REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF HEALTH WORKFORCE INITIATIVES PURSUANT TO SJR 308 OF 1995

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 5

COMMONWEALTH OF VIRGINIA
RICHMOND
1996

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Preface

Senate Joint Resolution (SJR) 308 of the 1995 Session requested the Joint Commission on Health Care, in cooperation with the Secretary of Education, the Secretary of Health and Human Resources, and the State Council of Higher Education, to study the organization and effectiveness of state health workforce reform initiatives. This report contains the results of the study as well as a summary of public comments on the report.

Primary care is a cornerstone of a cost-effective health care system. Since the early 1990s, Virginia has implemented a series of health workforce reform initiatives to assure that communities will have adequate numbers and distribution of primary care providers. These efforts include community needs assessment, health professions education reform, and special programs for recruiting and retaining primary care providers in underserved areas of the Commonwealth. Those involved in health workforce reform include the Secretary of Education, the Secretary of Health and Human Resources, Virginia's three academic health centers, and multiple state agencies and private organizations. With the help of these and other entities, Virginia has built one of the most comprehensive and innovative approaches to health workforce reform in the country.

Looking to the future, the overarching policy question is how to coordinate Virginia's health workforce reform efforts across multiple secretariats and agencies, and avoid the pitfalls of fragmentation. For the near term, this report recommends consideration of a joint executive budget development process involving the two Secretaries, and a cooperative review process within the legislative branch. For the long term, the General Assembly may wish to consider reconstituting the Virginia Health Planning Board as the Virginia Primary Care Board with responsibility for overseeing health workforce reform initiatives.

A related policy issue is the need for clear designation of agency responsibility for health workforce reform. One concern is that the Virginia Department of Health does not have a clear statutory mandate to carry out its responsibilities for health workforce development. The General Assembly may wish to consider legislation to give the Virginia Department of Health clear statutory responsibility for assessing

community primary care needs, and for coordinating health professions recruitment and retention efforts in underserved areas. The General Assembly also may wish to consider legislation to move statutory authority for the Statewide AHEC Program from the Board of Health to Virginia Commonwealth University - Medical College of Virginia, given that AHEC's mission is primarily educational in nature. In addition, Virginia's three medical schools and the Statewide AHEC Program should work more closely on programs for student recruitment and community-based education, and develop integrated budget requests which reflect a real partnership between the schools and the local AHECs.

A third area of concern is the financial future of Statewide AHEC Program. Since its inception, AHEC has been funded with federal and state dollars. As federal funding for AHEC declines, the General Assembly will have to decide whether to increase state support or consider options for restructuring the program. The final chapter of the report focuses on the future of the Statewide AHEC Program and the pros and cons of several restructuring options.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study. In addition to the report and public comments, an overview of the Statewide Area Health Education Center (AHEC) Program was presented to the Joint Commission by Dr. Jack O. Lanier, Chair of the Statewide AHEC Board.

Jane N. Kusiak
Executive Director

October 31, 1995

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Authority for Study

Senate Joint Resolution (SJR) 308 of the 1995 Session requested the Joint Commission on Health Care, in cooperation with the Secretary of Education, the Secretary of Health and Human Resources, and the State Council of Higher Education, to study the organization and effectiveness of state health workforce reform initiatives. Specifically, SJR 308 requested an evaluation of the need for each initiative and an assessment of the effectiveness of each program in addressing health workforce needs in the Commonwealth. The resolution also requested an evaluation of the most effective organizational structures for:

(i) conducting health workforce needs assessment;
(ii) coordinating health professions education initiatives with health professions recruitment and retention initiatives;
(iii) developing comprehensive budget and policy proposals which integrate the various health workforce reform initiatives and prioritize among program goals; and
(iv) monitoring progress toward improving the supply of primary health care providers in medically underserved areas.

Chapter I of this report examines the need for health workforce reform. Chapter II describes Virginia's overall approach to health workforce reform, and presents recommendations for improving executive and legislative oversight. Chapter III reviews current efforts for health workforce needs assessment. Chapter IV reviews efforts to recruit Virginia students into the primary care health professions. Chapter V provides an assessment of health professions education initiatives. Chapter VI reviews provider recruitment and retention efforts. Chapter VII reviews issues and options related to the future of the Statewide AHEC Program.

Chapter I
The Need for Health Workforce Reform

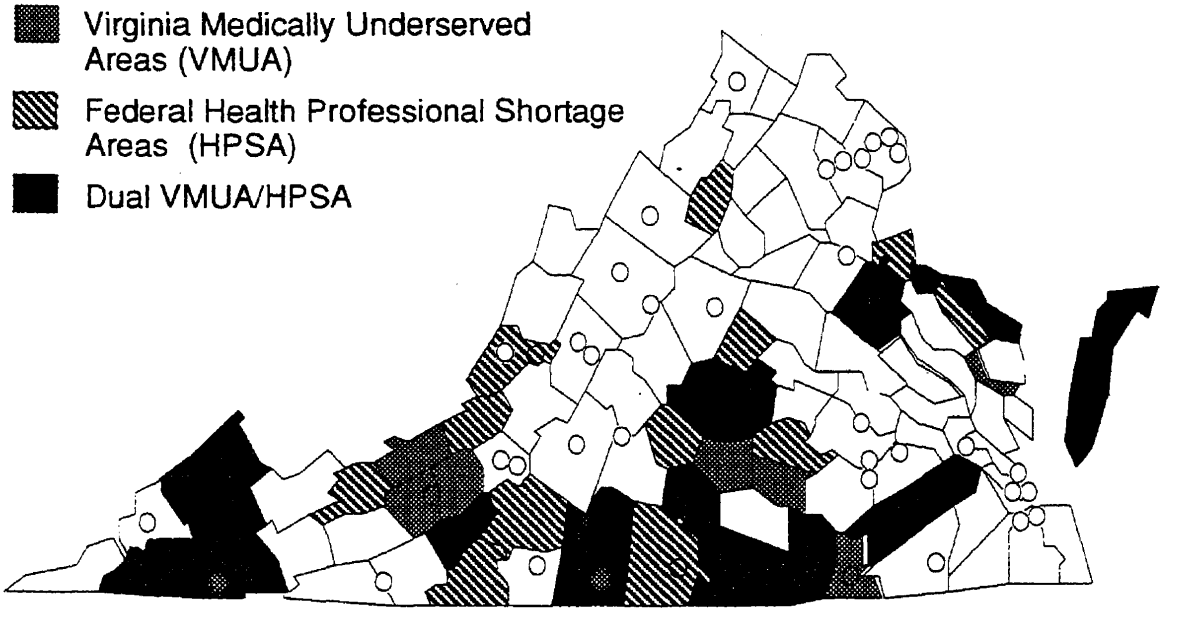
Primary care is a cornerstone of a cost-effective health care system. When one considers that primary care includes preventive care as well as diagnostic, treatment, consultative, and referral services, it is clear that lack of access to needed primary care services can cause personal suffering. It is also true that the costs of an inadequate primary care system are borne by the larger community as well. People who cannot obtain needed primary care services are at greater risk for secondary and tertiary care problems which are more costly to treat. Also, communities without an adequate primary care system may face economic development problems as businesses search for communities which are able to meet the health care needs of their employees.

Health workforce reform is important for addressing Virginia's primary care access problems. Numerous Virginia communities lack adequate access to primary care services, and primary care provider shortages are a major cause of this problem. As managed care becomes the predominant mode of health care delivery in Virginia, the demand for primary care services is increasing. As this occurs, the demand for high quality primary care providers will increase as well.

Citizens of many Virginia communities do not have adequate access to primary care

A variety of measures indicate that citizens of many Virginia communities do not have adequate access to primary care. As shown in Figure 1, 44 Virginia localities are designated as Virginia Medically Underserved Areas (VMUAs) or Federal Health Professional Shortage Areas. Compared to the state as a whole, VMUA communities tend to be rural or inner city, poorer, have an older population, and be served by fewer primary care providers. These factors place these communities at risk for inadequate access to primary care and other health care services.

Figure 1
Virginia Medically Underserved Areas and Health Professional Shortage Areas



A shortage of primary care physicians is one of several factors contributing to primary care access problems

While this report is focused on primary care workforce initiatives, it is important to recognize that solutions to primary care access problems require more than an enhanced supply of providers. In addition to primary care provider shortages, other barriers to primary care include:

* **Lack of health coverage.** Over 900,000 Virginians lack health coverage, including large numbers of children. Research shows that people without health coverage are more susceptible to preventable health problems, less likely to obtain appropriate primary care services, and more likely to use hospital emergency rooms for primary care.

* **Inadequate health care delivery systems.** Primary care practice cannot exist in a vacuum. There must be adequate hospital services and other health care services within a region if primary care practice is to be viable. Unfortunately, this is not always the case.

For example, according to a 1993 Virginia Health Department (VDH) report on developing primary care services in Virginia, one in three health districts reported that the chronically ill and elderly had particular needs for continual primary care which were not being met because of gaps in the scope of services available in the community.

* **Poor access to health promotion and disease prevention.** Preventive care is an important facet of a strong primary care system. According to the VDH study referenced above, one out of four local health districts reported problems with poor access to health promotion and prevention services, including screening.

* **Inadequate community support.** Communities must be willing to take responsibility for their own health care needs. Community leaders must identify health care as an important priority, and the health care community and others must be willing to respond to problems. This type of commitment and leadership is not always present in communities with primary care needs.

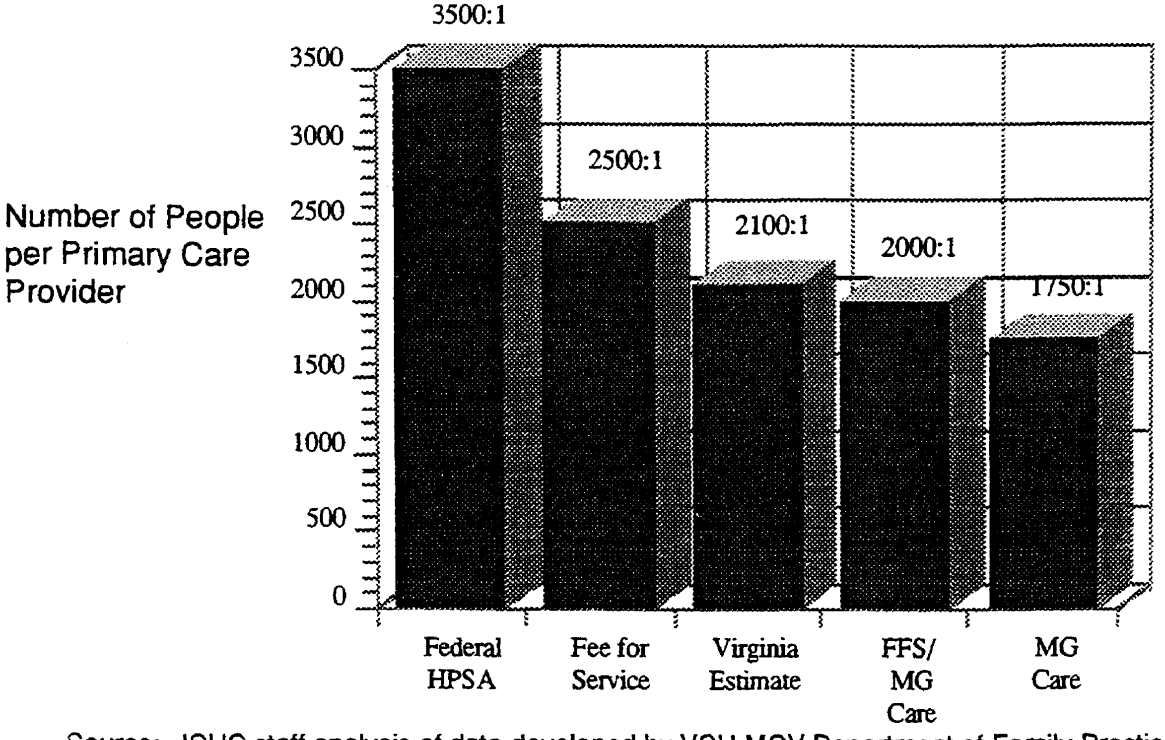
The need for quality primary care providers is increasing as managed care takes hold

Managed care is changing the landscape of health workforce reform. Most major Virginia employers, including the Commonwealth, have chosen managed care as the preferred mode of health care financing and delivery. Virginia Medicaid has also embraced managed care, and is developing plans for an eventual statewide system of capitated managed care plans for Medicaid recipients. Managed care systems generally require greater numbers of primary care providers. These providers must also have specific skills to function effectively in the managed care environment. In addition, managed care is spurring new relationships between physicians, nurse practitioners, physician assistants, and others. This means that health workforce reform efforts should focus on the emerging needs of a managed care health workforce as well as strategies to solve problems in underserved areas.

Virginia has significant regional primary care provider shortages and may experience statewide shortages after the turn of the century

Primary care provider shortages are typically measured in terms of optimal ratios of primary care providers per unit of population. The appropriate ratio depends on the characteristics of the population and the nature of the local health care delivery system. Figure 2 shows several ratios, ranging from the Federal HPSA minimum ratio (1 provider per 3500 population) to a ratio for an area with moderate managed care penetration (1:1750).

