REPORT OF THE
VIRGINIA DEPARTMENT OF HEALTH

Developing Primary Care Services in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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DEVELOPING PRIMARY CARE SERVICES IN VIRGINIA

INTERIM REPORT

PRIMARY CARE NEEDS ASSESSMENTS

PREFACE

The Commission on Health Care for All Virginians, through Senate Joint Resolution 179, asked the Virginia Department of Health to provide local leadership in developing solutions to the lack of access to primary care services apparent across the state. To do that, the local health district directors were charged with calling together representatives from the community to first assess the primary care needs of the area, and second to develop a plan for addressing that need. This interim report is presented following the first year of work and includes a statewide needs assessment for primary care.

This document was prepared by the Virginia Department of Health under the direction of the Commissioner, Dr. Robert B. Stroube, M.P.H.

SJR 179 Logistics Committee:

The Honorable Debbie D. Oswalt

Dr. Robert B. Stroube, M.P.H.

Bruce Behringer, M.P.H.

Dr. James E. Burns

Amy Domeika

Dr. Carol C. Hogg

Joanne Jorgenson, R.N.

Susan R. Rowland, M.P.A.

Parker H. Sternbergh, M.H.A.

SJR 179 Staff:

Parker H. Sternbergh, M.H.A.

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EXECUTIVE SUMMARY

In accordance with the directives of SJR 179, local health directors, along with representatives of the private medical care community, businesses, schools, hospitals, consumers, non-profit service organizations, and many others, compiled data to identify what people in their locality did not have access to primary care health care services, and what barriers prevented that access. While the findings were not surprising, their work allowed all participants to see together what problems they were facing and the impact of these problems on the general well being of the community at large.

Findings

In general, the needs assessments together found that Virginia does not lack for primary care providers in terms of sheer numbers. Those providers are spread throughout the state, but are more concentrated in urban areas near hospitals and sparce in rural areas and even within certain urban and suburban communities. Together, these assessments found that the state needs between 253 and 361 primary care physicians located in identified underserved communities.

In addition to a provider manpower shortage, other barriers to care were identified:

- Poor access for persons not covered by insurance, public or private.
- Lack of transportation to medical providers.
- Insufficient perinatal and pediatric services.
- Limited services for chronically ill and elderly, particularly those of low income and the uninsured.
- Lack of health promotion and disease prevention activities.
- Poor health care provider perception of Medicaid services.
- High teen pregnancy rates.
- Inappropriate use of hospital emergency rooms for regular primary care.

Some differences across the state are clearly evident, such as the percentage of providers accepting Medicaid payment. A far higher percentage of primary care physicians in the southwest region of the state accept some level of Medicaid reimbursement for care than in the northern region. Other needs reported by community advisory groups may not directly reflect needs as illustrated by other means. For example, only one district in the eastern region identified teen pregnancy as a problem even though other districts also have high teen pregnancy rates.

Other variations in local need are more apparent in reviewing each district's analysis of its needs assessment. Summaries of those findings as reported by each health district are found on pages 10 - 27 of the full report.

This year's work clearly documents what local communities across the Commonwealth have identified as critical health care needs in their own communities. In 1992, the Advisory Committee will develop cooperative plans for addressing the most critical needs. Many plans will be similar, but each unique to meet that locality's needs, environment, and resources. A final report of these activities will be reported to the Governor and the 1993 session of the General Assembly.

PRIMARY CARE NEEDS ASSESSMENTS
Summary of Findings

INTRODUCTION

Numerous studies, legislative and otherwise, have pointed to the lack of access to comprehensive, available, and affordable primary health care services as a major problem in the Commonwealth. The Commission on Health Care for All Virginians determined that much of the solution to this issue rests at the local level. Senate Joint Resolution 179 (SJR 179) was adopted because the General Assembly understood the uniqueness of primary health care issues in each of the regions of the state and the differences in needs among communities. The General Assembly also realized the importance of local community leadership in assessing and solving these problems with meaningful, multidisciplinary, community-based approaches. Through SJR 179, local health departments are charged with coordinating a community effort to assess local needs and to plan cooperative solutions to the problems found. The first year focus is an assessment of the needs and the second year focus is the development of an initial plan to address the identified needs. This report summarizes the local health departments' needs assessments and findings.

THE PROCESS

Local health department SJR 179 activities have incorporated hundreds of people and perspectives. The importance of community-wide involvement in local primary care needs assessments and planning cannot be over emphasized. Each local health director began by calling for the involvement of local church, government, school, health, minority and other civic leaders. Local advisory committees were created by district directors to obtain the broadest community-based perspective when first analyzing the needs assessment data and then planning for action in year two.

Early in the year at the state level, support for the process was solicited from 26 statewide organizations with local chapters or activities. Representatives from such organizations as the Medical Society of Virginia, the Virginia Municipal League, the Virginia Farm Bureau Federation, the Virginia Association of School Superintendents, and the Small Business Administration, to name but a few, were invited to participate by informing their members about the issue and the actions planned through the resolution. Many included articles in newsletters and did encourage local member participation through meetings and other methods.

The SJR179 charge is of particular importance because, while primary care is not a traditional public health program, the increasing number of person without access to adequate primary care services creates a substantial and expensive demand on secondary and tertiary medical care treatment resources. This demand may otherwise be avoided through adequate and appropriate access to primary care services.

Local health department roles and priorities in this task have required clarification in some communities. Local health departments traditionally provide preventive services, health protection and environmental services, and in some localities are the primary care provider of last resort. While the amount of primary care services provided by local health departments varies by locality, the stated mission of the health department is "...to provide a coordinated prevention-oriented program that promotes and protects the health of all Virginians and ultimately results in optimal health for all citizens of the Commonwealth."

As the work of the year was completed and evaluated, each local advisory committee collectively reviewed local data and together made assessments about the local primary care gaps and causes. Appendix 1 contains the tool provided to district directors to facilitate the work and allow consistent reporting of findings. As expected during this first year's assessment, significant problems concerning the availability and accessibility to primary care were identified in many areas of the state. In some places in Virginia, many simply do not have access to primary medical care because no providers are available, while in other areas, with a plethora of providers, Medicaid recipients and uninsured persons cannot access the physician's care. The problems are varied among and within the state's 35 health districts.

This report completes the first phase of SJR179 activities and summarizes the findings of local advisory committees across the state in identifying primary care needs in their communities. During the second year (1991-1992), these same community groups will develop locally-based plans to address identified needs at the community level. A second summary report will follow at the conclusion of that work.

THE FINDINGS

Any needs assessment relating to primary care access immediately recognizes the vast difference between measurements of availability of health professionals and accessibility to primary care services. Although lack of availability is one form of access problem, the needs assessments have identified a variety of others. These include financial barriers, lack of acceptance of insurance reimbursement, lack of transportation, linguistic and cultural barriers, and lack of knowledge of how to use the health care system properly.

Primary Care Manpower Shortages

The health district needs assessment included the study of the supply and demand for primary care manpower. The methodology employed by the federally funded Community Health Centers throughout the country was used as the standard methodology for manpower analysis in the local needs assessments. In addition, several localities used alternative methodologies and are identified in local needs assessment summaries included in this report.

In recognition of the difference between availability and access, the term medically underserved area (MUA) has been created. It indicates more than availability of physicians (i.e., physician, to population ratios). In Virginia, MUAs are often found in areas where a health care system is lacking. Five criteria are used to designate MUAs: (1) the five year infant mortality rate; (2) the ratio of primary care physicians to population; (3) the percentage of population age 65 and over; (4) the most recent annual rate of unemployment; and (5) the percentage of population at or below 100% of poverty. The most acute medically underserved areas are designated as level 3 (area of high need) and level 4 (area of greatest need). There are currently 69 level three and level four designated medically underserved areas.

