REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF A CENTRALIZED PLANNING AND FUNDING MECHANISM FOR HEALTH WORKFORCE ACTIVITIES PURSUANT TO ITEM 12 OF THE 1998 APPROPRIATION ACT

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 49

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RICHMOND
1999

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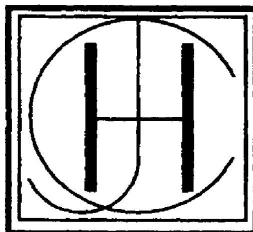


Preface

Item 12 of the 1998 Appropriation Act directed the Joint Commission on Health Care to study and develop a centralized planning and funding mechanism to ensure that the Commonwealth's health workforce activities and initiatives related to improving access to care in underserved areas are designed, administered, and funded in a coordinated manner that maximizes their efficiency and effectiveness.

The Appropriation Act directed the Joint Commission's study to focus on the following workforce initiatives and activities: the Area Health Education Center (AHEC) program; the Department of Health's Center for Primary Care Resource Development, including recruitment, scholarship and loan repayment programs; those activities of the Generalist Physician Initiative which relate to improving access to care in underserved areas; and other related, private, non-profit community-based organizations.

It is important to keep in mind that this report focuses on establishing a centralized process for coordinating and reviewing health workforce initiatives. The report does not evaluate the effectiveness or value of the current programs.

Based on our research and analysis during this review, we concluded the following:

- in order to recruit and retain primary care providers in Virginia's underserved areas, the Commonwealth needs a coordinated program of effective health workforce initiatives;

- responsibility for health workforce programs is dispersed across two secretariats and multiple state agencies, consequently, there is no single executive branch agency which has full purview over health workforce activities or responsibility for achieving results;

- the health workforce initiatives are all inter-related which makes it difficult to measure the effectiveness of each program;

- the experiences of some Virginia family practice residents reflect a need for better coordination of Virginia's health workforce initiatives;

- while a great deal of effort has been devoted to producing more generalist providers, greater emphasis is needed on

recruitment and retention of these providers in underserved areas;

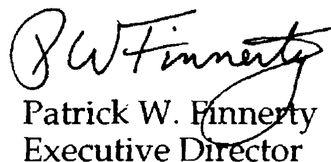
- representatives of the various health workforce programs generally agree there is a need for a more coordinated approach to planning and funding these initiatives; however, there is less agreement on how this should be accomplished;

- there are essentially two approaches to establishing a centralized planning and funding mechanism: (i) modifying or "fine-tuning" the role of an existing entity involved in health workforce issues by assigning responsibility for monitoring the planning and funding of the various programs; or (ii) establishing a new, separate entity for this function; in either scenario, some level of local flexibility should be retained to ensure that programs have the ability to respond to local needs.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 35-36.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at Appendix B) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the staff of the Senate Finance and House Appropriations Committees, the Virginia Department of Health, the Virginia Statewide AHEC Program, the Academic Health Centers, the Virginia Generalist Physician Initiative, the Virginia Center for the Advancement of Generalist Medicine, the State Council of Higher Education in Virginia, the Virginia Health Care Foundation, the Virginia Rural Health Association, and the Virginia Primary Care Association for their assistance during this study.



Patrick W. Finnerty
Executive Director

February 3, 1999

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I.
Authority for Study/Organization of Report

Item 12 of the 1998 Appropriation Act directs the Joint Commission on Health Care to study and develop a centralized planning and funding mechanism to ensure that the Commonwealth's health workforce activities and initiatives related to improving access to care in underserved areas are designed, administered, and funded in a coordinated manner that maximizes their efficiency and effectiveness. The budget language provides that the analysis include the following health workforce activities and initiatives:

(i) the Area Health Education Centers (AHEC) program;
(ii) the Department of Health's Center for Primary Care Resource Development, including recruitment, scholarship and loan repayment programs;
(iii) those activities of the Generalist Initiative which relate to improving access to care in underserved areas; and
(iv) the role of other related private, non-profit community-based organizations.

The Primary Focus Of This Report Is To Study And Develop A Centralized Planning And Funding Mechanism For Health Workforce Initiatives; The Report Is Not Intended To Be A Comprehensive Evaluation Of The Relative Effectiveness/ Value Of Each Initiative

As will be discussed in this report, the Commonwealth's health workforce initiatives include a number of complex and inter-related programs and activities designed to improve access to care in underserved areas. While the process of studying a centralized planning and funding mechanism for these workforce activities inherently involves some level of assessment of each activity, this report is not intended to serve as an evaluation of the relative effectiveness or value of each initiative. Such an evaluation would require significantly greater amounts of time and resources than that available for this study. In addition to the level of resources needed for such an evaluation, a one-time evaluation of these activities provides only a "snap-shot" of the programs' effectiveness.

In an era of ever-changing health care needs, issues, and markets, the greater need is for a process that provides continuing analysis and coordination of the various workforce initiatives. While a one-time evaluation of these initiatives certainly would provide useful information, an ongoing evaluative process that is part of the centralized planning and funding mechanism would be

far more valuable to the Commonwealth. Accordingly, this report focuses on establishing a process for coordinating and reviewing the health workforce initiatives, rather than on evaluating the current effectiveness/value of each individual component.

