The Steering Committee reviews a draft of a survey instrument and adapts it to fit the community needs and issues. The Steering Committee may add questions to the survey if there are specific local concerns. For example, one county asked residents if they would support a tax increase for a new hospital.

The survey is designed to ask residents where they go for health care services and why.[3] The survey is conducted by telephone and is completely anonymous. A professional survey team conducts the survey through a system which randomly calls residents. Usually in rural communities, 200 completed surveys are sufficient for statistical reliability.

It is extremely important that the Steering Committee conducts a publicity campaign informing the residents that the survey will be completed on their behalf so that the local residents will be encouraged to participate. The Resource Team provides materials and suggests ways to advertise the survey. This includes the usual media outlets (newspapers, radio, etc.), but also includes more direct contacts such as adding the information to church bulletins, announcements at church, and/or other local civic meetings and activities. If the publicity campaign is successful, it is not unusual to receive a 70 to 80 percent response rate.

Since the survey addresses utilization of health care services, it will determine what health care services the residents are receiving outside the community and why they are going to these other providers instead of utilizing local health care services. For example, Idaho County examined the responses to the questions below.



Results of the survey questions were that 171 responding households out of the 200 total survey respondents had someone in

7a. Have you or someone in your household been to a specialist in the past 24 months?

☐ Yes
☐ No

7b. What type of specialist have you or someone in your household been to and in which city are they located?

Type of Specialist	City

7c. Did the specialist request further testing, laboratory work and/or x-rays?

☐ Yes ☐ No

7d. In which city were the tests or laboratory work done?

☐ Grangeville ☐ Lewiston
☐ Cottonwood ☐ Nez Perce
☐ Kamiah ☐ Orofino
☐ Kooskia ☐ Other ***(Specify)*** _____

7e. Are you aware that you can have your tests, laboratory work and/or x-rays performed at Syringa Hospital or St. Mary's Hospital regardless of the location of your specialist?

☐ Yes ☐ No

their family that had seen a specialist in the past 24 months. The two most frequently utilized specialists were orthopedist and cardiologist. For the total responses of all specialists, approximately 72.3 percent of the specialists requested further testing, laboratory work and/or x-rays. The survey results further showed that 81.5 percent of these procedures were completed outside the county. When asked whether the respondents knew that these tests could be done in the county, 74.5 percent responded that they were aware that they could do the procedures locally.

The survey yields answers to numerous utilization questions. Some examples from recent surveys in other counties include:

- Residents were going out of the county for primary care because there are not enough primary care physicians;
- Residents were going out of the county for primary care because they perceive the quality of care to be poor from the local primary care physicians;
- Residents believed that the larger urban health care services provide better quality primary care services;
- Some residents were not aware of the fact they can have the laboratory and/or x-rays conducted locally, even if the physician is outside the local area; and
- Residents were going out of the county because a service was not available locally such as kidney dialysis.

Once the concerns are identified through the survey, the Steering Committee can devise a plan to address the issues. Some examples include:

- ☑ Determine if the community needs additional primary care physicians and devise a plan to attract and retain more primary care physicians, if needed;
- ☑ Develop a specialty physician clinic so specialty physicians provide care in the community on a regular basis (once a week, once a month, etc.); or
- ☑ Evaluate whether additional or expanded health services identified in the survey would be economically feasible (such as kidney dialysis).

The plan and action steps that result generally improve and increase access to health care services and quality of health care services in the county. Consequently, this leads to better quality of life for the county residents as well as keeps the dollars at home, promoting economic development in the county.

The Idaho County study, "Phone Survey Form and Results for Idaho County, Idaho," as well as Phone Survey Results from other counties, are available from NACo's Health and Human Services webpage (*www.naco.org*) or the National Center for Rural Health Works website (*www.ruralhealthworks.org*).