Overall, the analysis shows a statewide surplus of primary care manpower of between 81.9 and 117.0 Full Time Equivalents (FTEs). However when the localities with shortages are added together without including those with surplus, a shortage of between 253 and 361 primary care physicians is identified. Appendix 3 provides detailed charts of primary care selected statistics by health district.

Some localities found that while the supply meets the demand in the district as a whole, there are specific areas within the district with primary care manpower shortages. The distribution of providers is skewed to larger towns and cities. Most practices are in fairly close proximity to a hospital or medical center. This distribution leaves many of the smaller localities with a primary care manpower shortage.

An example of this is Lenowisco Health District. The district service area is made of Lee, Scott, and Wise counties, and the city of Norton. The statewide methodology shows no shortage for the district. We know, however, that some localities have very poor access to care. When the distribution of physicians is assessed, one sees that the majority of physicians practicing within the district are doing so in the town of Wise and the city of Norton, both in Wise County. Localities in Lee and Scott are left with few providers.

No Access For the Medically Indigent

Seventy-four percent (74%) of local needs assessments reported the lack of access to citizens not covered by insurance or public funding sources as a substantial problem. Public funding sources provide little assistance for the working poor and those above minimal qualifying income levels. In addition, many middle class working people who cannot get insurance through their jobs and cannot afford coverage are included in this group.

State Medicaid coverage focuses on poor pregnant women, children and the elderly. Medicaid eligibility includes pregnant women and children (to age 6) up to 133% of poverty, all children born after 9/30/83 at or below 100% of poverty, qualified Medicare beneficiaries eligible for both Medicare and Medicaid, and the elderly who through "spending down" for their health care needs qualify for Medicaid. When compared nationwide, the Commonwealth of Virginia's Medicaid program is 44th in eligibility levels, 41st in Medicaid payments per capita, and 41st in average spending per child. While a critically important program for the populations eligible, many are not able to benefit

from this public financing system. The General Assembly makes indigent care appropriations to the Medical College of Virginia, the University of Virginia, and the Medical College of Hampton Roads. The appropriations for MCV and UVA compensate for bills that indigent persons cannot pay and for the associated costs of graduate medical education. The appropriations at Hampton Roads compensate faculty physicians for bills indigent persons cannot pay. To be eligible for monies from these appropriations a citizen must have an income of $8,900 or less and not be eligible for Medicaid. Hospital bad debt due to charity care is partially covered by the Indigent Care Trust Fund with funding from the state and the hospitals that provide less than the state median of charity care.

Many communities identified citizens caught between the Medicaid eligibility limit and a disposable income large enough to purchase care and medications with little ability to access primary care services. This group includes many citizens who work in minimum wage positions as well as working families with no access to insurance.

Transportation

Approximately half of the districts' primary care needs assessments reported that inadequate transportation is a major barrier to care. Transportation as an issue is further exacerbated by the manpower distribution problems within the state. A majority of the localities that are designated as medically underserved areas have transportation problems. In addition, many areas with adequate numbers of providers but with limited access for the poor report transportation difficulties in getting patients to clinics where they can be seen.

Perinatal and Pediatric Care

Sixty-two percent (62%) of the district assessments reported significant gaps in perinatal and/or pediatric care. For children over the age of six and above 133% of poverty and those children with no private or public funding for care, access is the most difficult. For those with Medicaid coverage, finding a physician who accepts Medicaid patients may be difficult. Many of these children end up in emergency rooms with problems that could have been avoided had access been available to a primary care physician who could manage the child's illness.

As has been reported in numerous other studies, access to perinatal care for Medicaid and low income patients is critically important. However, the problem of a lack of access remains as a majority of localities continue to report area physicians who limit or accept no Medicaid or indigent patients.

Limited Access for the Chronically Ill and Elderly

Approximately one third of the district assessments reported an increasing unmet need for services for the elderly and patients suffering from chronic diseases. The gaps are greatest in the low income and indigent populations who have poor access to regular primary and preventive care.

The elderly and the very young are the two fastest growing segments of the Virginia Population. Between 1990 and 2010 the population aged 85 and older will increase 100%. The elderly are the most prone to chronic disease. Continuity in care provided by one physician who knows the patient's medical history is essential for the proper management of chronic disease. Those who have poor access to primary care have far poorer access to care that has continuity. Many citizens with poor access to care end up in emergency rooms with acute conditions that could have been avoided had the illness been properly managed.

A few localities noted significant difficulty in accessing affordable medications required by chronically ill patients. Serious health repercussions and ultimately higher costs await those who cannot afford the drugs required to manage their condition.

Health Promotion and Disease Prevention

Approximately one quarter of the district needs assessments identified poor access to health promotion and prevention services, including screening, as a major problem. There are three components to the problem: (1) few insurance policies offer coverage for screenings, health promotion, or preventive services; (2) the general public does not understand the importance of prevention and screening activities in the prevention and limitation of chronic and debilitating diseases; and (3) those with poor access to primary care may only have or seek access to care during episodes of serious illnesses.

Provider Perceptions of Medicaid

Fifty-six percent (56%) of the district needs assessments reported that physicians' perceptions of the Medicaid program hampered access to care. The negative perceptions included low reimbursement rates for patient care and too much paper work. The chart in Appendix 2 shows the percent of physicians accepting Medicaid by physician primary care specialty. The numbers may not be a good proxy of physicians who see indigent and low income patients, however, as some communities have worked out free or reduced cost care program with physicians for persons not covered by the Medicaid program. In addition, there are discrepancies between localities that counted full time equivalents and localities that counted each provider accepting Medicaid.

Teen Pregnancy

Approximately one third of the district needs assessments reported teen pregnancy as a significant problem in their community.

Inappropriate Use of Emergency Rooms

Approximately one fourth of the district needs assessments cited the inappropriate use of emergency rooms as a major problem. Citizens with poor access to care, those who cannot seek care during the working day and those do not know where to access care may use the emergency room as their first source for primary care.

SUMMARIES OF FINDINGS BY LOCALITY

The chart on Page 9 graphically illustrates the frequency in which the nine preceding problem areas were identified with each of the four Virginia Department of Health regions. Some differences are clearly evident. For example, a far higher percentage of primary care physicians in the southwest region of the state accept some level of Medicaid reimbursement for care than in the northern region. The chart only exhibits the needs as identified by the community advisory boards, however, and may not reflect a need as defined in other terms. For example, only 1 district in the eastern region identified "teen pregnancy" as an issue for that community. However, a number of other districts in that region exhibit high rates of teen pregnancy.

Other variations in local need are more apparent in reviewing each district's analysis of its needs assessment. Pages 8 - 24 summarize those findings as reported by each health district.

FINDINGS BY LOCAL HEALTH DISTRICT

NORTHERN REGION

Central Shenandoah

Waynesboro, Lexington, Rockingham, Harrisonburg, Bath, Buena Vista, Rockbridge, Augusta, Staunton, and Highland

Each service area within the district was assessed for supply and demand for primary care providers: Service Area 1: Rockingham – Surplus, Service Area 2: Highland/Augusta -- Deficit (2.5 - 3.6), Service Area 3: Lower Augusta – Deficit (1.96 - 2.8), Service Area 4: Rockbridge – Deficit (1.99 - 2.8), Service Area 5: Bath -- Surplus, the total area has a surplus due to Rockingham and Bath County surpluses.