Section II of the report provides an overview of the need for and objectives of health workforce initiatives. Also, information regarding the areas of the Commonwealth designated as medically underserved and health professional shortage areas is presented. Section III identifies and discusses the various health workforce initiatives in Virginia. Section IV discusses the need for a centralized planning and funding mechanism for the Commonwealth's health workforce initiatives and discusses several alternatives for establishing such a process. Section V presents a number of policy options for consideration by the Joint Commission in addressing these workforce issues.

II.
Need For Health Workforce Reforms

Many Virginia Communities Do Not Have Adequate Access To Primary Care

According to state and federal analyses, many Virginia communities do not have adequate access to primary care. There are two primary processes for determining which localities have inadequate access to primary care. Pursuant to §32.1-122.5 of the Code of Virginia, the Board of Health has responsibility for identifying medically underserved areas. The Center for Primary Care Resource Development within the Virginia Department of Health (VDH) establishes these medically underserved areas based on specific criteria as shown in Figure 1. These areas are identified as Virginia Medically Underserved Areas (VMUAs).

In addition to the VMUA designation, the federal government identifies specific localities as Health Professional Shortage Areas (HPSAs). As described in Figure 1, the criteria for this designation focus more directly on the availability of providers than the VMUA designation which is based on broader health care data.

Figure 1

Criteria For Designating Virginia Medically Underserved Areas (VMUAs) and Health Professional Shortage Areas (HPSAs)

VMUA - **Virginia Medically Underserved Areas** (state designation)

- Primary care physician to population ratio
- Percent of population with income at or below 100% of the federal poverty level
- Percent of population 65 years of age or older
- Five-year average infant mortality rate
- Most recent annual civilian unemployment rate

HPSA - **Health Professional Shortage Area** (federal designation)

- Geographic area involved must be rational for the delivery of health services
- Specified physician-to-population ratio representing shortage must be exceeded within the area (usually 1:3,500)
- Resources in contiguous areas must be shown to be over utilized, excessively distant, or otherwise inaccessible.

Source: Virginia Department of Health, Center for Primary Care Resource Development

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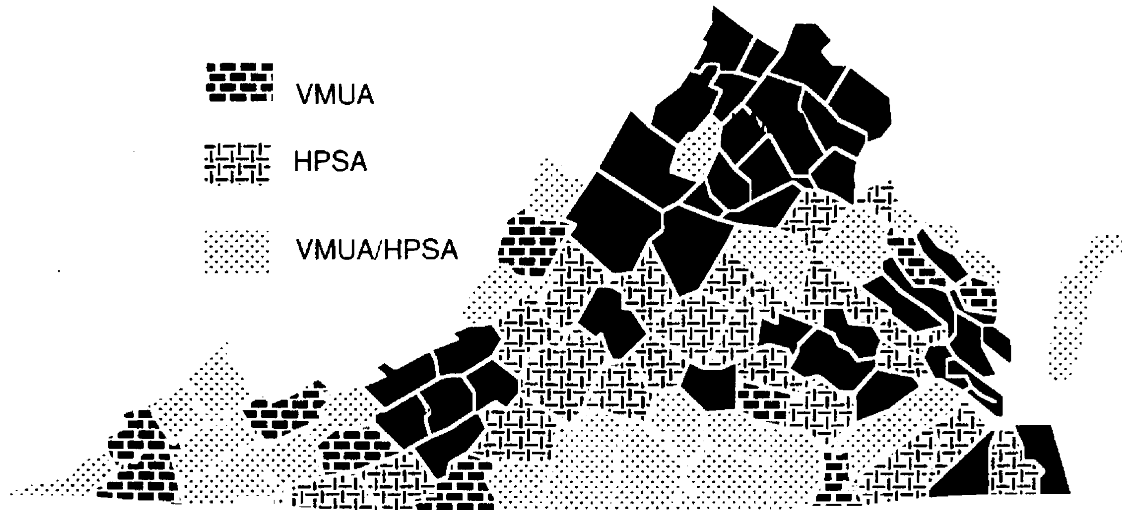
Based on information provided by the VDH's Center for Primary Care Resource Development, effective January 16, 1997, 43 Virginia counties and cities were designated as VMUAs. In addition, 54 localities were designated as HPSAs (35 whole counties as well as 19 partial counties/cities and 1 facility). Of these localities, 30 received a dual designation as both a VMUA and a HPSA. As illustrated in Figure 2, a significant percentage of Virginia citizens live in these underserved and provider shortage areas.

Figure 2

Virginia Medically Underserved Areas (VMUAs) and Health Professional Shortage Areas (HPSAs) (January 16, 1997)



Source: Virginia Department of Health, Center for Primary Care Resource Development

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Previous Studies Have Concluded That A Significant Number Of Additional Primary Care Providers Is Needed To Address Virginia's Provider Shortage And Medically Underserved Areas

A 1996 Joint Commission on Health Care (JCHC) study of health workforce initiatives reported that while available data indicate the total number of primary care providers statewide is adequate, there are acute regional shortage areas. The 1996 JCHC report also included estimates of the number of additional primary care providers needed to address these shortage areas.