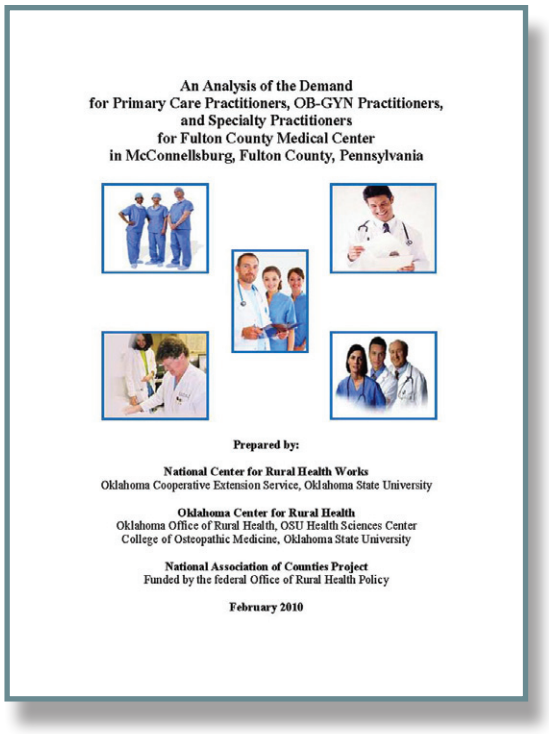
Health Feasibility Studies

Upon completion of the four meetings, the Steering Committee will develop an action plan.[3] The issues typically are divided into two areas: behavioral issues and needed health care services. Behavioral issues could be a large percent of mothers smoking during pregnancy or a high percent of births to teen mothers. When the issues are behavioral, the Resource Team assists in directing the Steering Committee to agencies which have proven programs to address these issues. When the issues identified by the Steering Committee reflect needed health care services in terms of access and utilization, the Resource Team assists in evaluating the need to determine whether or not the community can support a particular identified service. To illustrate this, two examples will be presented. These include:

1. A method to predict primary care and specialty care physician needs and
2. A method to evaluate the need for a kidney dialysis unit.

Primary Care and Specialty Care Physicians

Many Steering Committees identified the need for more primary care and specialty care physicians as an action plan. This being the case, the Resource Team conducts an analysis of the medical service area to determine the need for these professionals.[10] The Resource Team has developed tools to aid in such an analysis. Example results for a recent rural county study are presented in the table below. The medical service area has a population of 9,138.


An Analysis of the Demand
for Primary Care Practitioners, OB-GYN Practitioners,
and Specialty Practitioners
for Fulton County Medical Center
in McConnellsburg, Fulton County, Pennsylvania

Prepared by:

National Center for Rural Health Works
Oklahoma Cooperative Extension Service, Oklahoma State University

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Annual Primary Care Physician Office Visits Generated in the Example Medical Service Area

	Male			Female			
Age	Population	Visit Rate	Visits	Population	Visit Rate	Visits	Total Visits
Under 15	882	2.5	2,205	833	2.4	1,999	4,204
15-24	782	1.2	938	751	2.2	1,652	2,591
25-44	1,270	1.5	1,905	1,203	3.2	3,850	5,755
45-64	1,089	3.3	3,594	1,135	4.2	4,767	8,361
65-74	310	6.0	1,860	357	6.4	2,285	4,145
75+	207	7.7	1,594	319	7.1	2,265	3,859
TOTALS	4,540		12,096	4,598		16,818	28,914
Local Primary Care Physician Office Visits: (58.9%)							**17,030**

SOURCE: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center of Health Statistics, "National Ambulatory Medical Care Survey"; U.S. Census Bureau.

The population of the medical service area is presented by age and sex. The average annual visit rates are applied to estimate the number of primary care physician office visits in the medical service area.[11] For example, the 882 males in medical service area under the age of 15 generated 2,205 physician office visits (2.5 x 882). Females under 15 generated 1,999 office visits. All the residents in the medical service were estimated to make 28,914 total physician office visits per year. Data available annually from the U.S. Department of Health and Human Services estimate that 58.9 percent or 17,030 of these total physician office visits will be made to physicians active in primary patient care while the remainder will be made to specialists.

The average number of primary care physician office visits is about 5,000 per year. Thus, if 90 percent of the local residents utilize local primary care physicians, the medical service area would support three primary care physicians. The medical service area has two physicians, thus, the analysis clearly supports the fact that the demographics of the county can support another primary care physician.

Need for Specialty Physician Services

	Population to Physician Ratios	Specialist FTEs for Example Area
	Average	Average
Medical		
Allergy	93,782	0.10
Cardiology	25,501	0.36
Gastroenterology	41,111	0.22
Hem/Oncology	46,667	0.20
Nephrology	65,333	0.14
Neurology	40,667	0.22
Pulmonary	58,589	0.16
Rheumatology	85,557	0.11
Surgical		
ENT	35,370	0.26
General	12,834	0.71
Ophthalmology	23,638	0.39
Orthopedic	16,802	0.54
Urology	33,974	0.27

SOURCE: "The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-migrating Health Services," National Center for Rural Health Works, January 2007.

In addition, a tool is available to estimate specialty physician needs.[12] For example, specialty physician needs are estimated in the next table.

Population to physician ratios show the average population needed to support one full-time equivalent (FTE) specialist. For example, on average, a population of 93,782 would support one FTE allergist.

These ratios can be applied to the population of a rural medical service area to estimate the need for specialists in some of the more common medical and surgical specialties. The last column details the number of FTE specialists based on the example medical service area with a population of 9,138. For example, the average need shown for a cardiology specialist is 0.36 FTE (9,138/25,501). This can be compared to a specialist visiting the hospital on a basis of one to two times per week. The results show that a general surgeon is the most needed specialist. The population of the medical service area can support 0.7 FTE general surgeons, which is equivalent to approximately two to three days per week.