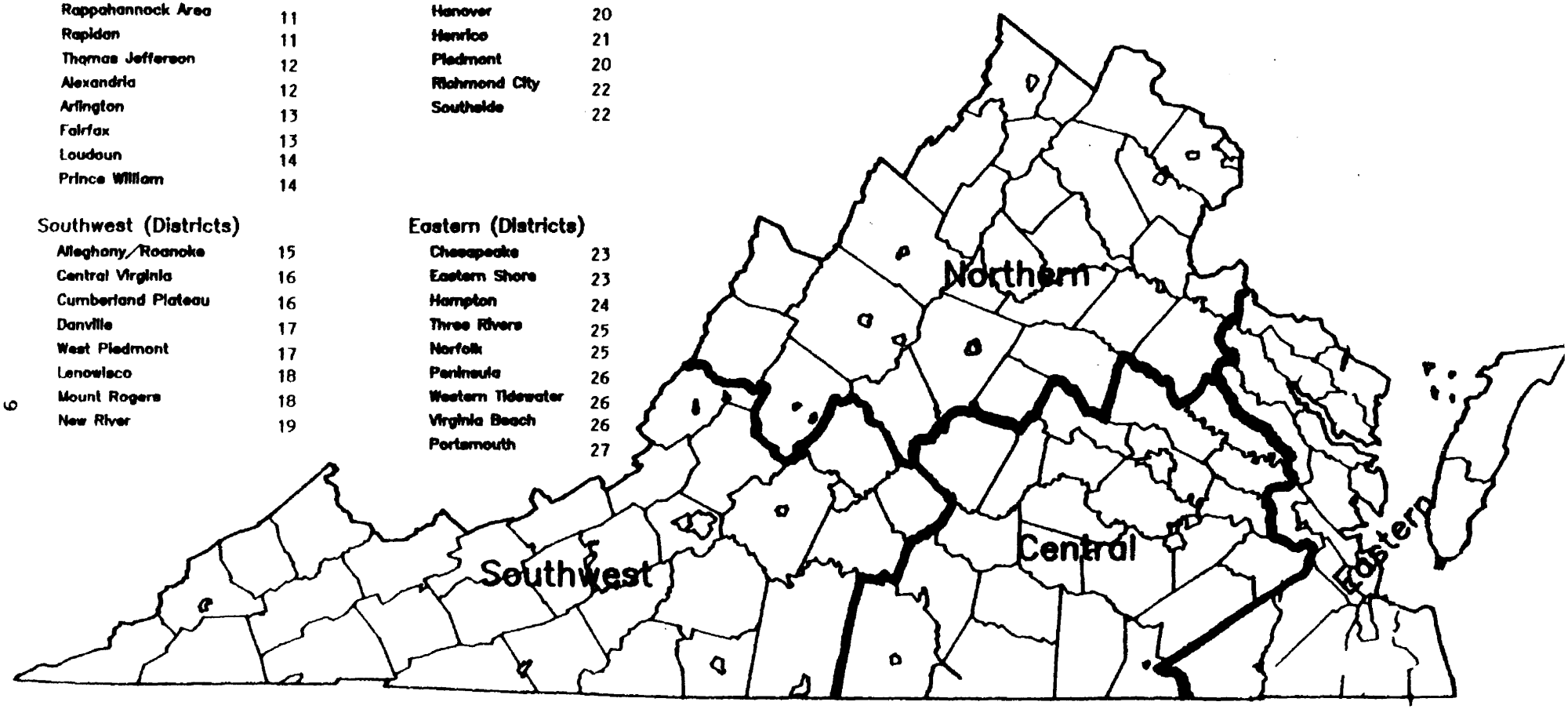
The review team identified the following health care problems in this district: Access to care – shortage of doctors, lack of insurance for working poor, need to increase funding for rescue squads; teen pregnancy; increasing aging population -- need for preventive health education and better understanding of how to use the system; need to improve the Medicaid system (transportation, the need for reimbursement for syringes and not just insulin, and reimbursement for hearing aids); need for more health education for all in community; need for adult indigent dental services.

Lord Fairfax

Clark, Page, Shenandoah, and Warren Counties, and Winchester

Overall assessment of the district finds a surplus of primary care physicians. Resources supplementing private practices include a free clinic near Winchester, a migrant clinic in Winchester, and a voluntary Medicare assignment agreement between Virginia Medical Society and Shenandoah Area Agency on Aging. However, while access is adequate in the northern portion of the district, some limitation is found in the lower three counties: Clarke/Frederick/Winchester – Surplus, Page – Deficit (2.13 - 3.00), Shenandoah – Deficit (1 - 1.6), Warren – Surplus.

Public Health Regions



Rappahannock

Fredericksburg and Counties of Caroline, King George, Spotsylvania, and Stafford

King George and Caroline Counties have been designated as medically underserved for some years. The district is served by Mary Washington Hospital in Fredericksburg. Rapid population growth has outstripped the local medical resources as evidenced by a calculated deficiency of between 28 - 40 primary care providers. Easy access to Washington, D.C., Richmond, and Charlottesville provides a safety valve.Morbidity and mortality data suggest that the population enjoys a level of health equal to that of the rest of the state. Nevertheless, the impression of the voluntary and governmental agencies who provide public services is that the uninsured and low income patients have great difficulty in obtaining primary medical care locally. Few physicians accept any Medicare or Medicaid patients. Mary Washington Hospital reports that its emergency room is in fact used as an outpatient clinic. The health department provides only prenatal, well baby, WIC, MICC, STD, and immunizations services. There are interstate bus and rail connections to the north and south but no intradistrict public transportation services. The medical society, health department, and hospital are working together to address this situation.

Rappahannock-Rapidan

Orange, Culpeper, Fauquier, Madison, and Rappahannock

Poverty rate is slightly higher than the state. Neither of the two hospitals has outpatient clinics. The district, especially Fauquier, is thought to be heavily served by contiguous providers. The health department methodology shows a deficit of 12 -- 17. The Community Health Care Committee felt that if correction is made for care being provided in contiguous areas, the deficit is 10 -- 12. Most of the deficit is from Fauquier. Obstetrical care is available only in Culpeper and Fauquier.In Culpeper, care is available within one week. In Fauquier, care is available in two to six months. In Culpeper, only one pediatrician and one family practitioner accept Medicaid for new patients (9 out of 15 providers). An additional physician accepts patients referred from the emergency room. Weekend and after hour abuse of emergency rooms appears to be a problem. Access to care for migrant workers is a problem

Thomas Jefferson

Charlottesville, Albemarle, Green, Nelson, Louisa, and Fluvanna

There is a surplus of physicians and primary care services (PCS), but distribution is a serious concern. One third of the population lives in four rural counties which together posses only 13% of the PCS. In Fluvanna and Greene there is one physician for every 10,300 persons, in Louisa one per 3,400, and in Nelson one per 2,300 (nurse practitioners included).

Two-thirds of the district's PCS are provided by physicians in private practice, one-quarter by UVA components including student health and emergency room, and the rest from a variety of sources including health departments. As a major state and national referral and tertiary care center, UVA provides relatively little primary care (equivalent to 17 MDs plus ER), and much of it is for non-district residents.

Transportation is the greatest barrier for rural residents. Financial access is of some concern with half of the physicians unwilling to see new Medicaid patients. Affordable, accessible prenatal services are the greatest need. The types of health problems are similar to those statewide with no single major concern. A variety of health promotion and prevention services are available, but more are needed with better accessibility. Despite the medical sophistication of a large segment of the community, the district has significant areas of primary care need.

Alexandria

City of Alexandria

Medicaid, Medicare assignment, and uninsured patients in the City of Alexandria probably experience the greatest financial barriers to care. Financial obstacles are particularly acute for women's health care patients with Medicaid or no insurance. The primary care need in this district could be met with a combination of local health department services and a maximum of 6% of private sector physicians' practices committed to Medicaid and indigent patients. The homeless population in the City of Alexandria is twice the proportion of the homeless population in the state. Cultural, linguistic, and physical access barriers are problems. Although there is a surplus of physicians, access for Medicaid, Medicare, and uninsured patients is difficult.