Estimates of the regional needs for primary care providers ranged from an absolute minimum of 95 to eliminate all of the HPSA designations to more than 800 new physicians to eliminate shortage areas in metropolitan areas, Northern Virginia, and metro-Richmond.

The Center for Primary Care Resource Development currently is developing a statewide provider tracking system that will support ongoing needs assessments and provide more accurate and current data on provider distribution.

Health Workforce Initiatives Have Been Established To Address The Shortage of Primary Care Providers In Virginia's Underserved Areas

Virginia, like many other states, has implemented a number of health workforce initiatives to address the need for additional primary care providers in underserved areas. While there are a variety of different types of programs, most health workforce initiatives are geared toward one of the following three basic objectives: (i) recruit, train and graduate more students in primary care specialties to increase the number of providers available to practice in underserved areas; (ii) provide incentives to recruit primary care providers to underserved areas; and (iii) provide practice support and other programs to retain primary care providers who have located in underserved areas.

Section III of this report identifies and discusses Virginia's health workforce initiatives.

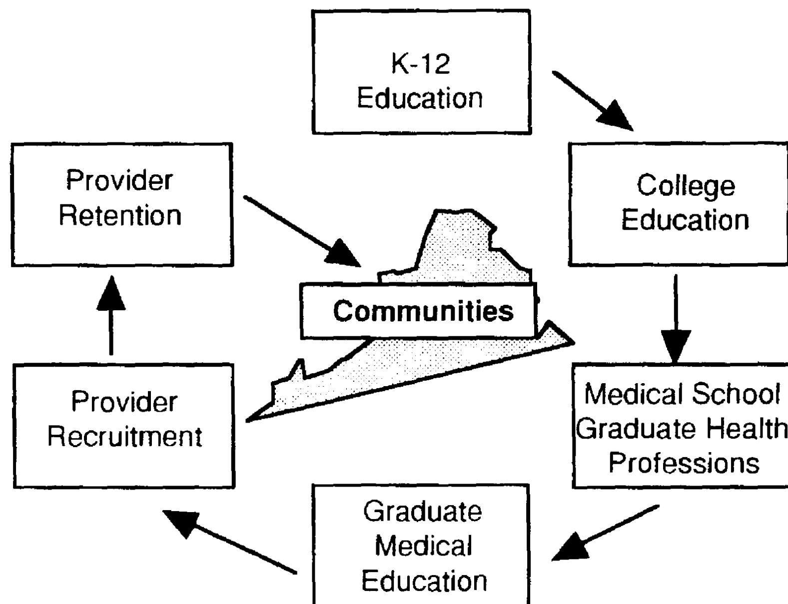
III.
Virginia's Health Workforce Initiatives

Virginia Has Implemented Numerous Initiatives To Address The Need For Additional Primary Care Providers In Underserved Areas

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 illustrated in Figure 3, the developmental cycle actually begins in the K-12 educational system and continues through health professions education, provider recruitment and community practice.

Figure 3

Developmental Cycle For Health Professionals



Virginia's health workforce initiatives are aimed at supporting prospective and practicing providers at various steps in the cycle by:

- conducting ongoing community needs assessment to determine which communities are in greatest need of additional primary care providers;

- providing K-12 and college students exposure to health professions careers through training opportunities and other educational experiences;
- recruiting qualified college students who are likely to become primary care providers in Virginia's underserved areas;
- developing health professions education programs, particularly medical education programs, which emphasize the importance of primary care;
- recruiting primary care providers to underserved areas; and
- supporting providers so that they will remain in areas where they are most needed.

There are several health workforce initiatives/programs which address the problem of underserved areas or have components related to this issue. In addition to other workforce programs initiated within the health professions schools, the Commonwealth's related health workforce programs are:

- **The Virginia Generalist Physician 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 and provide clinical experience for family practice physicians.
- **Virginia Statewide Area Health Education Centers (AHEC) Program.** A state/federal program with eight local AHEC sites whose mission is to promote health careers and access to primary care for medically underserved populations through community-academic partnerships.
- **Center for Primary Care Resource Development (CPCRD):** Located within the Virginia Department of Health (VDH), the CPCRD administers several health workforce programs/initiatives.
- **Recruitment/Retention:** the CPCRD coordinates the Commonwealth's efforts to recruit and retain primary care providers in underserved areas.
- **Scholarship and Loan Repayment Programs:** the CPCRD administers several health professions scholarships and loan repayment programs which help finance the education of primary care providers in return for a commitment to practice in an underserved area.

In addition to these state-supported workforce initiatives, there also are other non-state organizations actively involved in promoting access to primary care and recruiting providers in underserved areas. The Virginia Health Care Foundation is a private, non-profit foundation created by the General Assembly and devoted to providing financial grants to support innovative programs that improve access to primary and preventive care for Virginia's uninsured. Many, although not all, of the Foundation's grant awards support primary care provider recruitment and retention efforts.