Figure 2
Ratios of Population to Primary Care Providers

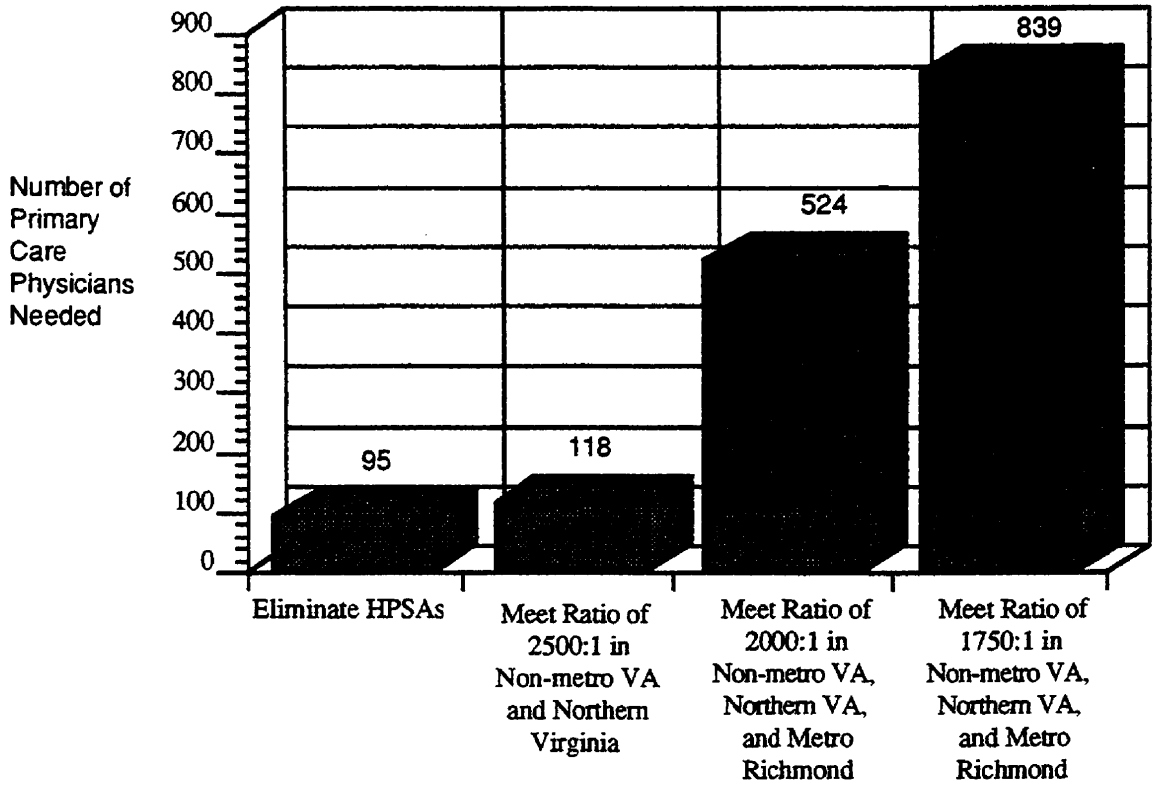


Source: JCHC staff analysis of data developed by VCU-MCV Department of Family Practice

As shown in Figure 2, the best available data indicates that Virginia has adequate numbers of primary care providers overall. The statewide primary care physician to population ratio is an estimated 2100:1, which is roughly in keeping with recommended levels for a mixed fee-for-service/managed care environment. However, as shown in Figure 3,

Virginia has acute regional shortages of primary care physicians, as summarized below.

Figure 3
Regional Needs for Primary Care Providers At Different Population/Provider Ratios



Source: JCHC staff analysis of data developed by VCU-MCV Department of Family Practice

* At an absolute minimum, Virginia would need an estimated 95 primary care providers to eliminate all of its Federal HPSA designations today.

* At a more reasonable fee-for-service ratio of 2500:1, Virginia would need an additional 118 providers to eliminate shortages in non-metropolitan areas and Northern Virginia alone.

* To reach the mixed fee-for-service managed care ratio of 2000:1 in these same areas, more than 500 physicians would be required to eliminate shortages in non-metropolitan areas, Northern Virginia, and metro-Richmond.

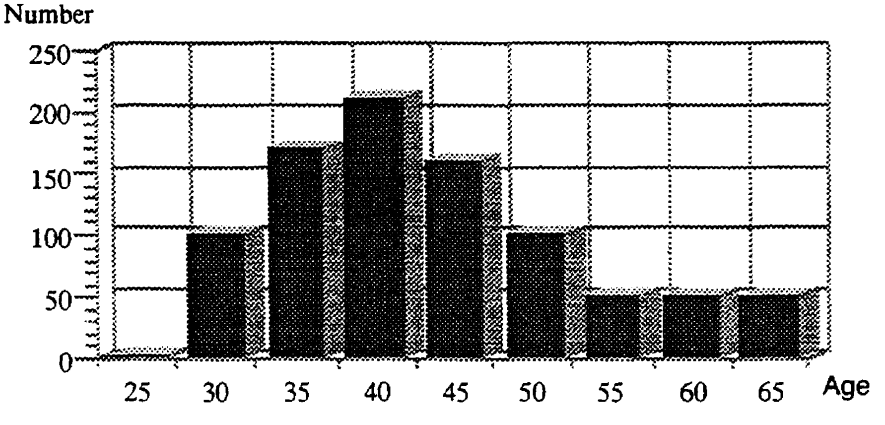
* To reach the moderate managed care ratio of 1750:1, more than 800 new physicians would be required to eliminate shortages in non-metropolitan areas, Northern Virginia, and metro-Richmond.

* Using an alternative approach based on the estimated productivity of primary care providers, in 1993 the Virginia Health Department estimated an immediate need of 250-360 additional primary care providers across the state.

The current level of need may be exacerbated by a spurt of retirements from the current physician workforce beginning after the turn of the century. As shown by the age distribution of practicing primary care physicians in Figure 4, Virginia is currently experiencing a "primary care physician boom" spawned in the 1970s and 1980s. This cohort of physicians is now nearing retirement age. According to a report by Virginia's medical schools, it is estimated that over 1,000 of Virginia's generalist physicians will reach retirement age between 1994 and 2001, with over 450 of these from rural areas. The pace of providers reaching retirement age will accelerate after that. This trend, coupled with increased demand for primary care providers from managed care plans, could result in an overall shortage of primary care physicians in Virginia.

Figure 4
Estimated Age Distribution of Virginia Primary Care Physicians

1994



Source: VCU-MCV Department of Family Practice analysis of Virginia Board of Medicine data

Chapter II
Virginia's Approach to Health Workforce Reform

Virginia's efforts to address its primary care workforce problems are best viewed in the context of the developmental cycle or "pipeline" for health professionals. As shown in Figure 5, the developmental cycle actually begins in the K-12 educational system and extends through health professions education, provider recruitment, and community practice. Virginia's health workforce reform strategies are aimed at supporting prospective providers at each step in the cycle by:

1. Conducting ongoing community needs assessment to determine which communities are in greatest need of improved primary care services;
2. Recruiting qualified K-12 and college students who are likely to become primary care providers in Virginia underserved areas;
3. Developing health professions education programs, particularly medical education programs, which emphasize the importance of primary care;
4. Recruiting primary care providers to underserved areas; and
5. Supporting providers so that they will remain in areas where they are most needed.

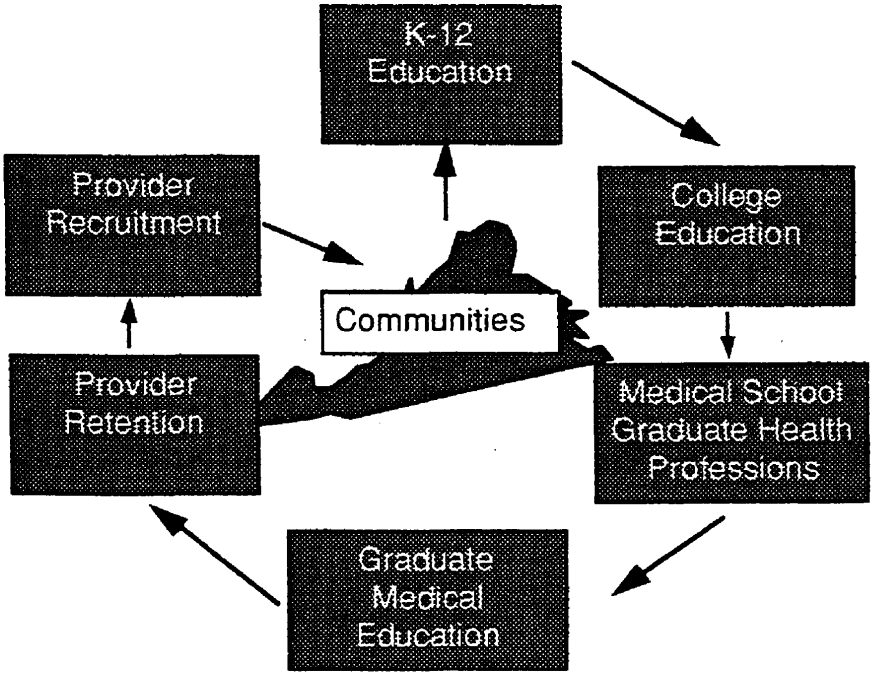
The General Assembly has launched numerous initiatives targeted at primary care development

In recent years the General Assembly has supported a variety of strategies to expand the primary care workforce. These are in addition to Medicaid reforms and other state initiatives aimed at directly financing or delivering primary care. The strategies include:

* **The Virginia Generalist Initiative**. A collaborative effort of Virginia's three medical schools to increase the supply of primary care providers available to serve the needs of Virginia.

* **Virginia Family Practice Residencies**. Residency programs located across the state which educate family practice physicians.

Figure 5
Developmental Cycle for Health Professionals



* **Virginia Statewide AHEC Program.** A state/federal program with eight local centers devoted to improving the availability of primary care through the provision of educational support to health professions students and practitioners.

* **Scholarship and Loan Repayment Programs**. Programs which help to finance the education of primary care providers in return for a commitment to practice in Virginia medically underserved areas.

* **The Virginia Health Care Foundation**. A private Foundation devoted to supporting innovative programs which provide access to primary and preventive care for Virginia's uninsured. Some, but not all, Foundation projects support provider recruitment and retention efforts.

* **The Virginia Practice Sights Initiative**. A collaborative effort of the Joint Commission on Health Care, the Virginia Health Department, and many other organizations aimed at enhancing Virginia's ability to recruit and retain primary care providers in underserved areas.

The Commonwealth will spend nearly $14.1 million on these health workforce development efforts during FY 1996 (Figure 6). Several programs, including the Virginia Generalist Initiative, the Virginia Practice Sights Initiative, and the Statewide AHEC Program, attract federal or private matching funds.

Figure 6
Targeted State General Fund Support of Primary Care Development Efforts

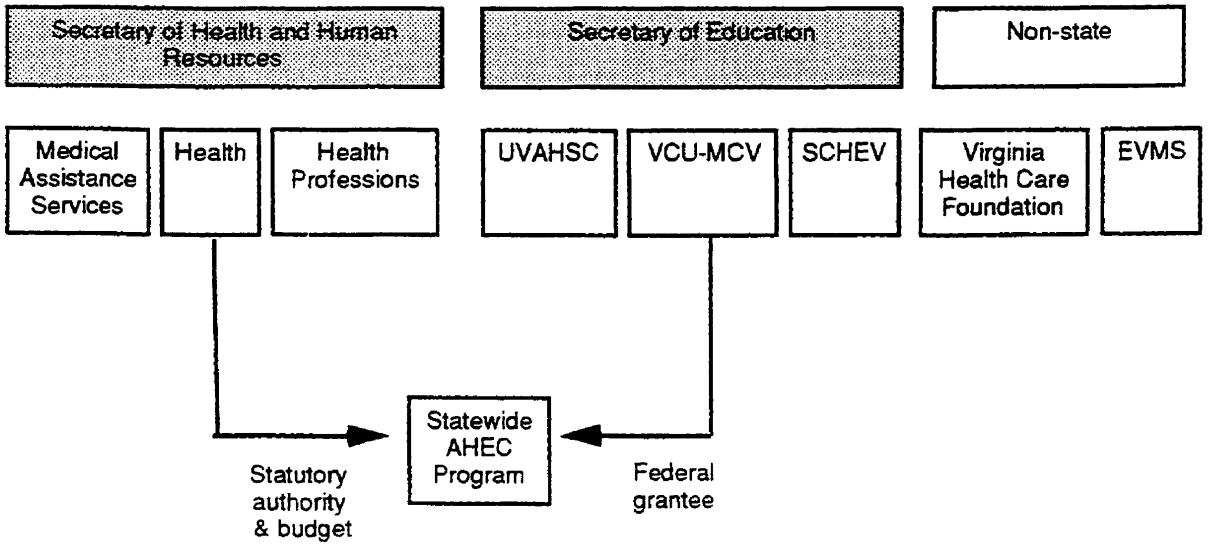
	FY 1995	FY 1996
*Virginia Generalist Initiative**		
Medical College of Hampton Roads	$697,050	$660,000
University of Virginia	$746,287	$713,616
Virginia Commonwealth University	$794,268	$687,688
Statewide Center at UVA	$127,500	$153,606
Subtotal	$2,365,105	$2,214,910
*Statewide AHEC Program**	$440,000	$558,139
Family Practice Residencies		
Medical College of Hampton Roads	$1,036,475	$1,031,475
University of Virginia	$2,462,079	$2,502,102
Virginia Commonwealth University	$4,793,605	$4,874,030
Subtotal	$8,292,159	$8,407,607
Scholarships and Loan Repayment		
Medical Scholarships	$445,000	$445,000
Dental Scholarships	$25,000	$25,000
Nurse Practitioner Scholarships	$25,000	$25,000
Physician Loan Repayment	$50,000	$50,000
Subtotal	$545,000	$545,000
*Virginia Health Department Staffing of Virginia Practice Sights Initiative***	$129,848	$133,330
Virginia Health Care Foundation***	$2,372,138	$2,229,810
Grand Total	$14,144,250	$14,088,796

* For FY 1996, the General Assembly appropriated $118,139 to the Statewide AHEC Program in support of student recruitment and admissions projects associated with the Virginia Generalist Initiative.
** Estimated.
*** Some but not all Virginia Health Care Foundation grants support provider recruitment and retention efforts.

Health workforce reform involves two secretariats and multiple state agencies

Responsibility for health workforce reform is dispersed across two secretariats and multiple state agencies (Figure 7). Within the Health and Human Resources Secretariat, the Virginia Health Department is responsible for health workforce needs assessment, administration of scholarship and loan repayment programs, the Statewide AHEC Program, and overall coordination of provider recruitment and retention efforts. The Department of Medical Assistance Services has a major influence on primary care development through its managed care programs and reimbursement policies. The Department of Health Professions is a resource for information on the number and location of providers across the Commonwealth.

Figure 7
State-Funded Agencies With Responsibilities for Health Workforce Reform



Within the Education Secretariat, the two state academic health centers (Virginia Commonwealth University-Medical College of Virginia

and University of Virginia Health Sciences Center) are responsible for health professions education reform. The State Council of Higher Education plays a major role in developing higher education policy in general, and medical education policy in particular. Outside the realm of state government, the Eastern Virginia Medical School is responsible for health professions education reform. The Virginia Health Care Foundation plays an important role in provider recruitment and retention. Not shown in Figure 7 are multiple private sector associations which contribute to efforts to educate, recruit, and retain primary care providers.

Effective health workforce reform will require active policy oversight and program coordination

Effective health workforce reform will require active oversight and coordination because of a rapidly changing policy environment as well as the need to coordinate activities across multiple secretariats and agencies. Priority policy issues include the following:

* The various agencies involved in health workforce reform must be assigned clear responsibilities and be held accountable for meeting these responsibilities.

* Agencies in different secretariats must be encouraged to work collaboratively on health workforce reform efforts.

* Health workforce needs must be assessed on an ongoing basis to track the immediate need for primary care providers as well as anticipated needs as managed care continues to evolve.

* Health workforce budget and policy proposals must be prioritized across secretariats so that available dollars can be appropriately allocated among the various initiatives.

* Medicaid and Medicare reforms must be evaluated for their impact on primary care providers in underserved areas as well as the academic health centers.

* The future of the academic health centers must be evaluated on an ongoing basis as managed care challenges their ability to shift clinical revenues to educational programs.