Arlington

Arlington County

There are limited low cost or free services available to those who cannot afford to pay. As many as 8,000 residents are thought to be undocumented and therefore ineligible for Medicaid assistance. Although there is a sufficient number of physicians, several medical facilities and physicians provide a disproportionately large share of the pro bono or reduced cost medical care. Most indigents can access emergency care, but few can access ongoing care for chronic conditions. There are also access problems with ancillary services. Language barriers exist and hamper the communication of information about available resources. Many of those with poor access do not understand the need for preventive and routine care. From the district's Health Care Program Summary Sheet: large number of undocumented multicultural residents; high incidence of AIDS/STD; increasing incidence of tuberculosis; lack of dental care.

Fairfax

Fairfax County, Fairfax City, and Falls Church

The Fairfax Health District illustrates how coordination and cooperation of public health and private practitioners can benefit the community and impact upon access to care barriers. The needs assessment shows a surplus of providers in general. A county primary care program, Community Health Care Network, public health clinics, and the Fairfax Hospital obstetrics clinic now offer additional access to care. Based on actual FY 1991 experience, these problems provide the capacity of 72,221 visits per year. This includes 17,000 visits to the Fairfax Hospital OB clinic, 20,459 visits to

the two county primary care centers, 13,273 MCH visits, and 21,489 adult health clinic visits. Even with the extended community efforts, access problems continue for some low income and uninsured residents. The Department of Community Action and the health department administer health programs to serve low-income, uninsured county residents. The Department of Community Action has designed programs of the working poor who earn too much to qualify for Medicaid.

Three programs designed to bridge the gap in primary care services have been developed: Medical Care For Children Project (MCCP) – a series of public/private partnerships, uniting county government, the medical and business communities, and the private sector to provide medical care for indigent children from one month to age 18; Low Cost Adult Health Care – designed to address treatment of acute medical conditions for low income, uninsured adults; and Community Health Care Network (CHCN) – the health department's primary care program made up of two county health centers staffed and managed through a contract with the PHP Health Care Corporation, community hospitals providing needed non-subsidized inpatient acute care on a charity basis, private physicians providing charity or reduced fee care, and churches and voluntary agencies which assist the CHCN patients with medical expenses not covered by the program through donations to the Patient Assistance Fund (PAF). To qualify for services under this program, a person must be a resident of Fairfax County or the City of Falls Church, have a family income below 200% of poverty, and have an absence of private insurance covering outpatient care.

Even with these efforts, the district reports concern: lack of availability of dental and eye care for low income persons, limitations regarding financial access to care, language/cultural diversity within the population, teen pregnancy and low birthweight babies, and health care for the elderly.

Loudoun

Loudoun County

While analysis of the supply of physicians in the county reveals a surplus, there is maldistribution of physicians and dentists with a relative surplus in well developed areas of the district. Head Start and day care services are marginal. Teenage pregnancy is a significant problem, yet resistance of local communities to family life education is evidenced by the withdrawal of 800 pupils. There is no school health program. The local health department is just beginning to extend home visit services to maternity and newborn patients. Very few local physicians and no dentists were found to accept Medicaid patients.

Prince William

Prince William, Manassas, and Manassas Park

Market place dynamics are largely influenced by the dominance of INOVA Health System in the region. Many primary care physician groups maintain offices in Prince William as well as in other areas of Northern Virginia. Many other physicians market services heavily in the Prince William area, but do not maintain local offices. Both groups use Fairfax Hospital facilities for hospitalization. With the advent of HMO's with local offices, the shift away from hospital services in Prince William has increased even more. This trend is particularly apparent in obstetrics – half of the babies born to District residents are born in hospitals outside the District. The burden of primary care for the indigent has fallen on local hospitals and physicians, since the HMO's and out-of-county physicians and hospitals do not serve Prince William indigent.

Acute care for the medically indigent is provided largely by the two local hospital ESD's or arranged through Healthlink, a private, non-profit program which links patients with acute care services for a greatly reduced fee. Prenatal care at the health department is available only for Income A and Medicaid patients. A clinic at Potomac Hospital sees some patients who do not qualify for health department prenatal services, but who cannot afford full fee care privately. Using state methodology, the district has a deficit of 39 - 56 FTE primary care physicians, primarily in OB/GYN and pediatrics. Special problems include the need to develop local capability to provide primary care to AIDS/HIV patients and special needs of pregnant teenagers.

SOUTHWEST REGION

Alleghany/Roanoke

Alleghany, Craig, Botetourt, and Roanoke Counties, and Cities of Roanoke, Salem, Covington, and Clifton Forge

The Needs Assessment Study Group felt that the methodology for determining physician supply was poor. Letters expressing concern were included in the local needs assessment report from the chief of staff at the V.A. Medical Center, the director of ambulatory medicine at Roanoke Memorial Hospitals, a Carillion Health System planner, and a joint letter from the group's chairs: Ken Cook (Southwest Health Planning Agency), Dr. Donald Stern (Roanoke District Health Director), and Dr. Molly Hagan (Alleghany District Health Director). Reasons for concern included: no mechanism for including the effects of regionalization; the 4.1 visits per person per year seemed inaccurate to the group; three populations (those at poverty level, the elderly and all other) should be assessed individually.After some debate, the somewhat controversial GMENAC physician-to-population ratio was used. The group projected a deficit of 31 FTEs. The statewide methodology calculates a surplus. The breakdown of physician distribution is not given in the needs assessment, but it is known that a substantial number of patients come to Roanoke from outside the planning district.

Initial health status indicators and major concerns included teen pregnancy, lifestyle behaviors that put citizens at risk for disease, infant mortality, and hypertension. Populations of major concern are indigent and black populations. Major barriers to primary care included cost of child care, cost of medications, physicians' attitudes towards Medicaid (Medicaid patients), and transportation.

Central Virginia

Cities of Bedford and Lynchburg and the four counties of Amherst, Appomattox, Bedford, and Campbell

One third of the total district population is in Lynchburg. Most health needs are met in private offices located in or around the cities of Lynchburg and Bedford. Rural care is provided by a few local area physicians or by travel to urban areas. There are several free-standing walk-in centers.In Lynchburg the health department, in cooperation with the Lynchburg Academy of Medicine, has offered primary care services to people meeting established eligibility guidelines. Lynchburg General's emergency room is used for primary care for those who cannot or will not seek other sources of care. Campbell, Appomattox, and Amherst have no pediatricians, OB/GYNs, or general internists.Bedford has one OB/GYN and no pediatricians. A deficit of 2.9 to 4.2 primary care physicians was calculated. These physicians are needed to see Medicaid, Medicare, and indigent patients.Health Care Program Summary Sheet: Indigent health care is limited; lack of knowledge concerning the appropriate use of the system; teen and illegitimate pregnancy; lack of available care for Medicaid/Medicare patients; no pediatricians or OB/GYNs accept new Medicaid patients; most family practice physicians will see only if family member is a patient already, or on a very limited basis.Minority areas have no or very limited health care. Many rely on the emergency room for care.