The Virginia Primary Care Association (VPCA) provides support services to 42 Community Health Centers (CHCs) across the Commonwealth including recruitment of providers to practice at the CHCs. The Rural Health Association advocates on behalf of rural areas regarding various health issues, including access to primary care providers.

The Commonwealth Will Invest Approximately $16.6 Million In Related Health Workforce Initiatives In FY 1999 And FY 2000

As seen in Figure 4, the Commonwealth will invest approximately $16.6 million in related health workforce initiatives in FY 1999 and FY 2000.

Total health workforce spending in FY 2000 ($16.6 million) will be approximately $2.6 million greater than total spending in FY 1995. As will be discussed later, funding for the AHEC program has increased during recent years due to decreasing federal support. Spending for the Generalist Initiative, scholarship and loan repayment programs and the Virginia Health Care Foundation have remained relatively constant.

While Figure 4 illustrates state general fund support, several of these programs, including AHEC, the Virginia Generalist Initiative, the Virginia Practice Sights Initiative and the Virginia Health Care Foundation also generate substantial financial support through federal government, university, local government, or private matching funds.

The Virginia Generalist Physician Initiative Is A Collaborative Effort Dedicated To Increasing The Number Of Generalist Physicians

The Generalist Physician Initiative (GPI) is a collaborative effort between the three medical schools (the University of Virginia School of Medicine (UVA), the Medical College of Virginia/Virginia Commonwealth University (MCV/VCU), and the Eastern Virginia Medical School (EVMS)) dedicated to increasing the number of generalist physicians in Virginia. In addition to the involvement of the three medical schools, the Virginia Center for the Advancement of Generalist Medicine (VCAGM), located at UVA, coordinates the activities of the GPI. The Joint Commission on Health Care, the State Council of Higher Education, the Virginia Department of Health and the Statewide Area Health Education Centers program all are major partners of the GPI. The Robert Wood Johnson (RWJ) Foundation also provides financial support to the GPI. The RWJ grant ends in June, 2000.

Figure 4
State General Fund Support of Related Health Workforce Initiatives

	FY 95	FY 96	FY 97	FY 98	FY 99	FY 2000
VA Generalist Initiative:						
MCHR	$ 697,050	$ 660,000	$ 772,500	$ 772,500	$ 772,500	$ 772,500
UVA	746,287	713,616	813,616	813,616	813,616	813,616
MCV/VCU	794,268	687,688	887,688	887,688	887,688	887,688
Statewide	127,500	153,606	253,606	253,606	253,606	253,606
Subtotal	$ 2,365,105	$ 2,214,910	$ 2,727,410	$ 2,727,410	$ 2,727,410	$ 2,727,410
Statewide AHEC [1,2]	$ 440,000	$ 558,139	$ 558,139	$ 858,139	$ 1,208,139	$ 858,139
Family Practice Residencies:						
MCHR	$ 1,036,475	$ 1,031,475	$ 1,098,663	$ 1,098,663	$ 1,098,663	$ 1,098,663
UVA	2,462,079	2,502,102	2,545,815	2,615,746	2,703,972	2,856,267
MCV/VCU	4,793,605	4,874,030	4,987,449	5,288,982	5,446,218	5,622,071
Subtotal	$ 8,292,159	$ 8,407,607	$ 8,631,927	$ 9,003,391	$ 9,248,853	$ 9,577,001
Scholarship and Loan Repayment:						
Medical	$ 445,000	$ 445,000	$ 445,000	$ 445,000	$ 465,000	$ 465,000
Dental	25,000	25,000	25,000	25,000	25,000	25,000
Nurse Practiitoner	25,000	25,000	25,000	25,000	25,000	25,000
Physician Loan Repayment [3]	50,000	50,000	50,000	100,000	100,000	100,000
Subtotal	$ 545,000	$ 545,000	$ 545,000	$ 595,000	$ 615,000	$ 615,000
VDH CPCRD [4]						
Rural Health	$ 45,000 *	$ 45,000 *	$ 47,609	$ 46,042	$ 150,000	$ 150,000
5 Yr PriCare Plan					175,000	175,000
SWVA Med. Ed. Cons.					197,000	295,920
Subtotal	$ 45,000 *	$ 45,000 *	$ 47,609	$ 46,042	$ 522,000	$ 620,920
Va. Health Care Foundation**	$ 2,372,138	$ 2,229,810	$ 2,229,810	$ 2,229,810	$ 2,229,810	$ 2,229,810
Grand Total	**$14,059,402**	**$14,000,466**	**$14,739,895**	**$15,459,792**	**$16,551,212**	**$16,628,280**

NOTES:
1. For FY 97 and 98, $118,139 was appropriated to AHEC for support of Generalist Initiative, in FY 99 and 00, $158,139 was appropriated to AHEC for Generalist Initiatives.
2. For FY 95 and succeeding years, amount includes $200,000 included in the appropriation for EVMS to support the Eastern Virginia AHEC.
3. FY 98-FY 00 includes $50,000 for Va. Physician Loan Repayment Program for medically underserved areas in Lee, Scott, and Wise Counties and the City of Norton. Unexpended amounts can be used in other medically underserved areas of the Commonweealth.
4. RWJ Foundation grant which supported Practice Sights will end in FY 98; these activities will be supported by GF appropriations in FY 99 and FY 00.