There is a need for a single locus of responsibility for health workforce reform in the executive branch

The policy agenda outlined above will require a significant commitment from those agencies involved in health workforce reform. This commitment has been difficult to achieve because there is no single executive branch entity which has full purview over health workforce reform. Consequently, there is no single entity which is accountable for identifying health workforce problems and overseeing progress. As a result, there has been little coordination between the secretariats in developing budget and policy proposals for health workforce reform. This makes it difficult for health workforce reform to receive adequate scrutiny and consideration in the executive budget process.

The Joint Commission on Health Care has tried to provide the necessary oversight and coordination of health workforce reform. In recent years, most of the budget and policy initiatives related to health workforce reform have been introduced by the Joint Commission. Even within the legislative branch, however, it has been difficult to present a comprehensive view of health workforce reform. For example, the legislative money committees are organized into separate subcommittees for education and health and human resources, making it difficult to demonstrate the inter-relationship of funding requests across secretariats. Furthermore, it has been difficult for the Joint Commission to provide ongoing oversight required of this issue while at the same time conducting policy studies across a broad range of health care issues.

Near-term Action (next six months). In the near term, there is a need for a thorough and coordinated review of health workforce reform budget requests for the next biennium in both the executive and legislative branches. This review could include funding requests for medical schools, graduate medical education programs, the Statewide AHEC Program,

scholarships and loan repayment, and the developmental activities of the Virginia Health Care Foundation. The following recommendations are made in order to facilitate this review:

Recommendation (1). The Joint Commission on Health Care may wish to consider requesting the Secretary of Health and Human Resources and the Secretary of Education, in cooperation with the Department of Planning and Budget and the State Council of Higher Education, to develop a joint budget development process for health workforce reform initiatives.

Recommendation (2). The Joint Commission on Health Care may wish to consider developing a process for cooperative review of health workforce reform budget requests by the Education and Health and Human Resources Subcommittees of the Senate Finance and House Appropriations Committees.

Long-term Action. In the long-term, consideration should be given to identifying a single executive branch entity which would be responsible for overseeing and coordinating health workforce reform. In considering the possibilities, it is important to recognize that health workforce issues involve both education policy and health policy. With this in mind, it appears that there is not an existing entity designed in a way to effectively deal with the education and health policy issues surrounding health workforce reform.

Some states have placed responsibility for oversight and coordination of health workforce reform with their higher education boards. In fact, the State Council of Higher Education has some statutory responsibility for oversight of health workforce programs. However, the State Council has no authority over Health and Human Resources agencies, and thus is not ideally suited to provide comprehensive oversight of health workforce reform.

A second possibility would be the Virginia Health Department. Here again, this agency has limited potential to provide comprehensive oversight because of its limited scope of authority. While the VHD does have responsibility for a number of primary care development activities, education reform and Medicaid reform fall outside its purview. Also, in

the most recent budget cycle this agency placed a low priority on health workforce reform initiatives.

A third possibility would be the Statewide Area Health Education Centers Program. This program has a statewide board which includes representatives from the various health professions as well as state government and consumers. It also is involved in both health professions education and educational aspects of provider practice support. However, the Statewide AHEC Program is primarily an educational organization. Also, its board, while diverse, is not organized to provide high level state policy oversight.

A fourth possibility would be the Virginia Health Planning Board. The Virginia Health Planning Board was established in 1989 to supervise and provide leadership for statewide health planning. The Code of Virginia designates the Secretary of Health and Human Resources as the Chair of the Board, and requires the appointment of 18 additional members representing consumers, providers, and state agency heads. The Board is charged with responsibility to develop and revise as necessary a State Health Plan. It is also authorized to make recommendations to the Governor and the General Assembly concerning health policy, legislation, and resource allocation.

The Virginia Health Planning Board has essentially been inactive in recent years. The last Board meeting was held in 1991, and the last State Health Plan was published in 1990. At present, the Board does not have devoted staff. The Virginia Health Department is assigned responsibility for staffing the Board. Also, the current organization and scope of authority of the Virginia Health Planning Board extends beyond what would be needed to oversee and coordinate health workforce reform.

Another possibility would be to consider restructuring the Virginia Health Planning Board as a primary care planning board. This would involve reconstituting the Virginia Health Planning Board as the Virginia Primary Care Planning Board with the following structure and responsibilities:

* Membership would include, at a minimum, the Secretary of Health and Human Resources, the Secretary of Education, the health sciences vice presidents of the three academic health centers, the Health Commissioner, the Director of the Department of Medical Assistance Services, the Director of the State Council of Higher Education, representatives of the Virginia Generalist Initiative, the Virginia Practice Sights Initiative, and the Statewide AHEC Program and the Virginia Health Care Foundation; and consumer and provider representatives. Consideration could also be given to legislative representation on the Board.

* The Board would be responsible for making recommendations to the Governor and the General Assembly on primary care development needs. Toward this end, the Board would commission and oversee primary care needs assessment, review health workforce reform and other primary care development initiatives, and develop annual budget and policy recommendations.

* The Board would be responsible for coordinating health workforce reform efforts among the various state agencies and private sector organizations.

* The Board would be responsible for evaluating the need for and location of new residency programs in the Commonwealth.

This option would assign clear responsibility for developing prioritized budget and policy proposals for health workforce reform. It would also include broad representation on the board from those responsible for and interested in primary care development. It would not require the creation of a new entity, but the restructuring of an existing body. The creation of a statewide Virginia Primary Care Board also could eliminate the need for a Statewide AHEC Board. This would have the benefit of streamlining operations and allowing the Statewide AHEC Program to report directly to the high level decision makers on the Virginia Primary Care Board. One concern would be representation of local AHECs in the state-level structure. This could be accomplished through the formation of an AHEC executive committee, the chair of which could sit on the Virginia Primary Care Board.

Staffing would be another concern. Given the scope and complexity of the issues, it would be difficult for staff from any one agency to adequately support the Virginia Primary Care Board. One option would be to staff the Board with a management group consisting of staff from the various agencies. While staff may be available from the Virginia Health Department, the State Council of Higher Education, the Statewide AHEC Program, the Virginia Generalist Initiative, and the Virginia Practice Sights Initiative, the Board would need dedicated staff.

Recommendation (3). The General Assembly may wish to consider reconstituting the Virginia Health Planning Board as the Virginia Primary Care Board and charging that board with responsibility for overseeing Virginia's health workforce reform efforts.

Chapter III
Health Workforce Needs Assessment

Background

Community needs assessment is the cornerstone of health workforce reform because needs vary according to community characteristics and local market forces. Effective community needs assessment should begin with a set of accepted guidelines for designating primary care provider shortage areas. These guidelines should be applied using accurate information about current primary care practice patterns and community health status. However, numeric ratios alone are not always accurate indicators of primary care needs. Quantitative measures of primary care needs should be confirmed by community perceptions of primary care access.

Furthermore, it must be recognized that health workforce needs assessment is not an exact science. It is difficult to find completely accurate data on the numbers and locations of primary care providers. To date, needs assessment has been city and county-based, when the reality is that people often cross locality boundaries to obtain health care services. Health care providers, like people in other parts of society, move for personal and family reasons in addition to career reasons. Given these variables, state health workforce needs assessment should be viewed as an important first step in identifying communities at risk for primary care shortages at a given point in time.

Current Initiatives

The Virginia Health Department has lead responsibility for health workforce needs assessment. The Virginia Primary Care Association and the academic health centers are also contributing to health workforce needs assessment, as described below:

* The VHD has a statutory mandate to identify medically underserved areas in Virginia. Toward this end, the VHD conducts needs assessments in support of efforts to designate geographic areas of the Commonwealth as eligible for federal primary care resources.

* The VHD is responsible for developing a comprehensive Primary Care Management Information System and a methodology for identifying communities with the greatest primary care needs as part of the Virginia Practice Sights Initiative. The latter will be used to determine which communities will be eligible for consulting services as part of the Provider Services Consulting Initiative to be administered by the Virginia Health Care Foundation.

* The VHD works with the Virginia Primary Care Association to develop the Virginia Primary Care Access Plan. This plan provides an assessment of primary care needs in each locality and recommends actions to improve local primary care systems.

In addition to initiatives at the VHD:

* The Virginia Commonwealth University-Medical College of Virginia (VCU-MCV) Department of Family Practice conducts annual surveys of primary care provider supply in Virginia, and more recently is attempting to develop projections of future primary care workforce needs in the Commonwealth. This data is used in the Virginia Primary Care Access Plan.

* The University of Virginia Center for the Advancement of Generalist Medicine, as part of the Virginia Generalist Initiative, is developing a longitudinal data base for ongoing evaluation of the initiative. The data base will track high school and college students participating in Virginia Generalist Initiative programs through their training careers and their practice careers. This data base, after several years time, will allow for an evaluation of whether the Virginia Generalist Initiative is actually producing providers who are meeting the needs of Virginia communities.

Issues

Accurate data on primary care practice patterns has been difficult to obtain

The primary source of information on the supply and distribution of Virginia physicians is the licensure data base maintained by the Department of Health Professions. While this data base is adequate for licensure purposes, it has several drawbacks as a data base for health workforce needs assessment:

* It vastly overstates the number of providers who are actually practicing medicine in Virginia -- recent estimates by VCU-MCV indicate that the number of licensed primary care physicians may be as much as one-third greater than the number actually practicing primary care in Virginia.

* It is not an accurate source of physician specialty information. Prior to 1995, physician specialty information was only requested upon initial licensure. Earlier this year, the Department stopped collecting any specialty information because such information is not essential for licensure.

* It is not an accurate source of information on provider scope and location of practice. The physician address submitted for licensure may not be the address of the physician's actual practice. Some physicians practice in multiple geographic areas, and still others practice multiple specialties. Thus, even if the existing data base were completely accurate, it would still be difficult to determine whether an individual primary care physician was practicing full-time at the address listed on the license.

In 1994 the Joint Commission on Health Care successfully introduced legislation authorizing the Department of Health Professions to collect information on the location and scope of primary care practice as part of the licensure process. After months of studying the logistics of implementing this legislation, the Department of Health Professions has concluded that the cost of implementation would be approximately $130,000 per year. Furthermore, the Department requested the advice of the Attorney General on whether it is legal to use provider licensing fees to

defray the costs of any activity other than that which is essential for administering the licensure process. The Office of the Attorney General opined that provider licensing fees should not be used to defray the costs of collecting information on the location and scope of primary care practice because such information is not essential for licensure.

The Virginia Health Department is attempting to develop the necessary data through other means such as commercially available provider data bases and data available from Trigon BlueCross BlueShield. While it is doubtful whether these data bases will provide all of the information which could be obtained through an annual survey, they would be a significant improvement over current data resources.

There is a lack of consensus on optimal levels of primary care provider supply

As indicated in Chapter I, there is no single accepted measure of adequate primary care supply. Measures range from the Federal Health Professional Shortage Area criterion of one physician per 3500 population to recommended ratios as low as 1750:1 and below. The lack of a uniform system of measurement makes it difficult for organizations involved in health workforce reform to agree on the specific nature of the problem as well as potential solutions. It also makes it difficult to prioritize among areas with different levels of need.

Community input is needed to improve the needs assessment process

The available information on primary care needs mostly consists of quantitative measures of need such as poverty rates, age of population, infant mortality rates, and physician-to-population ratios. While such measures are useful as initial assessments of primary care need, they must be interpreted in the context of local community perceptions. This is important to assure that global measures of access do not mask underlying patterns of actual health care utilization. It is also important to assure that communities are aware of the strengths and weaknesses of their own local health care systems.

The value of this type of information was illustrated in the 1993 Virginia Health Department report Developing Primary Care Services in Virginia. This report, developed in response to Senate Joint Resolution 179 (1991), included systematic assessments of primary care needs in each local health district. In addition to quantitative indicators of need, these assessments included valuable insights about local health care utilization patterns, perceptions of Medicaid reimbursement, provider commitment to indigent care, and special service needs of local citizens. Such information is critical for the development of local strategies for enhancing access to primary care. Although the original intent was for local health directors to follow this assessment with primary care action plans, the initiative has not been carried forward.

Physician workforce projections are needed to evaluate the Virginia Generalist Initiative

The Virginia Generalist Initiative is intended to meet Virginia's current and future needs for primary care physicians. The medical schools included a basic assessment of current and future primary care physician needs in its FY 1996 budget request. To the extent available data will allow, this assessment should be updated and refined annually to recognize the changing demands of the managed care market place, retirement rates, physician immigration, and physician outmigration. The production goals of the Virginia Generalist Initiative can then be evaluated in the context of the projected need for primary care physicians in the Commonwealth.

Recommendation

The following recommendation is presented as a strategy for improving health workforce needs assessment in the Commonwealth.

Recommendation (4). The General Assembly may wish to consider amending the Code of Virginia to require the Board of Health, in addition to its responsibility to establish criteria to identify medically underserved areas in Virginia, to: (i)

Establish standard measures of primary care provider supply in Virginia; (ii) Direct local health district directors to annually assess primary care needs of their areas and develop plans for addressing those needs; (iii) Conduct an annual assessment of current and future needs for primary care providers in the Commonwealth; and (iv) Provide the Governor and the General Assembly with an annual assessment of need to be used in evaluating health workforce programs.

CHAPTER IV
Student Recruitment

Background

Effective student recruitment and admissions strategies are critical for developing a pool of health professions trainees who are willing and able to become primary care providers in areas of need. Research indicates that students who are going to choose primary care have likely developed that interest before medical school. Students from rural and urban underserved areas are also more likely to pursue primary care. Minority students in particular tend to practice more in minority/underserved communities. These findings suggest that student recruitment and admissions efforts should be focused on developing a pool of applicants with a strong interest in primary care and with personal characteristics which indicate that they might be more likely to eventually practice in a rural or urban underserved area.

This chapter focuses on student recruitment efforts of the Statewide AHEC Program and Virginia's medical schools. Medical school admissions reform is discussed in the next chapter along with medical school curriculum reform and graduate medical education reform.

Current Initiatives

The Statewide AHEC Program provides health careers recruitment programs for minority and disadvantaged students

Development of health careers recruitment programs for minority and disadvantaged students is one of the Statewide AHEC Program's three major goals. The Statewide AHEC Program reports that it has accelerated its efforts in this area over the past two years, providing programs for more than 3,000 students (the vast majority being elementary, middle, or high school students) in FY 1994 and more than 14,000 students in FY 1995. The Statewide AHEC Program plans to provide programs for more than 24,000 students in FY 1996. Four local AHECs have hired full- or part-time

staff to conduct health careers promotion programs, and at least one local AHEC plans to hire staff in the near future.