Cumberland Plateau

Buchanan, Dickenson, Russell, and Tazewell Counties

Providers in Grundy, Bluefield, and Tazewell areas serve some Bland County and West Virginia residents. However, the number of Cumberland Plateau residents seeking care outside the district is more than the population served from outside the district. District residents also obtain care in Bluefield, West Virginia, and in Abingdon, Bristol, and Wise.State methodology calculates a deficit of 4 to 6 primary care FTEs. Six may be more in order due to the large population of children and elderly. Six primary care physicians will retire next year. Physician offices cluster around hospital locations -- Richlands, Tazewell, Grundy, Lebanon, Clintwood, and Bluefield, West Virginia.Clustering exacerbates the primary care deficit problem because many patients must travel 15+ miles on mountainous roads to reach the nearest doctor. A large number of physicians have offices in Tazewell County. Transportation is a particular problem for obstetrical patients because, at present, the only OB services are in Richlands. Some patients feel that physicians schedule more visits than necessary,

both per patient and per day, in order to increase their income. In its Health Care Problem Summary Sheet, the district reports the following issues: teen pregnancy, black lung, accidents; over/under utilization of providers caused by reluctance to see providers whose English is poorly understood; poor access for uninsured and low income; low reimbursement; and public perception of low quality of care.

Pittsylvania-Danville

Danville City and Pittsylvania County

Based on the needs assessment worksheets, a minimum of 14.5 FTEs and a maximum 20.7 FTEs were calculated as needed in this district. Currently, there are 38.5 primary care FTEs in the district. The minimum additional FTEs needed to meet the shortfall would require an increase of 38% over the existing resources.

Most of the physicians are located in and around Danville. There is one physician in the northern part of Pittsylvania County, three FTEs in the central part, two in the western part, and none in the eastern part of the county.

Lack of health care for the district's indigent population is a significant problem. Twenty-two of the primary care physicians accept new Medicaid patients routinely. However, the availability of care to Medicaid patients differs greatly according the type of patient. Health care funding by Medicaid to some categories of patients is fairly limited. Significant numbers of patients lack insurance and are not covered by Medicaid. The health department and the Sandy River Community Health Center are the only two facilities routinely offering primary care on a sliding scale fee basis.

Pediatric care for the indigent is a special problem. Only one of the full-time pediatricians routinely accepts Medicaid patients. Four family practitioners provide some pediatric care and also accept Medicaid.

West Piedmont

Franklin, Patrick, and Henry Counties and the City of Martinsville

Each locality in this district is designated as either a Medically Underserved Area (Henry, Patrick, and Martinsville), or a Health Professional Shortage Area (Franklin and Patrick). Each locality has a higher percentage of its population below 200% of poverty than that for the state as a whole.

The needs assessment showed a deficit of between 27.3 and 39 primary care physician FTEs. Significant problems exist in Henry County and Martinsville, where a shortage of maternal care providers for indigent women exists. District hospitals do not operate outpatient primary care services, and no other primary care clinics are available to residents. Other significant problems facing the district and noted on the report's Health Care Problem Summary Sheet include homicide and suicide, and the threat of small hospitals discontinuing deliveries.

Lenowisco

Lee, Scott, and Wise Counties and the City of Norton

Many in Lee County seek care in other states. The number of young and aged are higher than the national average proportionally. Primary care providers are located predominantly in the county seats and larger towns. The largest number are in Wide, and Norton in Wise County. Norton has the largest concentration of physicians. Many residents of Scott County receive care in Kingsport. Physicians there estimate that between 10 - 15% of their patients are from Scott County. OB services are in Norton, Wise, and in Big Stone Gap. Lee County is without an OB, although one is being recruited to replace the one who left two years ago. There is no hospital in Scott County. Lee County and northern Scott County OB patients often have more than fifty miles to travel to a provider. High risk patients go to Tennessee. Transportation is a big problem. Using the methodology, Lenowisco has a small surplus of physicians. There is a public perception that physicians schedule more visits per day and more visits per patient than feasible or desirable due to low reimbursement. Health Care Problem Summary Sheet: Accessibility -- few evening or Saturday hours, waiting time, transportation; financing -- low income and indigent; perception of low reimbursement rates; black lung; need to educate people on appropriate access and utilization of services.

Mount Rogers

Bland, Wythe, Smyth, Carroll, Grayson, and Washington Counties and the Cities of Galax and Bristol

The Mount Rogers District localities rank among the four lowest per capita incomes in the state; and the adjusted gross income is ranked lowest among the state's Planning Districts. Of the 12,235 persons eligible for Medicaid, only 9,435 are actually recipients. While two interstate highways course through the District, the terrain is largely mountainous and there are no large population centers. This often produces long difficult travel to medical providers for the predominantly rural populace. The District borders Tennessee, West Virginia, and North Carolina, with many residents seeking primary care and/or referral to tertiary medical centers in Winston-Salem or Durham, and Johnson City/Knoxville. A District shortage of obstetricians, compounded by maldistribution, has led to a very tenuous situation regarding assured delivery, especially for the indigent. High poverty rates, a higher than average number of un- or under-insured, and very low reimbursement rates have contributed to a current deficit of primary care physicians of between 19.7 and 28.1 FTEs. Each county in the District has been designated both as a Medically Underserved Area and Health Professional Shortage Area.

New River

Montgomery, Floyd, Giles, and Pulaski Counties and the City of Radford

The population below 200% poverty averages 8.6% higher than the state. Access to primary care is complicated by the following factors: 35% of persons eligible for Medicaid are not enrolled, only 64.2% of primary care physicians serve Medicaid clients, and only 45.7% accept Medicare assignment. This population is uninsured or underinsured because they work for hourly wages or small businesses that do not offer insurance. Unemployment is another factor. The unemployment rate in all localities, ranging from a high of 14.8 in Giles to a low of 10.1 in Pulaski, is higher than the State's rate of 4.2%. Of the five political jurisdictions, four have hospitals. Floyd residents travel to

contiguous areas for hospital care, including delivery. Mountainous roads lengthen access time to hospital and primary care sources. The statewide methodology shows a surplus of primary care physicians; however, university physicians serving an estimated university population of 31,000 are included. Health care problems identified on the summary sheet include: inadequate transportation; teenage pregnancy; alcoholism/substance abuse; stress related mental health concerns; poor nutrition/obesity; AIDS; incapacitating diseases of the aging; dental care for indigent adults; numerous medically uninsured or underinsured and under utilization of available services.

CENTRAL REGION

Chesterfield

Chesterfield and Powhatan Counties, and the City of Colonial Heights

Chesterfield and Powhatan are rapidly growing areas of the state. Access to indigent and low income patients is affected by a lack of public transportation, Medicaid/Medicare funding, and the number of physicians accepting Medicaid/Medicare patients. Chesterfield has 29,717 individuals with incomes below 200% poverty level. The Chesterfield Advisory Board feels that an upward adjustment in office visit capacity would improve the methodology. The statewide methodology shows a deficit between 1.08 and 1.54 FTEs.

Crater

Petersburg, Emporia, Hopewell, Prince George, Sussex, Surry, Dinwiddie, and Greensville

Crater used the statewide methodology, but was concerned that the numbers used in the formula to estimate "annual expected office visits" for primary care providers grossly underestimates the actual number of annual office visits provided by primary care physicians in the District. The distribution of physicians is a problem. Some rural areas have few accessible physicians. A deficit of between 6 - 9 physicians was calculated for the District. Limited availability of transportation and an increased number of low income residents with no insurance coverage are also issues that impact on accessibility in this area.

Hanover

Charles City, Goochland, Hanover, and New Kent Counties

Chronic diseases account for the bulk of productive life years lost. Major barriers to care are lack of: finances or health insurance, transportation, and knowledge of how and where to access services.

In addition, there is a calculated district deficit of 7.2 to 14.9 primary care physician FTEs depending upon the ratio of patient visits per physician used. The most noted absence of specialty is OB/GYN, one of whom practice in Goochland or New Kent Counties. Similarly, no pediatricians practice within Goochland, Charles City, and New Kent. According to a physician survey, however, there is a relatively high level of participation in Medicaid, as is typical with the rural areas. Also, a substantial number of practitioners provide some free care and make house calls.