The Fulton County study, "An Analysis of the Demand for Primary Care Practitioners, OB-GYN Practitioners, and Specialty Physicians for Fulton County Medical Center in McConnellsburg, Fulton, County, Pennsylvania," is available from the NACo's Health and Human Services webpage (*www.naco.org*) or the National Center for Rural Health Works website (*www.ruralhealthworks.org*).

Kidney Dialysis Unit

A county completed CHEP and realized that many residents were traveling 100 miles for kidney dialysis treatments. A patient would need to drive or be driven three times a week for these services, involving a considerable amount of time for the provider and the patient. The Steering Committee wanted to know if a kidney dialysis unit was economically feasible in the community.

The tool applied to the situation estimated the number of patients needing service annually was 22. Based on the 22 patients needing dialysis services, the budget was constructed with both capital costs and annual operating costs for a unit with eight dialysis stations operating three days per week [4]. The analysis included estimating revenues based on insurance and Medicare payment structures. The results are shown in Table 3.

The proposed kidney dialysis unit would have total revenue of $813,980 and total costs of $794,494, for a profit of only $19,486. The hospital made the decision to provide a kidney dialysis unit despite the very low return. Their reasoning was twofold: 1) to provide the service to local residents and 2) to generate additional revenues at the hospital from the laboratory services provided to dialysis patients which would supplement the low return on investment.

Table 3

Feasibility of a Kidney Dialysis Unit		
Total Revenue		**$813,980**
Total Capital Costs	($78,572)	
Total Annual Operating Costs	($715,922)	
Total Costs	**($794,494)**	
Total Revenues less Total Costs		**$19,486**

Available Health Feasibility Templates

Listed below are the health feasibility templates available from the National Center that could be provided to a Steering Committee:

- Primary Care Physician
- Obstetrics/Gynecology Physician
- Pediatrician
- Emergency Medical Services (EMS) (Basic, Intermediate, or Advanced)
- Emergency Medical Responder (EMR) Systems (First Responders)
- Outpatient Rehabilitation
- Adult Day Services
- Kidney Dialysis
- Assisted Living Facilities
- Community Health Centers (CHCs or FQHCs)
- Rural Health Clinics
- Specialty Physicians

In summary, the health feasibility studies enable the Steering Committee to determine the profitability and need for additional services. By providing more health services locally, the residents are spending more of their health dollars locally. This enhances the county economy.

Summary

In addition to ensuring appropriate care meets their local residents' health needs, the Rural Health Works process can assist county commissioners in identifying how health care can be an economic engine for their county.

County commissioners are extremely interested in economic development and providing the best health services for their residents. The recent Patient Protection and Affordable Care Act will bring renewed focus to available healthcare resources; and inevitably, increased demand for local health services. This publication summarizes the Rural Health Works Community Health Engagement Process which measures the economic impact of the health sector on the county economy and provides a community health assessment process.

The Community Health Engagement Process involves county members from all aspects of the county convening for a minimum of four meetings to design a health action plan. During the four meetings the leaders receive four reports:

1. The economic impact of health services on the county's economy;
2. Health services directory;
3. County data and information report; and
4. The results of a county health survey.

The final outcome is a county health action plan; the plan results from the community health engagement process lead by the county commissioners. Data from the four reports provide information to assist the county leaders in devising the health action plan. If the plan requires additional analysis in regard to adding or expanding health care services, this can be provided through additional tools that evaluate the feasibility of adding or expanding a particular health care service.

The participation of county elected officials, especially the county commissioners, is crucial. Their leadership indicates to the public their commitment for quality health services and their understanding of the economic impact of health services on the local economy. If county officials participate in the process, other community leaders are willing and ready to be actively involved. In addition, often local county officials can also assist in carrying out an active plan

NACo has had several grants from U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), to conduct Community Health Engagement Processes in counties across the nation. The average time it takes to complete the Community Health Engagement Process is four months. This generally consists of one meeting each month for four consecutive months. Information and reports for participating counties can be obtained from the NACO or Rural Health Works websites. The counties that have completed the Rural Health Works program are listed below:

<u>2009</u>

- Fulton County, Pennsylvania
- Idaho County, Idaho
- Sumter County, Alabama

<u>2008</u>

- Grimes County, Texas
- Holmes County, Florida
- Summers County, West Virginia

<u>2007</u>

- Adams County, Ohio
- Grand County, Utah
- Linn County, Missouri

<u>2005</u>

- Grand County, Colorado
- Mason County, Washington
- Pondera County, Montana

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For your notes...

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