AHEC health careers promotion programs include a wide a range of approaches designed to develop student interest in and preparation for health careers. Among the strategies used are health career fairs, mentoring experiences in hospitals and clinics, career counseling regarding career options and financial aid, provision of equipment and educational materials to schools, and others. Several of the local AHECs are working with the medical schools to develop programs in response to the Association of American Medical College's Project 3000 by 2000, which has the goal of recruiting nationally 3,000 underrepresented minority students in medicine by the year 2000. The essence of health careers promotion is to link students, providers, and health professions schools in an effort to expose students to health careers and give them the preparation they need to pursue health careers education, as illustrated by the following example from the Southside AHEC:

> *The Southside Middle College Program is a cooperative venture of the Southside AHEC, Charlotte County Public Schools, and Southside Community College. These organizations developed a program to identify prospective college-bound students, expose them to the appropriate high school curricula, encourage them to pursue a health career, and encourage them to return to the Southside area upon completion of their training. Eleven 11th and 12th graders participated in the program during 1993-1994. These students were given educational and career counseling and participated in shadowing/mentorship programs at Southside Community Hospital and Halifax Regional Hospital. Both hospitals offered a stipend to each student. All five students who enrolled in a similar program in 1992-93 are currently enrolled in a post-secondary health career program or pre-health science program at a local college.*

The Virginia Health Care Foundation will collaborate with the Statewide AHEC Program to develop health careers promotion programs

The Virginia Health Care Foundation will begin participating in health professions student recruitment efforts during 1995 as part of the Virginia Practice Sights Initiative. The Virginia Health Care Foundation

will collaborate with the Statewide AHEC Program on the development of a Community Mentor Initiative aimed at developing private sector resources to support mentorship programs for students who would like to become primary care providers and return to practice in their local areas.

The three state medical schools are attempting to recruit students who are likely to become generalists and practice in areas of need

One of the major strategies of the Virginia Generalist Initiative is to recruit and support potential future medical students who are most likely to become generalists and practice in areas of need. This strategy was affirmed by the 1995 General Assembly when it approved budget language expressing its intent that "...Virginia Generalist Initiative recruitment and admissions programs shall be designed to increase the number of Virginia medical students with an interest in generalist medicine from medically underserved areas of the Commonwealth." The 1995 General Assembly also approved more than $118,000 in state general funds (provided in the appropriation to the Statewide AHEC Program) to support medical student recruitment efforts. A summary of student recruitment strategies planned for FY 1996 is provided below:

Regional Conferences on Primary Care Health Professions. A statewide task force consisting of Virginia Generalist Initiative staff and Statewide AHEC Program staff is developing a series of conferences to promote primary health care careers and to educate high school and college advisors on the educational requirements for health professions education. The first conference took place on July 19, 1995, in Wise County. This conference series is supported with state general funds and other funds.

Statewide Seminar on Medical School Recruitment. This annual seminar is to be targeted for college pre-health advisors, local AHEC directors and health professions recruitment specialists, and medical school admissions directors. The purpose is to discuss, evaluate, and strengthen local recruitment efforts to reach minority and

disadvantaged students and encourage them to pursue primary care careers. This seminar is to be supported with state general funds, and is in the planning stage.

Educational Video Project. This project involves the production and distribution of two educational videotapes to describe the need for and the importance of the primary care physician. The videotapes will be distributed to middle and high school students. The videos are nearing the completion of production and will soon be distributed. This project is supported with non-general funds.

Statewide Summer Primary Care Mentorship Program. This program is intended to provide selected high school students from underserved areas with a six-week mentorship experience with a primary care physician. The students would attend the program during the summer between their junior and senior year. The goal is to increase the students' interest in and understanding of primary care medicine. This is a collaborative venture of the three medical schools, and is to be supported with state funds. This project is in the planning stage.

Expansion of Summer Enrichment Program at Eastern Virginia Medical School. Eastern Virginia Medical School plans to use local funds, to the extent they are available, to expand its summer enrichment program for minority college students interested in medical careers.

Summer Seminar Program at VCU-MCV. VCU-MCV plans to develop a two-week summer seminar on campus for 15 high school science teachers and counselors from underserved areas. The seminar will be designed to help teachers enhance their science skills and to help counselors understand the requirements of generalist medicine so that they may provide more effective student counseling. This seminar is to be supported with state general funds.

Increased Outreach to Public Schools. All three medical schools have committed to doing more outreach to area public schools in an effort to encourage students from underserved areas to pursue primary care careers. State general funds will be used to support these efforts at VCU-MCV and UVAHSC.

Issues

The Virginia Generalist Initiative and the Statewide AHEC Program have overlapping responsibilities for medical student recruitment

Currently, staff from the Virginia Generalist Initiative and the Statewide AHEC Program are working together on a statewide task force to implement statewide recruitment and admissions initiatives developed as part of the Virginia Generalist Initiative, as is appropriate given the overlapping missions of the two initiatives. The Virginia Generalist Initiative did not receive the full amount of funding it requested for medical student recruitment initiatives in FY 1996. Thus, the plans outlined above may have to be adjusted to according to available resources. To the extent possible, local AHECs should reallocate staff resources and federal grant funds to help support budget shortfalls in medical student recruitment initiatives associated with the Virginia Generalist Initiative. In the future, the two initiatives should collaborate and share resources on all Virginia Generalist Initiative efforts to recruit medical students with an interest in primary care from Virginia's underserved areas.

Student tracking and program evaluation are important for assessing the cost-effectiveness of AHEC health careers promotion programs

The local AHECs encounter thousands of precollegiate minority and disadvantaged students each year through health careers promotion programs. If health careers promotion efforts are effective, the payoff in terms of an expanded and diversified health workforce could be significant. Effective tracking and program evaluation will be critical to determine program effectiveness.

The local AHECs should accelerate their efforts to identify and track the students they encounter in health career promotion programs. This tracking information should be shared with Virginia medical schools so

that it may be incorporated into the comprehensive tracking program being developed by the Virginia Generalist Initiative. In collecting the tracking information, efforts should be made to identify the minority or disadvantaged status of the students as well as the home locale of the student. This information will aid program evaluation efforts and help the medical schools identify students with an interest in primary care who are minority or who live in an underserved area.

Recommendations

The following recommendations should be considered to improve student recruitment and admissions efforts:

Recommendation (5). The Virginia Generalist Initiative and the Statewide AHEC program should collaborate and share resources in their efforts to recruit students into primary care medicine. To the extent possible, the Statewide AHEC Program should reallocate federal grant funds and staff resources to address budget shortfalls in medical student recruitment efforts associated with the Virginia Generalist Initiative.

Recommendation (6). Future budget requests for support of medical student recruitment initiatives of the Virginia Generalist Initiative should specifically address the role of the Statewide AHEC Program in carrying out those initiatives and identify staff and financial resources to be provided by the Statewide AHEC Program.

Recommendation (7). The Statewide AHEC Program should accelerate efforts to establish a system for tracking student participation in health careers promotion programs. This tracking system should have the capability to identify minority and disadvantaged students who participated in programs. Tracking data should be shared with the Virginia Generalist Initiative for inclusion in that initiative's statewide tracking system.

CHAPTER V
Health Professions Education

Health professions education includes medical education, nursing education, dental education, and allied health education. Medical education programs are obviously critical to Virginia's health workforce reform efforts. In order to meet the objectives of the Virginia Generalist Initiative, Virginia medical schools are implementing significant undergraduate medical education reforms including changes in the medical school admissions process and restructuring of medical school curricula. Graduate medical education programs (residency and fellowship programs) are also a focal point for reform because generalist residents are the most immediate pool of prospective physicians who might be recruited to Virginia areas of need.

Collaborative and multidisciplinary education programs are also becoming more important as vehicles for increasing collaboration between physicians and mid-level providers. Several different organizations are working to bring trainees from different settings together in the clinical setting.

Medical Education Reform

Background

Medical education reform is important for meeting the future physician workforce needs of the Commonwealth

Virginia's medical schools have agreed to meet a major challenge. By the year 2000, 50 percent of their graduates will enter generalist practice, and half of those will enter generalist practice in Virginia. In addition, output of Virginia graduate medical education programs will be consistent with the 50 percent goal. Furthermore, the academic health centers have committed to working with the Virginia Practice Sights

Initiative to develop strategies for eliminating generalist physician shortages in medically underserved areas of Virginia.

This commitment will result in a significant increase in the number of generalist physicians produced by Virginia medical schools. As shown in Figure 8, in 1994-95 Virginia medical schools graduated 141 students, or

Figure 8
Output of Students Intending to Enter Generalist Practice
Virginia Medical Schools

	1995 Estimate	1995 Goal	1996 Goal	1997 Goal	1998 Goal	1999 Goal	2000 Goal
EVMS							
Number	39	40	43	45	47	49	51
Percent	38	40	43	45	47	49	51
VCU-MCV							
Number	50	70	76	81	85	86	88
Percent	32	44	48	51	53	54	55
UVAHSC							
Number	52	49	56	60	64	65	69
Percent	39	37	40	43	46	47	50
Total Number	141	159	175	186	196	200	208

Source: Virginia medical schools

approximately 36 percent of total graduates, who planned to enter a generalist career after residency training. The number of graduates entering generalist careers will increase by 48 percent to 208 by the year 2000 if the medical schools achieve their 50 percent goal for total output of generalists. If the 50 percent retention goal is met, at least 104 of these

physicians will enter generalist careers in Virginia. The figure of 104 represents about one fifth of Virginia's estimated current need for at least 500 generalist physicians (based on a ratio of 1 physician per 2000 population, and based on shortages in nonmetropolitan areas, Northern Virginia, and Metro Richmond).

Among the three schools, UVAHSC met its objective for 1994-95 and EVMS was fairly close. VCU-MCV fell well short of its objective. While VCU-MCV has a significant task ahead, it is important to recognize that 1994-95 graduates received little if any exposure to the major interventions of the Virginia Generalist Initiative. The career choices of future graduates will be a better measure of the performance of Generalist Initiative programs.

In considering the role of Virginia medical schools in addressing health workforce problems, it is important to recognize that the academic health centers cannot guarantee that new graduates will be recruited and retained in Virginia areas of need. Ultimately, recruitment and retention will depend on the success of the Virginia Practice Sights Initiative and other factors which influence the desirability and viability of medical practice in underserved areas. For their part, the academic health centers can aid provider recruitment and retention efforts by recruiting and admitting students and residents who are interested in generalist careers in Virginia, providing these students with strong primary care role models, and exposing them to positive educational experiences in Virginia areas of need.

Medical School Admissions Reform

Background

The three medical schools are reforming their admissions processes to admit more students who are likely to become generalists in Virginia areas of need

All three medical schools have reformed their admissions process to admit more students who are likely to become generalists in Virginia areas

of need. Figure 9 provides summary data on the entering medical school classes of 1994 and 1995, and each school's approach is described below.

Figure 9
Medical School Admissions Profile: Entering Class of 1995

	EVMS	UVAHSC	VCU-MCV**
Total Applicants	7354	5435	5298
Total Offers	200	278	174
Total Matriculants	101	139	153
Minority	6	21	16
Male	50	83	89
Female	51	56	64
Interested in Primary Care	71	NA*	84
Virginia Matriculants	75	96	115
Interested in Primary Care	45	NA*	64
From VMUA/HPSA Localities	11	29	28

* Not available until Sept. 95.
** VCU-MCV expects to make additional offers and accept as many as 170 matriculants by September of 1995.

Minority representation ranges from 6 percent at EVMS to 15 percent at UVAHSC, (although it is important to note that the three schools use different methods for classifying students as minorities). More than half of the entering classes at EVMS and VCU-MCV have expressed an interest in primary care. While UVAHSC data were not finalized at the time of this study, data for the UVAHSC entering class of 1994 showed a similarly rich mix of students interested in generalist medicine. One out of four Virginia students entering UVAHSC and VCU-MCV are from localities designated as Health Professional Shortage Areas or Virginia Medically Underserved Areas. Fifteen percent of EVMS matriculants are from designated underserved areas.

VCU-MCV. During the past year VCU-MCV has taken the following steps to reform its medical school admissions process:

* Expanded generalist faculty representation on the Admissions Committee

* Required that four of the eight students on the Admissions Committee be committed to generalist careers

* Added questions to the admissions application to help identify applicants with an interest in generalist medicine

Although 153 students have accepted offers to enter VCU-MCV in the fall of 1995, the entering class size may be as many as 170. Of known matriculants, 11% are minorities. Seventy-five percent of matriculants are Virginians. Of these, 56% expressed an interest in primary care during the admissions process. Twenty-four percent of Virginia matriculants are from localities designated as Federal Health Professional Shortage Areas or Virginia Medically Underserved Areas.

UVAHSC. UVAHSC achieved the following objectives in its admissions reform efforts during FY 1995:

* Expanded generalist faculty representation on the Admissions Committee

* Increased the number of students on the Admissions Committee who are interested in primary care

* Met a target of interviewing a minimum of 250 students (one half of interviewees) who appear to be interested in generalist medicine

* Met a target of 50% of matriculating students rated as being likely to enter a generalist career

* Began work on a longitudinal data base to evaluate the success of their admissions screening process.

UVAHSC expects a total of 139 students in the entering class of 1995. Of these, 15% are minorities. Sixty-nine percent of the expected matriculants are Virginians. One third of these Virginia matriculants are from localities designated as Federal HPSAs or Virginia MUAs. Information on the number of Virginia matriculants interested in primary care is not yet available. Sixty-two percent of the class was rated as likely to enter a generalist career.

EVMS. EVMS has implemented the following changes to its admissions process:

* Expanded generalist faculty representation on the Admissions Committee

* Trained admissions interviewers to screen applicants for their interest in generalist medicine

* Changed the admissions scoring and ranking policies to give greater weight to students interested in generalist medicine

* Developed a data system for evaluating the effectiveness of the screening process.

EVMS experienced a significant increase in its medical school applications during 1994-1995. The total number of applications (7,354) marked an increase of 30 percent over the previous year. Offers were made to 200 applicants, and 101 accepted. Of these 101, 6% are minorities, and 71% expressed an interest in primary care. Seventy-five percent of the entering class of 1995 will be Virginians. Of these, 60 percent have expressed an interest in primary care. Fifteen percent are from localities designated as Virginia MUAs or Federal HPSAs.

Issues

Virginia's medical schools should continue their efforts to admit more students with an interest in generalist medicine from underserved areas of Virginia

The medical schools appear to be on track with their admissions reform efforts. As discussed in the preceding chapter, effective student recruitment programs are important to enhance the medical schools' ability to admit more students with an interest in generalist medicine from underserved areas of Virginia. The medical schools should continue to provide annual status reports on their progress so that their progress may be evaluated by the General Assembly.

Medical School Curriculum Reform

Current Efforts

Virginia's medical schools are implementing medical education curriculum reforms which reflect the best available knowledge about high quality generalist education. The general approach is to emphasize early and continuing exposure to experienced generalist physicians, community-base patient care experiences, increased small group problem solving, and increased emphasis on linking basic science material to actual clinical problems. This approach is based on research which indicates that medical students who are exposed to strong primary care role models and community-based, primary care education are more likely to choose generalist careers. Virginia's approach marks a significant departure from traditional medical education programs which have relatively little exposure to community-based generalist medicine.