It is felt that the SJR 179 process has strengthened the relationship between the health departments and the private sector. However, it is recognized that resolution of these problems will require both substantial planning, coordination, and especially resources.

Piedmont

Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward

Surrounded on three sides by the metropolitan areas of Richmond, Charlottesville, and Lynchburg, the district is entirely rural with no interstate highways and no major municipal water or sewage systems. The principal town, Farmville, located centrally in the district, has the district's only public transportation system and is the site of the district's only hospital with its associated groups of the medical specialists including three Obstetrician/ Gynecologists.

One of the most sparsely populated districts, Piedmont's per capita personal income level is the third lowest in the State. Six of the seven counties are medically underserved and five meet the criteria of federally designated Health Professions Shortage areas.Sixteen percent of the population is over the age of 65 years, but only fifty percent of providers of primary medical care in the District accept Medicare assignment.

Health care needs are great in Piedmont as evidenced by the high infant mortality rate, high percent of low birth weight infants, high teen pregnancy rate, lack of primary care providers, lack of access to routine and preventive care for the working poor, and increasing proportion of the population over 65 years of age. Health education, education regarding secondary prevention, provision of affordable health maintenance, and affordable pharmacy services are needed to combat the toll in years of productive life lost to chronic disease.

Henrico

Henrico County

Henrico County has a general population of 218,000, which requires approximately 670,000 primary care visits per year. There are 261 primary care physicians practicing in Henrico, and the medical establishment of the County (physicians, hospital out-patient departments, and health department clinics) is capable of providing 1,336,664 primary care visits per year, or approximately double what is needed by the population.

We interpret this to mean that there is no shortage of primary care providers in Henrico; in fact, there are easily more than enough providers to meet the need of Henrico residents. Excess visits beyond what is required for Henrico residents are probably being provided to out-of-county residents from the surrounding metropolitan area who travel to Henrico to receive their care.

Approximately 60% of the total of primary care providers are also Medicaid/Medicare providers; however, only 25% of OB/GYNs accept Medicaid.

Even though it is clear that Henrico is a physician-rich area in terms of primary care, there are issues to be addressed:

1) the low percentage of OB/GYNs who accept Medicaid;

2) the primary care needs of the working poor (employed, do not qualify for Medicaid, income near the poverty level, have inadequate or no health insurance) who cannot afford care; and

3) the inability of the health department to meet the demand for care from indigent clients.

Richmond City

City of Richmond

Richmond City is urban with a large minority population. It is subdivided by census tracts into Northside, East End, Downtown, Southside, Near West End and Far West End. There are vast differences from one end of the city to the other in primary care needs. The East End is predominantly non-white and is designated medically underserved. The Far West End is predominantly white with an array of resources. While 26,929 persons in Richmond are eligible for Medicaid, only 12,899 (less than half) are enrolled as Medicaid recipients.

The physicians on the Advisory Board believe that office visits per physician vary between 21.3 and 10.7. Many believe that the number of visits per year has increased with more visits from chronic diseases among the elderly. Resources for the indigent include MCV's A.D. Williams Clinic, MCV Non-acute Emergency Department, MCV Pediatrics Emergency Department, Crossover Clinic, Fan Free Clinic, Street Center, Planned Parenthood, and the Richmond City Health Department Clinics. The MCV Emergency Department is used inappropriately by a large number of patients. The distribution of physicians is skewed away from areas with high indigent populations. The methodology shows a surplus of physicians.

Health Care Program Summary Sheet: Lack of adequate prenatal care and pregnancy prevention; homicide; chronic diseases; substance abuse, HIV/AIDS; need to educate citizens about services available and how to access them.

Southside

Halifax, Mecklenburg, and Brunswick Counties, and the City of South Boston

The Advisory Board states that some physicians see far in excess of the number of patients as prescribed in the annual office visits for physicians in the methodology. The emergency room is inappropriately used on weekends and after hours due to access barriers including the unavailability of physicians, the lack of transportation, patients unable to see a physician during working hours, and affordability problems. There is a large population below 200% of poverty in this district. The unemployment rate is currently double the state rate. A deficit of between 4 and 6 primary care FTEs is calculated using the statewide methodology.

The Health Care Problem Summary Sheet indicates a lack of pharmacy services; lack of patient transportation; lack of vision care and dental care for the indigent; lack of insurance; illiteracy and Spanish speaking clients; inappropriate use of the emergency room.

EASTERN REGION

Chesapeake

City of Chesapeake

The needs assessment methodology calculations show a deficit of between 10.3 and 14.7 physicians. Transportation is the major concern for residents in need of primary care services.

Chesapeake Health District's action to address adult primary care needs (CHAMP) is a public/private initiative designed to provide primary care and pharmacy services through the Adult Clinic in cooperation with private physicians. The health department Adult Clinic has a caseload of 700 chronically ill adults and a waiting list of 200. The population has grown at an average rate of 3.3% per year since 1980. This trend has produced a 56% increase in poverty in the last five years. A similar program for children, CHIP, is being initiated in Chesapeake. A mobile clinic was acquired through the Texaco overcharge program. The clinic will provide pediatric/adult medical and family planning clinics. The unit is a shared effort with the Portsmouth, Virginia Beach, and Newport news Health Departments.

Other issues noted on the district's Health Care Problem Summary Sheet include: lack of adequate pediatric care (only 16% of those at or below 133% poverty and eligible for EPSDT received services in 1989-90); need for more personal care and home health services as the elderly population continues to increase the need for a health department pharmacy; the need for adequate staffing to meet needs of a rapidly growing city.

Eastern Shore

Accomack and Northampton Counties

The Eastern Shore District is connected to the Eastern Shore of Maryland on the north and separated from the Virginia mainland by the Chesapeake Bay. Northampton County has the highest poverty ranking of any county in the Commonwealth. Accomack County ranks 131/136 in state per capita income.

The recruitment and retention of physicians on the Eastern Shore is a critical problem. In the past two years, three pediatricians and three family practice physicians have left the area. Two family practice physicians were lost due to retirement and death. Those under 18 and the elderly have the highest demand for primary care services. There is a strong need for preventive services. There is an unsatisfactory visit status of 18,320, a strong indicator of the critical shortage physicians in this area. The retention of physicians and retirements make this region volatile of underservice.

Hampton

City of Hampton

Forty-two percent (42%) of the population is non-white and 32.9% of the population lives below 200% of poverty. Three different methods used to analyze the supply and demand of primary care physicians. The statewide method indicated a shortage between 8.94 and 12.94 primary care physicians; a modified method using AMA physician marketplace statistics, 1990 for annual physician office visits indicates a shortage of 18 primary care physicians. The third method used 1980 GMENAC physician-to-population ratios and indicates a 38 FTE shortage. There is a lack of physicians accepting new Medicaid patients and a large number of older physicians. Thirteen (13) of the existing primary care physician on Sentara Hampton General Hospital's medical staff are older than age 60.

The most frequently cited barrier to Medicaid recipients' access to care has been the perception of low Medicaid reimbursement that does not allow the physician to meet practice costs. The chairman of Emergency Medicine at Sentara Hampton General says there is a shortage of accessible primary care of all types. Dr. Schmidt has seen an increasing number of patients presenting in the emergency room who have been unable to find appropriate primary care and have developed an emergency condition that may have been preventable.

Three innovative approaches to providing medical care for the indigent have been developed in this district. The Hampton Physician Care Cooperation was formed by Hampton obstetricians to provide delivery services to indigent women. The Hampton Health Department provides the prenatal and post-partum care. The City of Hampton, in cooperation with the health department, provides all patient and third party billing and collections activities. The health care demonstration project for infants, children and adolescents required the development of liaisons between the hospital, the emergency room, the private physicians, the public schools, and other social service providers. Sentara Hampton General Hospital provides acute ambulatory care in the emergency room when the department's clinics are not in operation. The private pediatricians provide inpatient hospitalization when necessary. AIDS care is provided to the indigent through cooperative efforts between the Hampton Medical Society and the Peninsula AIDS Foundation.