* Estimates

Begun in 1994, the GPI is a comprehensive approach to increase the output of generalist physicians from the three medical schools. In addition, the GPI continues to focus attention on the needs of rural, underserved and disadvantaged populations.

The Primary Objective of the GPI Is 50% Generalist Output By FY 2000

As expressed by the General Assembly in the Appropriation Act, the goals of the GPI are:

- by the year 2000, at least 50% of Virginia medical school graduates will enter generalist practice;
- by the year 2000, at least 50% of Virginia medical school graduates entering generalist practice will enter practice in Virginia upon completion of residency training; and
- output of Virginia graduate medical education programs will be consistent with the 50% goal.

The Appropriation Act also provides that the academic health centers, in cooperation with Virginia's "Practice Sights Initiative," will actively contribute to strategies for eliminating generalist physician shortage areas of Virginia. Lastly, the Appropriation Act also states it is the intent of the General Assembly that: (i) the GPI recruitment and admissions programs be designed to increase the number of Virginia medical students with an interest in generalist medicine from medically underserved areas of the Commonwealth, and (ii) GPI education programs shall be designed to increase educational experiences in community settings in general, and in medically underserved communities in particular, for both students and generalists.

While The GPI Has Made Significant Progress In Meeting Its Objectives, Not All Goals Have Been Met In Producing Generalist Physicians

Many of the objectives of the GPI have been met as a result of the work completed by the three medical schools. Each school has revised its medical education curriculum to incorporate a greater emphasis on primary care. The admissions process also has been revised to place more emphasis on primary care by including generalists on the respective Admissions Committees of each school. These are major accomplishments given the fact that these changes required not only a change in "process" at the institutions, but, more importantly, a change in the "culture" of medical education.

In addition to the progress made at the individual schools, there have been other statewide accomplishments which reflect the cooperative approach taken

by the three schools and the VCAGM. These include: (i) completion of the planning, development, and early implementation of a statewide tracking and outcomes database covering all phases of the "generalist pipeline;" (ii) establishment of the Statewide Task Force on Recruitment and Admissions (STFRA) which educates potential medical students on the need for generalists and how to prepare for a medical career, and educates high school and college counselors and teachers about the medical school selection process; and (iii) implementation of the statewide component of VMedNet, an independent website providing educational and practice support services for generalist physicians.

While the GPI has made significant progress in several areas, progress toward the primary goal of having 50% of Virginia medical school graduates intending to enter generalist practice by FY 2000 has been less than projected. Preliminary FY 1998 data indicates improvement by all three schools.

The 1998 Appropriation Act Includes Language Stating That Funding For GPI Will Not Be Continued Beyond FY 2000 If Goals Are Not Met; SCHEV Has Been Directed To Monitor Results Of The GPI

Through the 1998 Appropriation Act, the General Assembly has indicated that future funding of the GPI will be contingent upon each school meeting its respective goals, and for the results of the program to be monitored more closely. Specifically, the 1998 Appropriation Act includes language in each of the three schools' appropriation items stating that funding for the GPI will not be continued in the FY 2000-2002 biennium unless the GPI goals for FY 2000 are met.

The General Assembly also included language in the 1998 Appropriation Act directing SCHEV, in cooperation with the three medical schools, to monitor the results of the GPI, especially the decisions of graduates from the undergraduate medical programs to enter generalist residencies and the composition of the residencies in the two associated academic health centers. The medical schools are required to report to SCHEV by October 1, 1999. SCHEV then will report its recommendations on funding for the program to the Governor and the General Assembly by November 15, 1999.

Family Practice Residencies Provide Clinical Experience And Training For Medical School Graduates And Play A Critical Role In The Commonwealth's Health Workforce Initiative