EVMS. EVMS's curriculum reform accomplishments during 1994-95 include:

* Assigned six part-time Generalist Clinical Scholars as student role models and curriculum reform leaders.

* Established a new course for first and second year students, Introduction to the Patient, which was implemented in August of 1994, one year ahead of schedule. This course meets one-half day a week and is designed to teach students the basics of patient assessment and expose students to the community medicine environment. Fifty-nine community physicians were recruited to serve as preceptors.

* Expanded ambulatory experiences in the core third-year clerkships.

* Significantly increased the integration of standardized patients in each training year to teach clinical skills and evaluate medical student performance.

* Implemented a series of faculty development workshops for community preceptors and small-group facilitators.

Plans for 1995-96 include:

* Initiation of a required fourth-year primary care ambulatory experience.

* Initiation of a one-month elective community-based primary care experience.

* Initiation of a new course, Clinical Pathophysiologic Correlations, which is taught mostly by generalists and focuses on the 20 most common reasons for visits to primary care practitioners.

One global measure of the impact of curriculum reform is the amount of contact hours students spend with generalist faculty. EVMS reports that in 1993-94, the total amount of student contact hours with generalist faculty during the four-year program was 872 hours. During 1994-95, generalist contact hours were increased to 1,483. By the year 2000, the goal is for generalist contact hours to exceed 2,100 hours.

VCU-MCV. Accomplishments during 1994-95 include:

* Implemented a required one-month community clerkship in Family Practice Medicine. Sixty-two percent of participating students were placed in rural areas.

* Recruited faculty and staff and developed a Generalist Longitudinal Curriculum for first and second year medical students. The course will provide students early exposure to generalist medicine through a half-day per week experience with a community physician.

* Continued the Student Family Practice Club and established student activity clubs for pediatrics and general internal medicine.

Plans for 1995-96 include:

* Implementation of the Generalist Longitudinal Curriculum for first and second year students. Over 200 community preceptors are being recruited for the course which will begin in the fall of 1995.

* Development of a required outpatient primary care internship for fourth year students.

* Development of an additional required experience in an underserved area for fourth year students.

* Plans for developing student rotations in Southwest Virginia are under development in cooperation with UVAHSC.

UVAHSC. UVAHSC has established a number of clinical courses which increase students' exposure to ambulatory or community-based generalist medicine. These include:

* Doctor-Patient-Illness. A first year course focusing on the physician-patient relationship and effective interviewing techniques.

* Physical Diagnosis. A first-year course featuring small group instruction in techniques of physical diagnosis.

* Family Practice Summer Elective. A one-week preceptorship with a generalist physician in a community setting, taken during the summer between the first and second year.

* Introduction to Clinical Medicine. Preceptors lead small groups of second year students through case studies.

* Supervision of History & Physicals. Second year students are matched one-on-one with a preceptor to do patient histories and physicals on actual patients.

* Second-year Community Preceptorship. A one-week experience in a private physician's office during the second year.

* Primary Care Ambulatory Clerkship. A required one month clerkship in a primary care ambulatory setting for third-year students.

Accomplishments during 1994-95 include:

* Established Office of Community Based Medical Education to recruit preceptors and coordinate the community-based components of the courses outlined above. The large majority of students participating in the Second Year Community Preceptorship were placed in rural areas.

* Established the Clinical Correlatives Resource Center. The Center was created to facilitate the incorporation of clinically relevant educational material into the basic science course curriculum during the first and second year of medical school. Generalist faculty serve as liaisons to basic science faculty, and particular emphasis is placed on having generalist faculty lead discussions on clinical topics in the basic science courses.

* Implemented the Generalist Scholars Program. Accepted three students committed to generalist medicine in the Fall of 1994 and awarded each student a $10,000 per year scholarship.

* Implemented a Standardized Patient program to help implement several of the courses outlined above.

Plans for 1995-96 include the maintenance of the above programs and the expansion of community-based experiences where possible. Plans for expanding student rotations in Southwest Virginia are under development in cooperation with VCU-MCV.

Statewide AHEC Program. The Statewide AHEC Program plays an important role in facilitating community-based educational experiences for medical students. During 1994-95, local AHECs supported community-based experiences for 195 medical students. Local AHEC support may come in the form of resources for student travel and lodging. Or, it may come in the form of AHEC support of community preceptors. The local AHECs have developed a program called Spectrum which provides

community preceptors with non-cash benefits such as library support, textbooks, software, and other materials.

Medical Education Funding Reform. The 1993 General Assembly requested the State Council of Higher Education to study possible fiscal policies and other incentives to stimulate the production and utilization of primary care physicians at the three academic medical centers. The 1994 General Assembly approved budget language linking medical education funding levels to the goal of 50 percent of graduates choosing generalist residencies. The State Council worked with the schools to develop a phased funding plan which would allow schools which meet their targets for graduates choosing generalist residencies to receive funding increases of up to five percent of their normal budget.

Issues

Better coordination is needed between the medical schools and the Statewide AHEC Program

As outlined above, the centerpiece of medical school curriculum reform is community-based medical education. Funding to support cash payments to community preceptors is the largest single item in the Virginia Generalist Initiative budgets of both UVAHSC and VCU-MCV. Together, these two institutions requested more than $700,000 to compensate community preceptors. They are presently examining their budgets to determine whether preceptor payment policies must be revised because they did not receive their full budget request.

The practice of making cash payments to preceptors is not widely accepted. Most medical schools across the country do not pay preceptors with cash, and within Virginia one of the three medical schools has chosen not to pay preceptors with cash. On the other hand, a growing number of medical schools are beginning to pay preceptors, and some of those that do not pay are exploring ways to do so. UVAHSC and VCU-MCV have adopted a cash payment policy in light of the large numbers of preceptors they need to implement their curriculum reforms, and the perception that

community practitioners are increasingly unwilling to teach without compensation due to the competitive pressures of managed care.

If Virginia medical schools are to pay community preceptors with cash, payment policies and budget requests must be closely coordinated with the local AHECs. One example of poor coordination is the fact that at least three local AHECs have requested a total of more than $100,000 federal dollars to pay medical student preceptors. This grant request was not coordinated with the medical schools, and the funds requested go above and beyond the state funds requested by the two medical schools. Such a lack of coordination creates the potential for duplicative cash payments to preceptors.

A related concern is the plan by at least one local AHEC to use federal grant funds to make cash payments to nursing and dental student preceptors in addition to medical student preceptors. By setting a precedent for cash payments, such a decision could have an adverse affect on public and private schools of nursing and allied health who have a need for community preceptors but have not traditionally compensated these preceptors with cash.

There is also a concern about coordination of preceptor recruitment activities. Both local AHECs and the medical schools are assuming some responsibility for recruiting medical student preceptors. Here again, there is the potential for unnecessary duplication and overlap among the two organizations. There is also the potential for confusion among community preceptors who may encounter two separate recruitment offices.

Recommendation (8). Decisions to make cash payments to health professions student preceptors should be made by health professions schools as opposed to local AHECs.

Recommendation (9). Cash payments to medical student preceptors should be: (a) made in amounts determined by the medical schools; (b) administered by the medical schools; (c) used in lieu of non-cash benefits provided by the local AHECs, and not in addition to non-cash benefits provided by the local AHECs. In

addition, cash payments for precepting should not be available to medical school faculty members who are already receiving a state salary.

Recommendation (10). Virginia medical schools and the Statewide AHEC Program, in their respective budget requests, should agree upon and specify the role of each organization in recruitment and support of medical student preceptors with the goal of avoiding unnecessary duplication and overlap of functions and resources.

Recommendation(11). The Statewide AHEC Program, as part of its biennial budget request, should include a plan for reallocating federal funds currently earmarked for cash payments to community preceptors. The first priority for reallocation should be to support programs related to the Virginia Generalist Initiative and the Virginia Practice Sights Initiative.

Graduate Medical Education

Background

While not all medical school graduates will receive residency training in Virginia, Virginia graduate medical education programs can play an important role in providing more generalists for Virginia. For instance, 35% of Virginia medical school graduates selecting generalist residencies in 1995 chose Virginia residency programs. Family practice residencies are a particularly important resource. For example, at VCU-MCV, 60 percent of family practice residents are Virginia medical school graduates, and 64 percent practice in Virginia upon graduation. Thus graduate medical education is a vital component of the Virginia Generalist Initiative.

The Commonwealth also has an abiding interest in graduate medical education (GME) reform because of its commitment to graduate medical education funding as well as its moral commitment to assure that graduate medical education programs at state institutions are effectively planned and operated to meet the needs of Virginians. Today, Virginia's graduate medical education programs are heavily geared toward specialty care, and it is unclear whether the current array of programs are needed. The academic health centers are developing plans for restructuring residency

programs to respond to the demand for more primary care physicians. GME restructuring should continue as a priority for the purpose of meeting Virginia's need for generalists as well as for the purpose of containing state teaching hospital costs.

Current Efforts

The Commonwealth provides substantial support for graduate medical education

Graduate medical education is financed through the medical schools as well as the state teaching hospitals. State funding for graduate medical education comes through several sources:

* For FY 1996, the General Assembly appropriated $8.4 million to support family practice residency programs at the three academic health centers.

* The Virginia Medicaid program also makes direct medical education payments to the two state teaching hospitals. These payments exceeded $9.4 million in FY 1993, of which the state share was $4.7 million.

* An estimated $4.9 million was paid for graduate medical education programs through Medicaid enhanced disproportionate share payments to the two state teaching hospitals in FY 1995. Total Medicaid enhanced disproportionate share payments reached $97.7 million in FY 1995. The state share of these payments was $48.9 million. Budget language specifies that these payments are to be used to defray the costs of indigent care and medical education at the state teaching hospitals. There is no definitive method for allocating a share of these payments to medical education versus indigent care. A conservative estimate of educational costs, based on a 1993 JLARC study, would place direct medical education costs at about 10% of total hospital costs. The estimate is based upon ten percent of the state share of enhanced disproportionate share payments in FY 1995.

* A fourth source of payment for graduate medical education is the $6.3 million appropriation to the Medical College of Hampton

Roads. It is unknown what portion of this money is used to defray the costs of graduate medical education.

The Secretary of Education is studying the feasibility of privatizing the two state teaching hospitals

Language in the 1995 Appropriation Act directs the Secretary of Education, in cooperation with the Department of Planning and Budget, UVAHSC, and VCU-MCV, to study the feasibility of privatizing the two state teaching hospitals. The study is to be submitted to the Governor and to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 1995.

The academic health centers are developing plans for graduate medical education reform

The academic health centers are engaged in a number of activities aimed at graduate medical education reform, as described below:

* In response to budget language approved by the 1994 General Assembly, a statewide task force of the three academic health centers is developing a comprehensive proposal for graduate medical education reform. The proposal is to include strategies for comprehensive planning of graduate medical education programs, the role of residents, fellows, and medical school faculty in the delivery of health care in the Commonwealth, and a recommended funding policy for graduate medical education. This plan will build upon preliminary reports submitted by each academic health center in the fall of 1994. The plan is to be submitted to the Joint Commission on Health Care and the State Council of Higher Education by July of 1995.

* The Statewide Center for the Advancement of Generalist Medicine (located at the University of Virginia) is working to develop an action plan for expanding generalist residency programs in Southwest Virginia, in response to budget language approved by the 1995 General Assembly. This action plan is to be submitted to the Governor, the State Council of Higher Education, the Chairmen of the House Appropriations and Senate Finance Committees, and the

Joint Commission on Health Care by Sept. 1, 1995. The academic health centers are exploring options for expanding elective family practice rotations in Southwest Virginia as part of the broader planning effort.

* EVMS has established a new joint residency program which allows achievement of dual board certification in Internal and Family Medicine. Plans are also underway for integrated residency experiences among pediatrics, internal medicine, and family medicine.

* VCU-MCV has completed a planning process in which 35 residents and faculty from the three generalist departments established common goals and common program objectives for generalist residency education.

* UVAHSC has set specific goals for increasing the percentage of residents who will enter generalist medicine from the disciplines of internal medicine, pediatrics, and family practice.

Issues

Virginia graduate medical education programs are heavily geared toward specialty care

Virginia's generalist residency programs graduated 153 generalist physicians in 1993-94 (Figure 10). Generalists represented 23% of all fellowship and residency program completes at UVAHSC, 32% at VCU-MCV, and 39% at EVMS. Because many residents only stay in Virginia programs for one or two years before completing their programs elsewhere, and other residents come for only one year to complete a program, these percentages do not provide a completely accurate picture of the emphasis on generalist residencies at each school. The institutions are developing what they believe to be a more accurate method for calculating the percentage of generalist output based on FTE resident output. (This method would raise the generalist output percentage to 31% at UVAHSC; the other two institutions are developing their own figures.) Whatever the method, it is clear that Virginia's graduate medical education programs are heavily geared toward specialty care.

Figure 10
Generalist Output from Graduate Medical Education Programs
1994

	EVMS	UVAHSC	VCU-MCV
Number of Generalist Residents Completing Programs	39	46	68
Generalists as Percent of All Completing Programs	39%	22%	32%
FTE Generalists as Percent of All FTE Completing Programs	NA	31%	NA

Source: Virginia Medical Schools

Graduate medical education reform is necessary to respond to the need for generalists and to contain costs

At this point, it is unclear whether Virginia needs all of its current array of graduate medical education programs. Most observers agree that the nation's supply of specialist physicians is more than adequate, and that the demand for some specialists is beginning to decline. New technologies and the pressures of managed care are causing a national decline in inpatient hospital days, and Virginia's state teaching hospitals are no exception to this trend. Given reports from academic health center officials that graduate medical education programs add unreimbursed costs to the overall expense of running teaching hospitals, this new environment begs the question of whether the current array of residencies is needed to meet the state's need for health care providers, and whether patient care would suffer if residency positions were eliminated.

Some of the major academic health centers across the country are asking this question and taking significant action. According to a recent

Boston Globe report, Massachusetts General Hospital and Brigham and Women's Hospital in Boston, Massachusetts are planning to reduce the number of medical residents they admit by as much as 15 percent. Duke University Hospital has announced that it will cut its 495-resident staff by 30 percent over four years. Henry Ford Health System in Detroit is considering plans to cut its residency programs by up to 25 percent.

These steps are being taken to reduce costs and to align graduate medical education programs with the actual need for new providers. Looking ahead, changes in Medicaid and Medicare in particular may pose a serious challenge to the academic health centers. At the federal level, Congress is considering changes to the Medicare program which could significantly reduce Medicare payments to teaching hospitals for graduate medical education. Congress is also considering caps on Medicaid spending growth which could eliminate or seriously limit federal Medicaid disproportionate share payments and Medicaid payments for graduate medical education.