Three Rivers

Essex, Gloucester, King and Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond, and Westmoreland

There are only nine incorporated towns in this 2,000 sq. mi. district, the largest of which has a population under 3,200. Four of the ten counties have no incorporated area. In general, primary care physicians are clustered in the counties of Essex, Gloucester, and Lancaster (where the hospitals are located). Six counties are considered medically underserved and four are on the Federal List of Health Professional Shortage Areas.

The statewide methodology indicates a shortage of primary care physicians between 12 and 17. Correcting for primary care visits to the three hospital emergency rooms (which are not staffed for such visits), the indicated physician shortfall rises to the range of 15 to 23. Prenatal care is offered by only seven of 54 private primary care physicians; only one does deliveries in the District; about 75% of deliveries to district residents take place in Richmond City, Hampton Roads, and Fredericksburg, all one to two hours away by road. Six counties have disproportionately high numbers of elderly; five of these also have elevated rates of poverty. Overall, 21% of all private patients are reportedly without health insurance of any kind. An additional major barrier to care is the lack of public transportation.

Norfolk

City of Norfolk

Almost half of Norfolk's population is below 200% of poverty, and 20.7% is the population below 100% of poverty. The statewide methodology indicates a surplus of primary care physicians. However, the advisory committee found that primary care clinics are crowded, too many emergency room visits are for primary care, too many people are hospitalized due to inadequate maintenance care for chronic diseases, and health indicators continue to show morbidity and mortality rates exceeding the state averages. The committee also believes that since Norfolk serves as the region's tertiary care center, a significant percentage of the medical capacity is filled by residents from other jurisdictions. The Health Care Problem Summary Sheet indicates the advisory committee identified the following problem areas: Communicable diseases; infant mortality; substance abuse; adolescent health.

Peninsula

York and James City Counties, Williamsburg, Poquoson, and Newport News

Except for some residents living in the westernmost part of the district, all are within 30 miles of a hospital. The percent of people living 200% below poverty is high. Although the majority of private physicians in the district do not accept Medicaid assignment, the City of Newport News still has one of Virginia's highest total expenditures for Medicaid. Only 13% of the general and family practitioners, 26% of the general internists, 10% of the obstetricians and even fewer pediatricians accept Medicaid patients. Still less will see new indigent patients that have no payment source.

The statewide methodology indicates a surplus of primary care physicians within the district. This surplus may be misleading, since residents of other areas such as Hampton, Middle Peninsula, and Hanover health districts use the primary care services in Peninsula. The care of low income residents, specifically non-Medicaid eligible adults and after hour care of children, poses a significant problem.

Western Tidewater

Cities of Suffolk and Franklin and the Counties of Southampton and Isle of Wight

The area is mostly rural. The percent of those at or below 200% poverty in Southampton in 46.7%. There is a large non-white population and a large proportion of elderly. The district-wide methodology indicates a deficit of between 2.7 to 3.8 FTEs. The deficit is underestimated, as emergency room visits were included in the supply of primary care resources. Public transportation is a major barrier to care. The vast number of physicians are clustered in three areas: Suffolk City near Obici Hospital, Franklin City near Southampton Memorial Hospital, and the town of Smithfield in Isle of Wight County. The breakdown of primary care physician surplus/deficit is as follows: Suffolk City -- surplus; Franklin City -- surplus; Isle of Wight County -- deficit 7.01 to 10.02; Southampton -- deficit 5.81 - 8.31.

Virginia Beach

City of Virginia Beach

Between 1980 and 1990, the population of Virginia Beach grew by nearly 50% to 393,069. The black population doubled to 55,000 and the Asian population climbed 159% to 17,025. Service industry jobs (which do not typically pay health insurance) and the military are the largest employers, and 26.3% of the population is estimated to be at or below 200% of poverty. Women of child-bearing age (15 - 44) and children (0 - 17) numbers in the City are greater than State or National norms by 5.8% and 3% respectively. These are also the ages with the greatest number of medical indigency. Primary care services for indigents in these age groups (and males 15 - 44) are provided by the health department, a small volunteer clinic, and the hospital emergency rooms. (The two Virginia Beach hospitals do not have outpatient clinic capabilities.)

Primary care for indigents is a critically needed service. Significant health care problems reflecting this need are: low birthweight; infant mortality rate; teen pregnancies; sexually transmitted diseases; HIV infection; and adult primary care for the medically indigent.

Portsmouth

City of Portsmouth

The needs assessment shows availability/accessibility of health care for indigents a major problem with need for more health services, improved transportation, and increased funding. Affordability is also a problem, especially with medications. No 24 hour pharmacy is available. Private physicians do not accept indigent patients except on an emergency basis. Emergency rooms frequently are used for primary care services. From 35% - 55% of emergency room visits are made by indigent clients, and 75% of these are not emergencies. There are barriers to receiving care such as long waits for appointments for routine medical services and excessive waiting time.

There is a need for coordinated, comprehensive services for substance abusing pregnant women/mothers and infants. There are environmental health issues, such as lead poisoning, sand-blasting, mercury poisoning, stackgas, fumes from vulcanizing ships, pollution of the river, and asbestos related lung disease. There are over-crowded public housing conditions and inadequate housing for indigents, especially adult males. There is a lack of sufficient data on health care services. The statewide methodology shows a deficit of between 1.8 and 2.7 primary care FTEs. The Mayor's Commission felt that the methodology did not accurately reflect the need (number of primary care visits) or the supply because of the failure to consider special needs of Portsmouth's large indigent population with 40% at or below 200% of poverty.

CONCLUSIONS

The past year's work clearly documents what local communities across the Commonwealth have identified as critical health care needs in their own communities.

Local advisory committees have already begun work on the cooperatively developed plans intended to address the most critical needs found during the past year. Many of these plans will be similar, but each will be unique to meet that locality's needs, environment, and resources. All of the plans, to be completed by July 1992, will speak specifically to child health needs and obstetrical care needs in each community, and each will identify a lead agency to facilitate implementation of the plan.

A final report of these activities will be presented to the Governor and the 1993 session of the General Assembly next year at this time.

1991 SESSION

LD9089137

SENATE JOINT RESOLUTION NO. 179

Offered January 16, 1991

Requesting each district health director within the Virginia Department of Health to assess his district's primary care needs and to develop a cost effective plan to meet those needs.