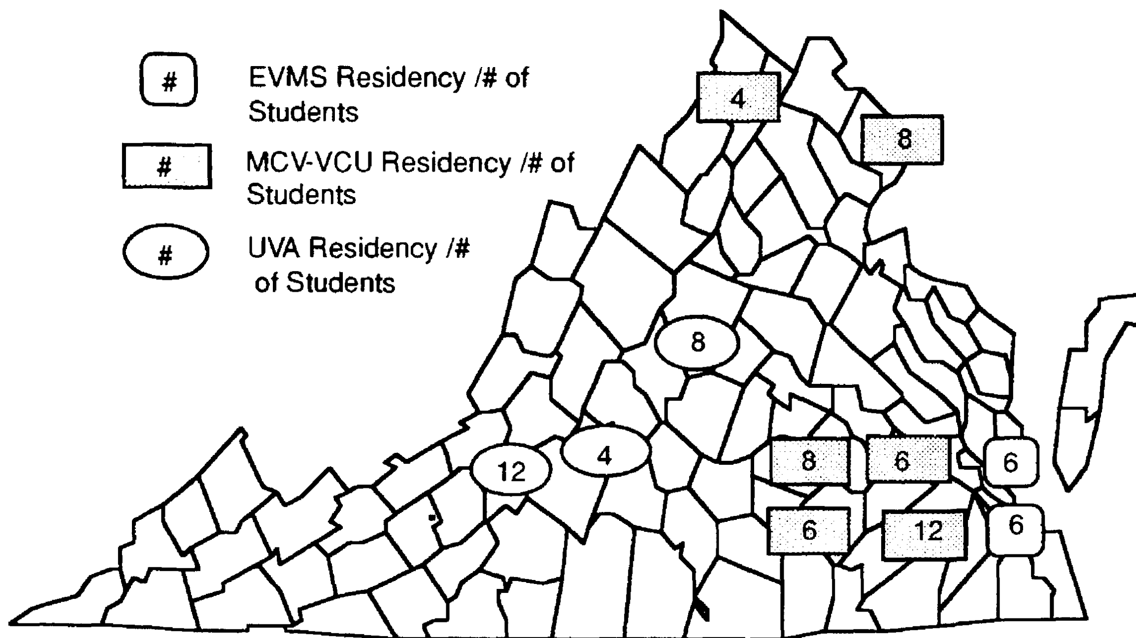
As seen in Figure 4, the Commonwealth will spend approximately $9.2 million in FY 1999 and $9.6 million in FY 2000 to support family practice

residencies across the Commonwealth. Family practice residencies play a critical role in the training of generalist physicians. Also, because physicians often remain to practice in close proximity to their residency, they are an integral part of Virginia's overall health workforce initiative.

As shown in Figure 5, each of the three medical schools provide family practice residencies. A total of 11 family practice residency programs are located across the state and provide residency training for 80 students. In addition to these programs, the 1998 Appropriation Act provides funding to VDH for the development of the Southwest Virginia Graduate Medical Education Consortium to create and support medical residency preceptor sites in rural and underserved areas in the southwestern portion of the state.

Figure 5

Virginia's Family Practice Residency Programs



Source: Virginia Center for Advancement of Generalist Medicine

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The Statewide Area Health Education Centers (AHEC) Program Promotes Health Careers And Access To Primary Care For Medically Underserved Populations Through Community-Academic Partnerships

The Virginia Statewide AHEC program was created in 1991 to help address the Commonwealth's need to expand access to primary care in medically underserved areas. As provided in §32.1-122.7 of the Code of Virginia, the mission of the Statewide AHEC program is to promote health careers and access to primary care for medically underserved populations through community-academic partnerships. The mission of the Statewide AHEC program is accomplished through four major areas of program activity:

- developing health careers recruitment programs for Virginia's students, especially underrepresented and disadvantaged students;
- supporting the community-based training of primary care health professions students, residents, and other health professions students in Virginia's underserved communities;
- providing educational and practice support systems for the Commonwealth's primary care providers; and
- collaborating with health, education, and human services organizations to facilitate and promote improved health education and disease prevention among the citizens of the Commonwealth.

The Statewide AHEC program is administered through a statewide office and eight community AHECs located throughout the Commonwealth. Figure 6 illustrates the location and service areas of the eight local AHECs.

Each community AHEC has a governing or advisory board comprised of community volunteers which typically include health providers, educators, consumers and business representatives. An Executive Director for each AHEC is responsible for developing and implementing programs that respond to identified local and regional health workforce needs. Policy guidance is provided by a statewide board of directors whose members represent the three medical schools, the VDH, the Virginia Primary Care Association, the community AHECs and others.

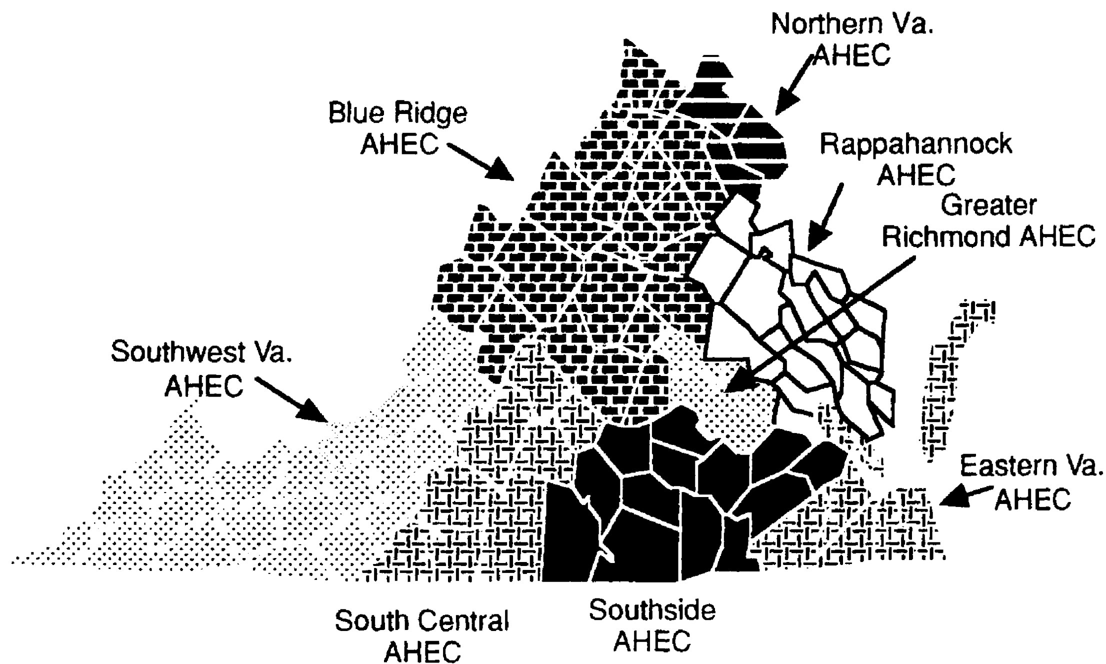
AHECs Receive State And Federal Funds As Well As Local/University Match Funds