Within Virginia, plans are being developed to eventually serve all Medicaid recipients through capitated managed care plans. It remains unclear how this type of system will affect the academic health centers and their graduate medical education programs. The Department of Medical Assistance Services has been requested to present an assessment of the impact of Medicaid reform on the academic health centers as part of a plan to be completed by September 1, 1995.

The Commonwealth should be certain that existing graduate medical education programs are fully utilized before appropriating funds for expanded residency programs

Graduate medical education reform is still in the planning stages. In the interim until comprehensive reform is implemented, it is important to ensure that existing graduate medical education programs are fully utilized before devoting additional resources to expanded residencies. A first step would be to develop better information on the placement of

graduates from Virginia graduate medical education programs. Based upon this information, there may be a need to develop plans for revising residency program admissions processes to identify those candidates who are most likely to practice as generalists in Virginia. Community-based rotations, such as those being explored as part of the Southwest Virginia residency planning project, should also be examined as one strategy for supporting the development of generalist residents interested in serving in Virginia.

Recommendations

Recommendation (12). The academic health centers should continue efforts to restructure graduate medical education.

Recommendation (13). The academic health centers should track the placement of their generalist residency graduates in order to determine the rate of placement in Virginia in general and Virginia underserved areas in particular.

Recommendation (14). The academic health centers should consider the potential of residency admissions reform and community-based residency rotations as strategies for increasing the number of generalist residency graduates interested in serving in Virginia underserved areas.

Recommendation (15). State Medicaid reform should be evaluated for its impact on undergraduate and graduate medical education.

Collaborative and Multidisciplinary Training

Local AHECs support community-based training for a variety of health professionals in training

In addition to medical students and residents, the Statewide AHEC Program supports community-based educational rotations for nurse practitioner students, physician assistant students, dental students, pharmacy students, and allied health students. This interdisciplinary focus makes the local AHECs an appropriate vehicle for supporting

collaborative training programs in the community setting. Three local AHECs supported these types of programs during 1994-95. For example:

> *During the summer of 1994, a multidisciplinary team of 6 dental students, 1 dental resident, 2 medical students, 1 medical resident, 1 nursing oncology student, and 1 pharmacy student, all from Virginia Commonwealth University, completed a one-week rotation in underserved communities of Southwest Virginia while conducting oral pathology screenings aboard a mobile dental unit. The Southwest Virginia AHEC arranged student and faculty support for this project, which provided needed services to 1,300 residents of Southwest Virginia.*

The academic health centers have been requested to work with the Area Health Education Centers to develop collaborative training models for physicians and nurse practitioners

The 1995 General Assembly passed HJR 512 requesting Virginia's academic health centers, in cooperation with the Area Health Education Centers, to develop collaborative training models for physicians and nurse practitioners. The schools are to report on their progress to the Governor and the General Assembly by October 1, 1995.

The Virginia Primary Care Association is a partner in the National Health Service Corps' Sceptor program. The Sceptor program provides health professions students an opportunity to experience primary care through multidisciplinary placements in Community Health Centers located throughout Virginia. A primary goal of the program is to encourage students to return to medically underserved areas to practice upon graduation. So far, four Sceptor students have been hired by Community Health Centers following their placements. The program provides financial support to students and participating preceptors.

The Sceptor program will exhaust its funding in August of 1995. The Virginia Primary Care Association is actively seeking alternative funding for the program. The estimated need for additional funding through December, 1995 is $40,000.

Recommendation (16). The Statewide AHEC Program and the Virginia Health Care Foundation should evaluate the possibility of using AHEC resources to support the Sceptor program on a permanent or temporary basis.

Many Virginia Health Care Foundation projects have a strong educational component

As described in Chapter I, the Virginia Health Care Foundation is supporting more than 40 projects across the state aimed at improving access to primary and preventive care for the uninsured. Many of these projects directly or indirectly support health professions education. For example, 18 current projects serve as a clinical rotation site for health professions students, and 14 are in medically underserved areas. The Foundation has also begun to sponsor programs which are targeted directly at health professions education. For example:

The Foundation has awarded a $100,000 grant to the College of Health Sciences at the Community Hospital Roanoke Valley to support the renovation of science and professional labs necessary to establish a physician assistant program. (The Southwest AHEC will be providing student preceptor support for the program.)

The Foundation has awarded a $30,000 grant to support development of a video presentation for preceptors in the Old Dominion School of Nursing's Distance Family Nurse Practitioner Program. This program uses interactive television satellite courses to offer baccalaureate-prepared nurses in rural areas the chance to pursue a master's degree and certification as a family nurse practitioner.

The Foundation has made a $101,000 grant to the Page Primary Care Consortium in Page County to establish a community-based, nurse managed, comprehensive primary care center for residents of Page County. The center will also serve as an interdisciplinary training site for health professions students. Page Memorial Hospital will provide the center site and all ancillary services and be a service agent for the project. The Northwest AHEC and the AHEC Regional Office at the University of Virginia Health Sciences Center helped to develop the grant proposal, the Northwest AHEC will help support student rotations at the center.

CHAPTER VI
Provider Recruitment and Retention in Underserved Areas

Background

Provider recruitment strategies should focus on primary care providers, particularly family practitioners, with backgrounds in rural or urban underserved areas

Research on physician placement patterns indicates that doctors who grew up in rural areas are more likely to go to rural settings. There is also evidence that among all types of generalist physicians, family practitioners are more likely to locate in rural underserved areas. One reason for this is that family physicians can treat a wide range of patients including the elderly, children, and pregnant women. In many cases, general internists and pediatricians have a difficult time establishing a viable practice because they treat a narrower stream of patients. This is not to imply that general internists and pediatricians cannot or should not be part of the solution for underserved areas. The point is that efforts to recruit pediatricians and general internists should be undertaken with the understanding that these providers may need special assistance to establish a viable practice.

Research also indicates that minority physicians are more likely to practice in minority/urban underserved areas. Minority representation in the primary care workforce is important from several perspectives. There is much greater morbidity and mortality among minorities as compared with the white population, and minority providers often have a particular interest in addressing these problems. Also, experience shows that cultural and language differences are often best addressed by physicians from the respective minority group. Finally, minority physician role models are important for encouraging minority students to enter primary health care.

Provider retention strategies should focus on improving the primary care practice environment

Research shows that the factors which appear to influence a physician's decision to locate in an underserved area do not necessarily influence the physician's decision to stay in the area beyond contractual requirements. It is logical to assume that retention is influenced by factors in the practice environment -- such as income growth, workload, and availability of local hospitals -- as well as the changing family situations of physicians. This suggests that strategies to support providers in practice are extremely important for retaining physicians in underserved areas. In addition, communities should focus on meeting the family needs of providers to the extent possible.

Current Efforts

A number of efforts are underway to improve Virginia's ability to recruit and retain primary care providers in underserved areas. Many of these efforts are organized under the Virginia Practice Sights Initiative. This initiative, supported through a three-year, $798,000 grant from the Robert Wood Johnson Foundation, is intended to enhance Virginia's recruitment and retention efforts. The current status and issues associated with each initiative are described below.

The Center for Health Professions Recruitment and Retention

In 1994 the Joint Commission on Health Care successfully introduced Senate Joint Resolution 113 requesting the Commissioner of Health to reallocate existing resources for the creation of an Office for Health Professions Recruitment and Retention in the Virginia Health Department. This office was established as a full-time Center in the Spring of 1995, and operates under the supervision of the Deputy Commissioner for Health Policy. The Center is envisioned as the main link between

underserved communities and the resources of the Virginia Practice Sights Initiative, and is responsible for:

* Developing the Primary Care Management Information System;

* Administering and marketing existing state and federal scholarship and loan repayment programs to students and residents across the country;

* Managing the Cooperative Agreement between the federal government and the Virginia Health Department;

* Helping to coordinate the provision of technical assistance to rural providers through the Virginia Office of Rural Health;

* Helping to coordinate the community development initiatives of the Virginia Health Care Foundation; and

* Developing an advisory consortium of public and private entities engaged in recruitment and retention efforts in the Commonwealth.

The responsibilities of the Center go beyond those currently articulated in the Code of Virginia. The Code gives the Virginia Health Department statutory responsibility for developing criteria to identify underserved areas, administering the various scholarship and loan repayment programs, and establishing a Statewide AHEC Program. The Center is intended to provide central coordination of recruitment and retention activities of public and private entities engaged in these activities in the Commonwealth. This level of responsibility is not spelled out in the Code. Legislation giving the VHD specific responsibility for leading health professions recruitment and retention efforts could help affirm the importance of this function and clarify the responsibilities of the VHD in this area.

Recommendation (17). The General Assembly may wish to consider amending the Code of Virginia to give the Virginia Health Department clear statutory responsibility for coordination of health professions recruitment and retention efforts.

Scholarship and Loan Repayment Programs

Virginia Medical Scholarship Program

This program provides $10,000 scholarships to medical students at Virginia medical schools and Eastern Tennessee State Medical School in return for a commitment of one year of service in a Virginia medically underserved for each year of scholarship. Total state funding for FY 1996 reached $445,000 after a series of significant increases. The medical schools are required to match state funds for new applicants after July, 1994. Eight scholarships have been placed in service in Virginia since FY 1991.

A total of 58 Virginia Medical Scholarships were made available during 1994-95. Of these, only 42 were awarded. The deficit came primarily from UVAHSC and EVMS, which together only awarded one of their 18 matching scholarships. ETSU was only able to award one of its four fully-funded scholarships. VCU-MCV was able to award two match funded scholarships from EVMS, and two fully-funded scholarships from ETSU. A total of $70,000 was returned to the general fund as a result of unused scholarships.

There are several possible reasons for this situation. One problem may be a lack of adequate marketing of the scholarships at EVMS and UVAHSC. Another problem mentioned by the schools is that students are increasingly hesitant to make the required service commitment (or face a triple-payback penalty for default) so early in their careers. (A related problem arising at EVMS was a situation in which the spouse of a student who died with an outstanding scholarship commitment had to wait months before receiving word that the scholarship would be forgiven.) It is also unclear what effect the requirement for medical school matching funds has had on the schools' commitment to support the scholarships.

Recommendation (18). Virginia's three academic health centers, in collaboration with the Center for Health Professions Recruitment and Retention in the Virginia Health Department, should develop a coordinated plan for recruiting Virginia Medical Scholarship Program recipients for 1995-1996.

Recommendation (19). The General Assembly may wish to consider amending the Code of Virginia to allow unused scholarship and loan repayment funds to be carried over for use in subsequent years.

Virginia Dental Scholarship Program

This program provides $2,500 scholarships to Virginia dental students in return for a commitment of one year of service in a Virginia medically underserved area for each year of scholarship. Total state funding for FY 1996 is $25,000. The per-scholarship amount of $2,500 is less than one quarter of the tuition costs of dental school. There is also a triple-payback provision for default. Nevertheless, all ten scholarships were awarded during 1994-95.

However, placement rates for scholarship recipients raise questions about the value of the program under the current scholarship amounts. Between 1986 and 1993, 30 participants became eligible for placement. Of these, 18 were placed and 12 defaulted. Although there has not been a detailed assessment of why recipients defaulted, program staff pointed out that a number of the defaulters "bought out" their obligations. It is currently unclear what affect the recently initiated triple-payback provision may have on default rates.

Recommendation (20). The General Assembly may wish to consider increasing the appropriation for dental scholarship to $111,000 to cover the full cost of dental school tuition.

Virginia Nurse Practitioner Scholarship Program

This program provides $5,000 scholarships to Virginia nurse practitioner students in return for a commitment of one year of service in a Virginia medically underserved area for each year of scholarship. During 1994-95, all five scholarships were awarded. Total state funding for FY 1996 is $25,000.

The Virginia Nurse Practitioner Scholarship Program was initiated in 1992. Since 1992, there have been a total of 9 recipients. Three are still in school and six have become eligible for placement. At least five are currently employed, but only one has been placed in a certified Virginia Medically Underserved Area thus far.

Concerns have also been raised about the amounts of nurse practitioner scholarships. In years prior to 1994-1995, it has been difficult to award all of the scholarships because applicants perceived the amounts available as too small to meet their need for tuition assistance.

Recommendation (21). The Board of Health should ensure that all nurse practitioner scholarship recipients under service obligations to the Commonwealth either complete their obligation to serve in a Virginia Medically Underserved Area or pay the required penalty.

Physician Loan Repayment

Three physician loan payment programs have been established in Virginia:

State/Federal Physician Loan Repayment Program. This program provides a maximum of $20,000 per year in loan repayment assistance in return for a minimum commitment of two years of service. Total state funding for FY 1996 is $50,000 to match $50,000 in federal funding.

Virginia Physician Loan Repayment Program. This program was established in 1994 with the intent of establishing a purely state funded loan repayment program. There is not state appropriation for the program.

National Health Service Corps Loan Repayment Program. This federal program provides loan repayment assistance in return for service in federally designated underserved areas. Total assistance available is $25,000 per year plus an additional stipend to offset income taxes. Twenty program participants were practicing in

Virginia as of January, 1995. The state does not administer this program.

Virginia's existing State/Federal Loan Repayment program has two providers under contract. By contrast, there are 20 Virginia providers under contract with the National Health Service Corps Loan Repayment Corps. Anecdotal evidence indicates that the National Health Service Corps presents a more attractive option to providers because it pays significantly more than Virginia's State/Federal Program. Also, the National Health Service Corps program allows greater flexibility in where the provider serves out the contract period. Right now, it is uncertain whether the State/Federal Loan Repayment Program or the National Health Service Corps program will survive federal budget cuts.

Virginia has established a state-only Virginia Physician Loan Repayment Program which has not yet been funded. The state-only program was established in an effort to avoid certain placement restrictions in the state/federal program, and in anticipation of possible federal budget cuts. Another potential benefit of a state-only program could be its utility as a vehicle for administering private loan repayment funds developed by the Virginia Health Care Foundation under the Virginia community resource initiative. Local private funds developed as part of a loan repayment package for a primary care provider could be administered through the state program. As yet, the regulations for the Virginia Physician Loan Repayment Program have not been established.

Recommendation (22). The Board of Health should initiate the process for establishing regulations for the Virginia Physician Loan Repayment Program.

Recommendation (23). The General Assembly may wish to consider an initial appropriation of funds to the Virginia Physician Loan Repayment Program.

Private Sector Initiatives

The Virginia Health Care Foundation is the lead organization for the Virginia Practice Sights Initiative efforts to develop private sector

involvement in provider recruitment and retention. Virginia Health Care Foundation responsibilities include:

The Healthy Communities Loan Fund. This fund would make low-cost loans available to individuals and organizations attempting to increase the supply of primary care providers in Virginia Health Professional Shortage Areas. The fund is being developed through a partnership between the Virginia Health Care Foundation, First Virginia Banks, Inc., and the Robert Wood Johnson Foundation. A loan from the Robert Wood Johnson Foundation would be used to leverage funds from First Virginia Banks, Inc. A $4.2 million pool of funds would be made available. In addition to increased access to capital, loan applicants would benefit from technical assistance provided by a diverse loan advisory group with representation from various provider communities and state agencies. The Robert Wood Johnson Foundation is currently reviewing Virginia's application for the loan fund.