Patrons—Walker, Schewel, Holland, E.M., Holland, C.A., Miller, Y.B. and Macfarlane; Delegates: Quillen, Marshall, Glasscock, Stieffen and Heilig

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Referred to the Committee on Rules

WHEREAS, a goal of the Commonwealth is that each Virginian have access to a health care delivery system for the provision of primary care that meets his needs; and

WHEREAS, primary care is continual health care and services that include prevention, maintenance, diagnosis, treatment, and management of most illnesses; and

WHEREAS, the Commission on Health Care for All Virginians has in its history studied primary health care and recognized its provision to the citizens of the Commonwealth as critically important in the continuum of health care services; and

WHEREAS, that emphasis on strengthening and expanding primary health care has included several initiatives engendered by the Commission on Health Care for All Virginians and adopted by the General Assembly, including appropriations for $1 million to establish four primary care pilot programs in the Commonwealth as a means to enlarge access and availability to primary care; and

WHEREAS, an individual's entering the continuum of health services at the primary level of care rather than requiring tertiary or secondary care mitigates both personal suffering and personal financial expense; and

WHEREAS, the provision of primary care is also a means of cost-containment for the Commonwealth in its role as health care provider; and

WHEREAS, primary care providers include family practitioners, general internists, general pediatricians, obstetricians, and mid-level providers; and

WHEREAS, the Virginia Department of Health has local health departments that serve each locality in the Commonwealth; and

WHEREAS, the Virginia Department of Health has thirty-six health districts with physician health directors who are responsible for providing public health, preventive medicine, and environmental health services to their communities; and

WHEREAS, several local health departments directly provide primary care services, in addition to traditional public health services; and

WHEREAS, all health directors have knowledge of health care providers in their communities and health directors are able by the nature of their positions to facilitate the development of a system to improve availability and access to primary care services; and

WHEREAS, the Commission on Health Care for All Virginians has determined that further study is needed on the provision of primary care for all citizens of the Commonwealth; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That as part of his public health mission, each district health director be given the responsibility of determining the availability and accessibility of primary care services to the residents of his district and developing a community plan for addressing problems identified in the accessibility and availability of primary care services, particularly for indigent persons; and, be it

RESOLVED FURTHER, That in the determination of the availability and accessibility of primary care services to the residents of his districts and his development of a cost effective community plan to address problems of such accessibility and availability, each district health director shall:

1. Complete, by November 1, 1991, in cooperation with community representatives and

health care providers including primary care providers, an assessment of the primary care needs in the district. This assessment will identify the availability of health manpower resources, identify accessibility to resources, and determine the need for specific services;

2. Develop, by July 1, 1992, a plan with the assistance of community leaders, other agencies, health care providers, and other groups to develop the capacity to provide primary care services in those areas where those services are not available through a public/private partnership; and

3. Formulate also, in conjunction with his development of a comprehensive primary care provision plan, a community plan to educate and inform citizens on the best means of accessing primary care and appropriately utilizing primary care services; and, be it

RESOLVED FURTHER, That in district health departments currently providing comprehensive primary care, the district health director shall develop a system to measure access, availability, utilization, and cost of those services; and, be it

RESOLVED FURTHER, That local medical societies, hospitals, medical training programs, community health centers, other providers of primary care, local governments, and voluntary health agencies are requested to participate with the Department of Health in providing leadership in the development of the analysis and plan for the provision of primary care services.

All agencies of the Commonwealth shall provide assistance to the Department for this study as appropriate.

The Department of Health shall report its interim findings and recommendations to the Commission on Health Care for All Virginians by December 15, 1991, and its final report to the Governor and the 1993 Session of the General Assembly. Both reports shall comply with the procedures of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Agreed to By The Senate		Agreed to By The House of Delegates	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Appendix 2

The methodology used for estimating Health Manpower Shortages is provided in this appendix. Actual calculations by locality are also provided.

Please call Parker Sternbergh at the Virginia Department of Health for a copy of the methodology. Her number is 786-4891.

DISTRICT NEEDS IDENTIFIED By Region				
	Regions (# of Districts)			
	Eastern (10)	Central (7)	Northern (10)	Southwest (9)
Need Providers[1]	6	5	3	5
Providers Accepting Medicaid[2]	42.7%	46.7%	33.0%	74.8%
Poor Access for Indigent	4	6	7	7
Transportation	3	5	3	5
Perinatal, Pediatric Shortages	6	4	5	6
Access for Chronic/ Elderly	4	3	3	1
Health Promotion	1	1	2	2
Poor Perception Medicaid	3	4	6	6
Teen Pregnancy	1	1	4	5
Poor Use of ER's	2	2	2	1

[1]Does not include districts that have overall surpluses with deficits in specific parts of the district.

[2]Some districts counted FTEs of providers, while others counted the actual number of physicians accepting Medicaid reimbursements.

DISTRICTS	Manpower Short	Poor Access fo Medically Indi	Transportation	Perinatal and Pediatric Care	Limited Access the Chronicall and Elderly	Health Promotic Disease Prevent	Provider Percep of Medicaid	Teen Pregnancy	Inappropriate of Emergency Ro	COMMENTS
NORTHERN REGION, PAGE 2										
Prince William	X	X		X				X		
TOTALS	6	7	3	5	3	2	6	4	2	

= Partial

= District identified as primary care issue or problem

DISTRICTS	Manpower Short	Poor Access fo Medically Indi	Transportation	Perinatal and Pediatric Care	Limited Access the Chronically and Elderly	Health Promotic Disease Prevent	Provider Percep of Medicaid	Teen Pregnancy	Inappropriate U of Emergency Roo	COMMENTS
SOUTHWEST REGION										
Alleghany/Roanoke		X	X	X		X	X	X		Drug abuse, affordable child car child abuse, suicide, ancillary services
Central Virginia	X	X		X			X	X	X	Lack of knowledge of appropriate use
Cumberland Plateau	X	X	X	X	X		X	X		Low quality and perception that doctors schedule more visits tha necessary, black lung, over/under utilization of doctors
Pittsylvania/Danville	X	X	X	X		X	X	X		How to access the system, access to immunization, child abuse/negl STD/AIDS
West Piedmont	X	X		X						Homicide, suicide
Lenowisco	P		X	X			X			Doctors schedule more visits for income, Saturday hours, waiting time, black lung, education on access

CONTINUED ON NEXT PAGE

P Partial

X District identified as primary care issue or problem

DISTRICTS	Manpower Shorta	Poor Access for Medically Indig	Transportation	Perinatal and Pediatric Care	Limited Access the Chronically and Elderly	Health Promotio Disease Prevent	Provider Percep of Medicaid	Teen Pregnancy	Inappropriate U of Emergency Ro	COMMENTS
SOUTHWEST REGION, PAGE 2										
Mount Rogers	X	X								
New River	P	X	X		X		X	X		Unemployment is a large factor, alcohol substance abuse, dental for adults, stress related mental illness, poor nutrition/obesity
TOTALS	7	7	5	6	1	2	6	5	1	

P = Partial

X = District identified as primary care issue or problem

DISTRICTS	Manpower Shor	Poor Access fo Medically Indi	Transportation	Perinatal and Pediatric Care	Limited Access the Chronicall and Elderly	Health Promotic Disease Prevent	Provider Percep of Medicaid	Teen Pregnancy	Inappropriate U of Emergency Ro	COMMENTS
CENTRAL REGION										
Chesterfield	X		X				X			
Crater	X	X	X							
Hanover	X	X	X	X	X		X			Where and how to access
Henrico		X		X			X			
Piedmont	X	X	X	X	X	X		X		Infant mortality
Richmond City		X		X	X		X		X	Homicide, substance abuse, HIV/AI educate population on how to acce system
Southside	X	X	X						X	Cannot see doctors during working hours, lack of pharmacy services, vision and dental care for indigen illiteracy, Spanish speaking client
TOTALS	5	6	5	4	3	1	4	1	2	

P = Partial

X = District identified as primary care issu r problem

DISTRICTS	Manpower Shorta	Poor Access for Medically Indig	Transportation	Perinatal and Pediatric Care	Limited Access the Chronically and Elderly	Health Promotion Disease Prevent	Provider Percept of Medicaid	Teen Pregnancy	Inappropriate Us of Emergency Roo	COMMENTS
EASTERN REGION										
Chesapeake	X		X	X	X					Personal care, elderly need health department pharmacy
Eastern Shore	P					X				Difficult to retain physicians
Hampton	X						X		X	Primary care physicians are older
Three Rivers	X		X	X	X					
Peninsula		X		X	X		X			
Western Tidewater	X		X							
Virginia Beach	X	X		X	X			X		STD, AIDS
Norfolk		X		X						Adolescent health, communicable diseases, substance abuse

CONTINUED ON NEXT PAGE

Partial

District identified as primary care issue or problem