The funding for AHEC activities comes from three primary sources: the federal government, state government, and local/university match amounts. AHECs are eligible for up to six years of core federal funding, with year four being the peak year of funding. As federal funding is phased out, the AHECs increasingly will have to rely on additional state funding and/or local/university match amounts to maintain the same level of activity. Local/university match amounts include cash, faculty and administrators at

affiliate health science centers, volunteer board and advisory members, in-kind contributions, grants, etc.

Figure 6

Virginia Statewide Area Health Education Centers (AHEC) Program: Location And Service Areas Of Virginia's Eight Community AHECs



Source: Statewide AHEC Office

A Key Policy Issue For The Commonwealth Is Whether To Appropriate Additional GF Dollars To Replace Diminishing Federal AHEC Funding

Figure 7 depicts the funding for Virginia's Statewide AHEC program for FY 1991 through FY 1999. As seen in Figure 7, the decremental federal funding presents a key policy issue for the Commonwealth as well as the community AHECs. For the Commonwealth, the issue is whether to increase its GF appropriations to offset the loss of federal dollars. For the AHECs, the issue is how to secure other sources of funds beyond what might be available from the state. Currently, five of the eight AHECs are receiving federal monies.

However, the number will decrease to only three in FY 1999 and only one AHEC in FY 2000.

A key reason for the increased state funding for AHECs in FY 1998 is that two AHECs (Blue Ridge and Southside) completed their core federal funding at the end of FY 1997. Likewise, the FY 1999 GF amount reflects the fact that the Southwest Virginia and Greater Richmond AHECs complete their core federal funding cycles at the end of FY 1998. In FY 2000, only the Northern Virginia AHEC will be receiving federal dollars. For the Commonwealth to assume the federal share of the South Central and Rappahannock AHECs funding for FY 2000, an additional $474,804 would have to be appropriated. In FY 2001, when no AHECs are receiving federal funds, the GF amount needed to replace the federal dollars would increase to $744,463.

Once All AHECs Complete Their Core Federal Funding Cycles, AHECs Are Eligible For Federal "Model AHEC" Funds

The "core" federal funding cycle for AHECs is six years. However, once all AHECs in a state have completed their core federal funding, the AHECs are eligible for federal "Model AHEC" funds. Local AHECs are eligible to receive a maximum of $250,000 per center with a maximum of eight AHECs in a state being eligible. There also is a $2 million maximum level of funding per state.

Once the Northern Virginia AHEC completes its core federal funding cycle in FY 2000, the Virginia AHECs will be eligible for this funding. However, the match requirements for the "Model AHEC" funding is more restrictive than core funding. "Model AHEC" funding requires a dollar for dollar match, whereas "core" funding requires only a 25% match which can be made in cash or in-kind contributions. Also, while the maximum "Model AHEC" funding is $250,000 per center, the average amount actually being received in other states is significantly less than the maximum. Nonetheless, the "Model AHEC" funding should be pursued by the AHEC program when the program becomes eligible in FY 2001.

Figure 7

Virginia Statewide Area Health Education Centers (AHEC) Program: Funding for FY 1991 – FY 1999

Fiscal Year	Federal*	State GF	Local/ University Match**	Total
1992	$622,069	$150,000	$237,500	$1,009,569
1993	1,176,789	200,000	227,900	1,604,689
1994	1,638,104	200,000	228,960	2,067,064
1995	1,485,690	440,000	486,150	2,411,840
1996	1,383,705	558,139	1,316,613	3,258,457
1997	1,853,268	558,139	1,486,000	3,897,407
1998	1,522,800	858,139	1,708,000	4,088,939
1999***	992,651	1,208,139	1,797,843	3,998,633
TOTAL	$10,675,076	$4,172,556	$7,488,966	$22,336,598

* Figures reflect combined direct and indirect costs and are rounded to the nearest dollar.