The Virginia Community Resource Initiative. This initiative will attempt to develop private resources to build upon publicly funded programs through private loan repayment, provider income subsidies, and low interest loan consolidation programs. It is currently in the planning stage.

Primary Care Practice Enhancement Initiative. This initiative will attempt to bring private sector resources to bear on operational issues facing primary care providers in underserved areas. Technical assistance will be provided in practice management, operations, and systems development. This initiative is currently in the planning stage.

Provider Services Consulting Initiative. This initiative will attempt to bring innovative approaches to primary care practice in a select group of underserved communities. Private sector consultants will aid in the development of delivery system models which meet the needs of one or more underserved communities. This project is in the planning stage.

Other Virginia Health Care Foundation projects. In addition to projects directly associated with the Virginia Practice Sights Initiative, the Virginia Health Care Foundation also aids primary care recruitment and retention efforts through its role of supporting

local public/private that extend primary and preventive health care services to Virginia's uninsured citizens.

Technical Assistance and Educational Support

Office of Rural Health

The Virginia Office of Rural Health is devoted to promoting improving access to health care for rural Virginians. In this context, the Office of Rural Health provides a wide range of technical assistance services to rural providers. One of the most important services is to provide assistance to primary care clinics desiring to become federally-designated rural health clinics, and thus become eligible for enhanced reimbursement from federal programs. Virginia currently has 18 such clinics, 15 of which have been designated over the past two years.

Virginia Primary Care Association

The Virginia Primary Care Association is a private association of community and migrant health centers (CHCs). CHCs are primary care providers which are not-for-profit, located in medically underserved areas, governed by volunteer community boards, and open to all regardless of ability to pay. There are currently 40 CHCs across the Commonwealth. The Virginia Primary Care Association provides a wide range of technical assistance services to help the CHCs become operational and optimize reimbursement. The Virginia Primary Care Association is also active in assisting CHCs in recruiting primary care providers.

Rural Health Resource Center

The Statewide AHEC Program and the Center for Health Professions Recruitment and Retention are co-sponsoring a series of workshops intended to help physicians learn more about the potential of using nurse practitioners and physician assistants. The workshops will be provided by the Virginia Rural Health Resource Center, a private consulting firm. The workshops will cover such topics as the knowledge and skills of nurse practitioners and physician assistants and the economics of integrating these providers into a physician practice. Private sector organizations will also co-sponsor the workshops.

Statewide AHEC Program

One of the priorities of the Statewide AHEC Program is to provide services to enhance the practice environment of primary care health professionals. Activities include the creation of regional continuing education consortia, direct sponsorship of continuing education programs, support of distance learning, and provision of library services. During 1994-95, the Statewide AHEC Program supported continuing education programs for more than 1,700 health care providers. The Program provided library and learning resources to more than 600 practitioners during 1994-95. The Statewide AHEC Program plans to increase its practice support activities significantly in 1995-96.

Reimbursement and Regulatory Policy

The Joint Commission on Health Care is assigned responsibility for evaluating a range of policy issues under the Virginia Practice Sights Initiative. One initiative has included the evaluation of barriers to practice for nurse practitioners. In 1995 the Joint Commission successfully introduced legislation to provide physicians the flexibility to supervise more nurse practitioners with prescriptive authority. The Joint Commission also introduced a study resolution requesting the academic health centers to work with the Statewide AHEC Program to develop collaborative training models for physicians and nurse practitioners.

During 1995-96, the Joint Commission will be responsible for evaluating the impact of provider reimbursement policies on primary care practice in underserved areas. A special focus of this study will be the impact of Medicaid managed care and the Medicaid fee structure under RBRVS. The hope is that Trigon BlueCross BlueShield and other Virginia payers will also review their payment policies for their effect on primary care practice in underserved areas.

Recruitment and Retention Advisory Consortium

The Center for Health Professions Recruitment and Retention is developing plans for a Recruitment and Retention Advisory Consortium which will provide advice and ensure that effective linkages with private sector recruitment and retention efforts are maintained. The Center and the Consortium will look for ways to:

* Maintain a current inventory of recruitment and retention activities within the state;

* Combine administration of programs as appropriate;

* Launch a coordinated marketing effort for attracting primary care providers to Virginia areas of need; and

* Develop a matching program to match the providers with Virginia underserved communities.

Chapter VII
The Future of the Statewide AHEC Program

The Virginia Statewide AHEC Program is actively involved in many different aspects of health workforce reform. The Statewide AHEC program is providing support in the areas of student recruitment, medical and other health professions education, graduate medical education, and practice support. The Statewide AHEC Program is unique among Virginia's health workforce initiatives in its multidisiplinary focus and in its special emphasis on health careers recruitment among minority and disadvantaged students. It is also a potentially valuable resource simply by virtue of its community-based perspective.

Several important decisions must be made about the future of the Statewide AHEC Program. While the program was created in part to promote the development of community-based health care delivery systems, it has evolved into a primarily educational support organization. Also, federal funding for the Statewide AHEC program will begin to decline during state fiscal year 1998, and Virginia will have to decide whether to assume increased responsibility for program funding. Finally, as pointed out in preceding chapters, the Statewide AHEC Program is not well integrated with Virginia's academic health centers. This chapter describes these issues, and presents a series of options and recommendations for the future of the Statewide AHEC Program.

Legislative intent for the Statewide AHEC Program should be clarified

The stated mission of the Statewide AHEC Program is to *"...optimize access to quality health care through community-academic educational partnerships that emphasize primary health care in underserved communities."* This mission is to be carried out through the following goals:

* Developing health careers recruitment programs for Virginia's minority and disadvantaged students;

* Supporting the training of primary care health professions students and residents in Virginia's underserved communities; and

* Providing educational practice support systems for the Commonwealth's primary care providers.

This statement of mission and goals does not fully reflect legislative intent for the Statewide AHEC Program as stated in the Code of Virginia. It does address the Code requirement that AHEC anticipate and avoid critical physician shortages by expanding opportunities for family practice preceptorships, clerkships, and residencies; as well as the requirement that AHEC recruit students to enter primary care specialties and to practice in underserved areas. However, the current AHEC mission and goals statement does not address these Code requirements:

* Establish professional practice support systems by linking the benefits and the medical expertise and research of the three medical schools with the delivery of health services to indigent individuals.

* Promote the development and implementation of innovations in the delivery of community health services such as after hours clinics in the three medical schools and community-based service demonstration projects.

There are two reasons for this situation. First, responsibility for developing delivery systems for community health services has largely been assumed by the Virginia Health Care Foundation and the various programs developed for this purpose under the Virginia Practice Sights Initiative. Second, most local AHECs are federally funded and therefore respond to federal priorities for local AHECs, which emphasize health careers promotion and support of community-based education. As a result, the Statewide AHEC Program has evolved into an organization whose primary focus is on health careers promotion and educational support as opposed to innovative service delivery and indigent care.

Furthermore, although the Statewide AHEC program has become a primarily educational organization, and the grantee for the statewide program is VCU-MCV, its statutory authority lies with the Board of

Health. Uncertainty about the role of AHEC has also clouded the relationship between the local AHECS and the state medical schools. This has been apparent from a reluctance of the respective organizations to cooperate in the budget development process as well as a hesitance to work together on various programs. These issues must be addressed if AHEC is going to play a productive role in bringing the programs of the academic health centers to the community.

The following actions are recommended to address current problems in the Statewide AHEC Program:

Recommendation (24). The General Assembly may wish to consider amending the Code of Virginia to redefine the mission of the Statewide AHEC program toward health careers promotion and health professions education support and relocate statutory responsibility for the Statewide AHEC program from the Virginia Health Department to Virginia Commonwealth University.

Recommendation (25). Standing AHEC task forces should be disbanded unless they are required to fulfill a legislative mandate or to improve AHEC program operations. Resources should be reallocated to support core services.

Recommendation (26). Regional AHEC offices should be consolidated with the Center for the Advancement of Generalist Medicine at each of the three academic health centers so that programs can be better coordinated, administrative costs can be reduced, and budgets can be better integrated.

Recommendation (27). Local AHECs should actively seek funding from non-state sources to supplement state and federal funding. The academic health centers should assist the local AHECs with the development of grant proposals.

The Statewide AHEC Program could be restructured as federal funding declines

The Statewide AHEC program is jointly funded by the state and the federal government. As shown in Figure 11, the total program budget for FY 1995 was more than $1.9 million, including $440,000 of state general funds. Nearly $420,000 of the state appropriation was allocated to the Eastern Virginia AHEC, which has exhausted its eligibility for federal

Figure 11
Statewide AHEC Budget
FY 1995

	Federal	State	Total	Decremental Funding Begins
Statewide Office	$247,116	$15,000	$262,116	
UVA Regional Office	$117,180	$5,150	$122,330	
Northwest AHEC	$270,000		$270,000	FFY 1996
Southwest AHEC	$181,440		$181,440	FFY 1997
South Central AHEC	$116,165		$116,165	FFY 1998
Southside AHEC	$280,800		$280,800	FFY 1996
Greater Richmond AHEC	$184,763		$184,763	FFY 1997
Rappahannock AHEC	$98,820		$98,820	FFY 1998
Northeast AHEC	$3,998		$3,998	FFY 1999
Eastern VA AHEC	$0	$419,850	$419,850	Receives no federal funds
	$1,500,282	$440,000	$1,940,282	

Source: Statewide AHEC Program

funding. Of these funds, $200,000 are allocated from the indigent care appropriation to the Medical College of Hampton Roads (the parent organization of EVMS), and the remaining amounts are allocated from the state appropriation to the Statewide AHEC. For state FY 1996, the AHEC program has been appropriated $558,139 in state general funds, of which $118,139 is earmarked for student recruitment programs associated with the Virginia Generalist Initiative.

Federal AHEC funding is designed to stimulate state commitment to the AHEC program, with the idea that the state will eventually assume full responsibility for funding. Virginia is due to receive federal funding of $1.7 million in FFY 1996 and $1.9 million in FFY 1997. Federal funding will drop to $1.4 million in FFY 1998, and continue declining thereafter. This

principle of "decremental funding" applies to individual local AHECs as well. As shown, two local AHECs per year will enter decremental funding beginning in FFY 1996, beginning with the Southside AHEC and the Northwest Virginia AHEC.

The State must decide whether to assume responsibility for funding the Statewide AHEC program as federal funding declines. As part of this decision, consideration should be given to the mission and goals of the Statewide AHEC program as well as several organizational and operational issues.

Is there a need for eight local AHECs? The current AHEC structure of eight local AHECs has not evolved in response to either federal mandates or a state-developed strategic plan. It appears that there has been an honest desire to bring AHEC services to all regions of the Commonwealth, and new AHECs have been created as federal funds have become available. If the state is to assume majority funding for the Statewide AHEC Program as federal funding declines, then the need for eight local AHECs should be justified based upon an analysis of the demand for AHEC services.

What is the appropriate role of the local AHECs in school-based programs for recruitment of minority and disadvantaged students? One of the most unique and potentially important functions of the local AHECs is their work in developing health career promotions programs in schools. It is difficult to evaluate the impact of these activities at this time because most of the students who have participated in these programs are not old enough to have entered health professions training. One concern about these activities is the potential overlap with programs already going on in the schools. If the state is to assume responsibility for funding these activities, it will be important to evaluate whether the local AHECs are in fact meeting a need that could be met by local school districts.

In addition to the operational recommendations presented in the previous section, the following options may be considered for restructuring the Statewide AHEC Program as federal funding declines:

Option 1. Consolidate the eight local AHEC programs into five, one for each Health Systems Area.

This option would require that the current system of eight local AHECs be consolidated into five regional AHECs to parallel the five Health Systems Agencies. This option also would reduce the number of local AHEC boards and the associated expenses. AHEC staff expenses could also be reduced. This option also would have the benefit of aligning the local AHECs with the state's existing infrastructure for health planning. Local AHEC boards and staff would have to serve larger populations and geographic areas. This option would also have to be evaluated for its impact on the state's eligibility for federal funding under the current three-year federal grant.

Option 2. Consolidate the eight local AHECs into three, one at each of the academic health centers.

This option would further consolidate the Statewide AHEC Program into three regional AHECs based at the academic health centers. This approach would reduce expenses for local boards and AHEC staff. This option would have the benefit of aligning the AHECs directly with the Commonwealth's major health professions education institutions. It would also have the benefit of making the academic health centers directly accountable for the performance of the AHEC program. Another benefit would be reduced expenses for AHEC staff and local boards.

A concern would be whether the academic health centers would remain committed to making AHEC resources available to local school districts and other health professions education institutions. Also, like Option 2, this option would have to be evaluated for its impact on federal funding. Each academic health center would have to establish a non-profit corporation with a community board in order to remain eligible for federal funding. This is not required of AHECs that do not receive federal funding, such as the Eastern Virginia AHEC.

Option 3. Eliminate the Statewide AHEC Program and establish three regional AHECs, one at each academic health center

This option would include all of the elements of Option 3 above with the additional provision of eliminating the Statewide AHEC Program and moving to three separate regional AHECs. This approach would make the academic health centers directly accountable for AHEC program performance. The state would have to be divided into three regional AHEC territories for which the academic health centers would be responsible. Each regional AHEC would have to be a non-profit corporation with a community board in order to maintain eligibility for federal funding. Again, this is not required of AHECs that do not receive federal funding.

APPENDIX A

SENATE JOINT RESOLUTION NO. 308

Requesting the Joint Commission on Health Care, in cooperation with the Secretary of Edu. tion, the Secretary of Health and Human Resources, and the State Council of Higher Education, to study the organization and effectiveness of state health workforce reform initiatives.

Agreed to by the Senate, February 23, 1995
Agreed to by the House of Delegates, February 22, 1995

WHEREAS, access to primary health care services is essential for the good health of all Virginians; and

WHEREAS, Virginia currently has an inadequate supply of primary care physicians relative to specialty care physicians; and

WHEREAS, many Virginia localities are experiencing chronic shortages of primary health care providers; and

WHEREAS, the health care system is rapidly evolving toward managed health care delivery systems which require increased numbers of primary health care providers; and

WHEREAS, the Commonwealth has implemented numerous programs to increase the supply of primary health care providers, including (i) the Generalist Initiative for increasing the number of primary care physicians produced by Virginia medical schools, (ii) the Practice Sights Initiative for recruiting and retaining primary health care providers in underserved areas through the use of scholarships, loan repayment programs, provider practice support, and other incentives, (iii) the Area Health Education Centers Program, which supports both the Generalist Initiative and the Practice Sights Initiative through health professions student recruitment and community-based educational programs, (iv) the Office of Rural Health, which supports the Practice Sights Initiative through provider recruitment and retention efforts in rural areas, (v) the Virginia Health Care Foundation, which supports public/private initiatives to recruit and retain primary care providers in underserved areas, and (vi) the Primary Care Cooperative Agreement, which supports primary care needs assessment and planning; and

WHEREAS, these programs involve multiple agencies in both the Education and Health and Human Resources Secretariats, as well as local, federal and private organizations; and

WHEREAS, these programs must be jointly planned and coordinated to address specific needs for primary health care providers in Virginia's local communities; and

WHEREAS, state funding policies for these programs must be based upon careful evaluation of each program and prioritization of the various initiatives; and

WHEREAS, there is no single organization with designated responsibility for coordinating the Commonwealth's health workforce reform initiatives and developing prioritized budget and policy proposals; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Secretary of Education, the Secretary of Health and Human Resources, and the State Council of Higher Education, be requested to study the organization and effectiveness of Virginia's health workforce reform initiatives. The study shall include an evaluation of the need for each program and an assessment of the effectiveness of each program in addressing health workforce needs in the Commonwealth. The study also shall include an evaluation of the most effective organizational structures for (i) conducting a health workforce needs assessment, (ii) coordinating health professions education initiatives with health professions recruitment and retention initiatives, (iii) developing comprehensive budget and policy proposals which integrate the various health workforce reform initiatives and prioritize among individual program goals, and (iv) monitoring progress toward improving the supply of primary health care providers in medically underserved areas.

The Joint Commission on Health Care shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the commission, upon request.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 3: Health Workforce Initiatives

Summary of Comments

Written comments on this report were received from 46 organizations or individuals. Seven were from state officials or agencies responding to the broad scope of the study. Eight were from non-state organizations responding to the broad scope of the study. Thirty-one were from local Area Health Education Centers (AHECs) or people they have served. The latter group focused most of their attention on recommendations related to the Statewide AHEC Program.

The comments reflected a diversity of opinions on the major recommendations presented in the study. A list of respondents is provided below. Comments are then summarized by issue area.

Comments from State Officials or Agencies Responding to Broad Scope of Study

Secretary of Education
Acting State Health Commissioner
State Council of Higher Education (SCHEV)
Virginia Statewide AHEC Program
Virginia Commonwealth University-Medical College of Virginia (VCU-MCV)
University of Virginia (UVA) Medical School
University of Virginia (UVA) School of Nursing

Comments from Non-state Organizations Responding to Broad Scope of Study

Eastern Virginia Medical School (EVMS)
Virginia Academy of Family Physicians (VAFP)
Medical Society of Virginia (MSV)
Virginia Primary Care Association (VPCA)
League of Virginia Health Systems
Virginia Academy of Physician Assistants
Virginia Health Care Foundation
Virginia Rural Health Resource Center

Comments from Local AHECs or People They Have Served

AHEC Student Participants	James Madison University
Augusta Medical Center	President
Virginia Cooperative Extension	James Madison University School of
UVA School of Nursing	Health and Human Resources
Highland Medical Center	Shenandoah University School of
Mary Baldwin Health Adm.	Nursing
Program	Buckingham County High School
Chair, Southside AHEC Board of	Guidance Department
Directors	Member of Greater Richmond
Family Medical Clinic	AHEC Board of Directors
Community Memorial Health	Richmond Technical Center
Center	Richmond Area High Blood
Prince Edward County High School	Pressure Center
Southside Community Hospital	Chair, South Central AHEC Board
Governor School for Global	of Directors
Economics and Technology	Carillion Health System
Northwest AHEC Board of	Department of Medical Education
Directors	
Northwestern Virginia Health	
Systems Agency	

General Comments on the Study

Acting State Health Commissioner

- Virginia has been lacking a concerted community-focused effort to facilitate local problem solving of primary care needs and the Virginia Department of Health is willing to work toward this goal.

- As federal and state funding for health workforce reform declines, there is a need to determine which programs should be continued, which require continued state funding, and which can be privatized.

- Health workforce initiatives need to demonstrate more understanding of emerging market structures.

- Mid-level providers and "the hybrid generalist/specialist model" must be taken into account in health workforce policy.

Other General Comments

- AHEC representatives, the Virginia Primary Care Association, and others emphasized the importance of community-driven solutions to health workforce problems.

- AHEC representatives, academic health centers representatives, and others emphasized that health workforce reform should encompass mid-level providers and other health professionals in addition to physicians.

- The Virginia Association of Physician Assistants emphasized the need to view PAs as part of the solution for underserved areas.

Comments on Recommendations for State Oversight of Health Workforce Reform

Recommendations

(1) *Consider requesting joint review of health workforce budgets by Education and Health and Human Resources Secretariats.*

(2) *Consider developing a process for cooperative review within the legislature.*

(3) *Consider reconstituting the Health Planning Board as a Primary Care Board with responsibility for overseeing health workforce reform.*

Comments

The Secretary of Education commented that Recommendation (1) is possible but not feasible for this biennium and that Recommendation (3) may be difficult due to scarce staffing resources.

The Acting State Health Commissioner commented that Recommendation (3) has the advantage of bridging secretariats, but has the disadvantage of fragmenting health policy by narrowing the Health Planning Board.

The State Council of Higher Education for Virginia (SCHEV) commented in support of cooperative budget efforts outlined in Recommendation (1), lacks staff to dedicate to the Board in Recommendation (3), and proposes that a broader health policy board with standing committees to deal with primary care and other issues could be effective.

The Statewide AHEC commented in support of cooperative budget efforts in Recommendation (1) and (2).

The University of Virginia School of Medicine commented in support of Recommendations (1), (2), and (3).

VCU-MCV expressed concern that a Primary Care Board may not be active enough and recommended consideration of having SCHEV produce periodic reports on Virginia's health workforce needs.

The Medical Society of Virginia expressed support for Recommendations (1), (2), and (3) (with physician representation).

The Virginia Primary Care Association (VPCA) commented that consideration should be given to refocusing the mission of the Board of Health or the Statewide AHEC Program to provide comprehensive oversight of health workforce reform.

The League of Virginia Health Systems expressed support for Recommendation (3) with representation from health care providers who provide clinical education.

The Virginia Health Care Foundation stated that if a Primary Care Board were to be formed, the Foundation would be pleased to have representation on the board.

The Virginia Rural Health Resource Center expressed support for Recommendation (3) with dedicated staff and representation from the Virginia Primary Care Association.

Comments on Recommendation for Health Workforce Needs Assessment

Recommendation

(4) *Consider amending the Code to require the Board of Health to establish standard measures of primary care provider supply, direct local health directors to annually assess primary care needs, and conduct annual assessments of workforce needs.*

Comments

UVA School of Medicine and the Virginia Primary Care Association expressed support for Recommendation 4.

SCHEV and the League of Virginia Health Systems cautioned against overlap in responsibility between a Primary Care Board and the Board of Health if Recommendations (3) and (4) are both enacted.

VCU-MCV recommended SCHEV as the appropriate agency to do periodic health workforce needs assessments.

Eastern Virginia Medical School (EVMS) commented that EVMS is better suited to the task of regional health workforce planning.

The Virginia Academy of Family Physicians (VAFP) and the Medical Society of Virginia expressed concern about local health department resources to do local needs assessment, and suggested that local AHEC boards may be able to review health workforce needs.

The Statewide AHEC did not specifically address the recommendation but emphasized its ability to contribute to needs assessment.

Comments on Recommendations for Student Recruitment

Recommendations

(5) *The Virginia Generalist Initiative and the Statewide AHEC Program should collaborate and share resources in efforts to recruit students into primary care medicine; AHEC should reallocate federal grant funds toward these efforts to the extent possible.*

(6) *Future budget requests for medical student recruitment should specify roles of AHEC and the medical schools.*

(7) *AHEC should accelerate development of its student tracking system.*

Comments

UVA School of Medicine, the Statewide AHEC Program, SCHEV, and the Medical Society of Virginia expressed general support. AHEC noted that it has a multidisciplinary focus which includes other providers in addition to physicians.

VPCA commented that AHEC funds should not be used to address budget shortfalls of the Virginia Generalist Initiative.

Comments on Recommendations for Health Professions Education

Undergraduate Medical Education Recommendations

(8) *Decisions to make cash payments to preceptors should be made by health professions schools as opposed to local AHECs.*

(9) *Cash payments should be administered by medical schools and not duplicative of non-cash benefits.*

(10) *Future budget requests should specify role of AHECs and medical schools in preceptor compensation.*

(11) *AHEC should plan to allocate federal funds earmarked for cash payments to preceptors, with Generalist Initiative programs as first priority.*

Comments

UVA Medical School expressed support for the recommendations.

The Statewide AHEC expressed support for leaving preceptor cash payment policies to the medical schools.

With regard to budget allocation, the Statewide AHEC agrees "that it is important for health workforce initiatives to share resources when goals and objectives are complementary."

SCHEV commented that preceptor payments should depend on the activity. Preceptor payments may be necessary for students early in their programs, but payments for precepting advanced students probably aren't necessary.

The VAFP commented in favor of cash payments to preceptors, with policies decided by the medical schools.

The Medical Society of Virginia commented that "some incentive" for preceptors is reasonable and should be determined by the medical schools.

Eastern Virginia Medical School commented that preceptor payments have the potential to disrupt the long tradition of community volunteer physicians who are integral to medical education in Eastern Virginia, and could undermine EVMS' capacity to function with a small full-time faculty and large complement of volunteer faculty.

With regard to reallocation of AHEC funds, the VPCA commented that "AHEC funds should remain with AHEC," but coordination with the Generalist Initiative should be increased. Also, program administrative costs should be carefully monitored.

Graduate Medical Education Recommendations

(12) *Academic health centers (AHCs) should continue efforts to restructure graduate medical education.*

(13) *AHCs should track placement of generalist residency graduates.*

(14) *AHCs should consider potential of residency admissions reform and community-based rotations as strategies for increasing generalists.*

(15) *State Medicaid reform should be evaluated for its impact on medical education.*

Comments

UVA Medical School commented in support of the recommendations except for residency admissions reform, stating the nature of the national matching system for residency placement would make such an effort virtually impossible.

EVMS commented in favor of GME reform, but expressed concern about future funding of these programs, particularly Medicaid funding.

The Statewide AHEC Program and the VPCA commented in favor of any changes that will result in additional training in community settings.

SCHEV commented in support of the recommendations, but cautioned that a "grow your own" approach may not be adequate to meet primary care needs. Consideration should also be given to attracting medical graduates from other states into primary care residencies within underserved areas of Virginia.

The VAFP commented in support of the recommendations, adding:

- The academic health centers should actively encourage Virginia medical students to apply to Virginia family practice residency programs.

- It is important to evaluate the impact of commercial insurance payment policies on medical education - many companies benefit from the training of physicians, but do not contribute to the cost of medical education.

The League of Virginia Health Systems commented in support of the recommendations.

The Acting State Health Commissioner commented that policy should focus on limiting the number of specialty physicians being produced by the medical schools as much as increasing numbers of generalist physicians. Additionally, Generalist Initiative funding should be linked to limiting or reducing the number of specialists trained as well as successful location of graduates in medically underserved areas.

Interdisciplinary Education Recommendation

(16) *The Statewide AHEC Program and the Virginia Health Care Foundation should evaluate the possibility of supporting the Sceptor Program on a permanent or temporary basis.*

Comments

The Virginia Health Care Foundation has asked the VPCA to submit a concept paper for consideration in the next Foundation funding cycle.

Comments on Recommendations for Provider Recruitment and Retention

Recommendation 17

(17) *Consider amending the Code of Virginia to give the Health Department clear statutory responsibility for coordination of health professions recruitment and retention efforts.*

Comments

The VAFP commented that the Virginia Office of Rural Health is the best location for recruitment and retention efforts, and that this office should be strengthened.

The Medical Society of Virginia commented that recruitment and retention could be part of a Primary Care Board's responsibilities.

The Virginia Rural Health Resource Center commented that the Health Department should seek input from community organizations which are highly experienced in provider recruitment.

Recommendations

(18) *The AHCs and the Health Department should develop a coordinated plan for recruiting Virginia Medical Scholarship Program recipients.*

(19) *Consider amending the Code of Virginia to allow unused scholarship and loan repayment funds to be carried over.*

(20) *Consider increasing the appropriation for dental scholarships.*

(21) *The Board of Health should improve oversight of nurse practitioner scholarships.*

(22) *The Board of Health should initiate regulatory process for Virginia Physician Loan Repayment Program.*

(23) *Consider an initial appropriation for the Virginia Physician Loan Repayment Program.*

Comments

SCHEV commented in support of the recommendations.

The Statewide AHEC commented in favor of carryover of scholarship and loan repayment funds and an increased appropriation for dental scholarships.

VCU-MCV commented in favor of increased funding for dental scholarships.

UVA Medical School commented in favor of carryover of unused funds and funding of the Virginia Loan Repayment Program; but emphasized that each medical school should be allowed to develop its own scholarship recruiting program.

The Secretary of Education commented that carryover of unused funds and increased funding for dental scholarships would have to be evaluated in light of overall budget priorities.

The UVA School of Nursing commented that current nurse practitioner scholarship amounts are no longer adequate to meet the need.

Comments on Recommendations for the Future of the Statewide AHEC Program

Recommendations

(24) *Consider amending the Code of Virginia to redefine the mission of the Statewide AHEC Program and locate within VCU-MCV.*

(25) *Discontinue standing AHEC task forces unless required to fulfill a legislative mandate.*

(26) *Consolidate regional AHEC offices with Generalist Initiative offices at academic health centers.*

(27) *Local AHECs should actively seek funding from non-state sources to supplement state and federal funding.*

Comments

The Statewide AHEC expressed support for legislation to clarify the mission of AHEC; the recommendation on disbanding task forces; ensuring that AHEC and Generalist administration are not duplicative; and gave examples of how AHEC is already seeking external funding.

VCU-MCV expressed support for clarifying the mission of AHEC and locating with VCU-MCV; but is against consolidating AHEC and Generalist offices because AHEC must be inclusive of other health professions.

UVA Medical School expressed support for consolidating the AHEC regional office and Generalist office at UVA; cautioned that the role of AHEC in provider recruitment and retention should be clarified before removing AHEC authority from the Health Department.

EVMS commented that it has been able to consolidate AHEC administrative structure, cooperate with other health workforce initiatives, and generate substantial local funding.

The VAFP expressed support for disbanding certain AHEC task forces.

The VPCA commented against locating AHEC with VCU-MCV and consolidating AHEC and Generalist offices.

Comments on Options to Consider as Federal AHEC Funding Declines

Options

(1) *Consolidate eight local programs into five, one for each Health Systems Area.*

(2) *Consolidate eight local AHECs into three, one at each academic health center.*

(3) *Eliminate the statewide AHEC program and establish three regional AHECs, one at each academic health center.*

Comments

The Statewide AHEC Program expressed support for the current configuration of eight AHECs.

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