** Local/university match amounts include cash and in-kind services from various sources

*** Estimated figures based on request in most recent federal grant application.

Source: Virginia Statewide AHEC

The Community AHECs Provide A Broad Spectrum Of Health-Related Educational Programs And Other Services

The local AHECs provide a broad spectrum of health-related educational programs and other services in their communities. Many of the AHECs have focused on improving the math, science, and related skills of secondary students who may eventually enter a health professional training program. Several AHECs also are providing educational programs to elementary and middle

school students. One AHEC, the Greater Richmond AHEC, includes pre-school children in its educational programs. Activities such as summer camps, job shadowing, and other hands-on learning opportunities are sponsored by many AHECs. The Statewide AHEC office reports that 16,050 minority and disadvantaged students participated in AHEC sponsored programs during 1997-1998.

Student and resident training also is a common activity of the AHECs. In this role, AHECs help identify community preceptors and partners with the academic health centers to support student training. The Statewide AHEC office reports that 1,604 trainees participated in community-based student and resident training programs in 1997-1998. AHECs also provide practice support services to providers in their localities. In this area, AHECs provided continuing education training to 3,823 trainees in 1997-1998.

While the eight AHECs provide many more programs and services than those identified below, the following is a sampling of the various programs being sponsored by the AHECs across the Commonwealth:

- The *Rappahannock AHEC (RAHEC)* supports clinical rotations for medical, nursing, dental, and physical therapy students; RAHEC also sponsors an Internet site to enhance the practice environment for existing health care providers.
- The *Northern Virginia AHEC (NVAHEC)* has sponsored programs to encourage minority students to pursue health profession careers; NVAHEC also is creating a health care interpreter bank to enhance practitioners' ability to interact with patients who speak limited English.
- The *Eastern Virginia AHEC (EVAHEC)* assisted in the development of the Portsmouth Community Health Center in a medically underserved area; EVAHEC also assisted in the implementation of a telemedicine project for the Eastern Shore that will allow grand rounds and other presentations at the academic health center to be viewed by primary care physician preceptors and their students in rural areas.
- The *Greater Richmond AHEC* focuses much attention on academic preparation in science, math and technology (SMT) for students pre-school through grade 12; in addition to SMT programs, programs in Wildlife Habitats and Water Quality Laboratory are offered; this AHEC also assists dental students, dental hygiene students, nurse practitioner and graduate nursing students receive clinical training in community-based health clinics.
- The *Blue Ridge AHEC* has provided resources to each of the region's nine Free Clinics including computer hardware and software, and

technical support; Blue Ridge also implemented an on-line health and human services directory for information and referral for the Central Shenandoah Planning District.

- The *Southside AHEC (SAHEC)* places significant emphasis on strategies to promote health careers to minority and disadvantaged students; a major accomplishment of SAHEC has been to support the expansion of family medicine clerkship rotations in the region by affiliating with the Blackstone Family Practice Residency; SAHEC also helped to re-establish a dental clinic in Charlotte County.
- The *Southwest Virginia AHEC (SWAHEC)* sponsors the Health Careers Summer Institute to educate students about health careers; SWAHEC also established as one of its priorities the expansion of collaborative practices utilizing nurse practitioners and physician assistants.
- The *South Central AHEC (SCAHEC)* sponsors hands-on science enrichment activities for 7th grade students in five county middle schools; students participate in hands-on science activities to study water, electricity, sound, machines, etc.; SCAHEC also works with the local provider community to help establish community-based rotation sites and identify preceptors for students training in the SCAHEC area.

The Virginia Department Of Health's Center For Primary Care Resource Development Serves As The Coordinating Entity For Recruitment And Retention Of Health Care Providers In Underserved Areas

The Virginia Department of Health (VDH) reorganized its primary care initiatives in 1996. The Center for Health Professions Recruitment and Retention, Office of Rural Health and Office of Primary Care Development were combined and renamed the Center for Primary Care Resource Development (CPCRD). For the past several years, the core funding for the activities of the CPCRD has been from a Robert Wood Johnson (RWJ) Foundation grant for the Practice Sights Initiative which ends this month. The CPCRD's activities will be funded in FY 99 and FY 00 through general fund appropriations. The CPCRD has responsibility for coordinating Virginia's recruitment and retention efforts and administering several health professions scholarships and two physician loan repayment programs.

Key Activities Of The Center For Primary Care Resource Development

Recruitment Clearinghouse: A recruitment clearinghouse has been established to facilitate the matching of medically underserved communities with primary care providers. The clearinghouse surveys Virginia's primary care practices and their recruitment needs which are matched against a listing of primary care providers seeking employment. The clearinghouse, established in

1996, has assisted in the placement of 28 providers throughout the Commonwealth.

Other Recruitment/Retention Activities: The Center is involved in other recruitment and retention activities, including the following:

- special mailings targeted to primary care practices in rural and underserved areas of the state;
- mailings to all Virginia AHECs, recruiters, the Virginia Primary Care Association and rural hospitals describing the Center's functions and surveying them about primary care practice opportunities;
- visits to primary care residency and nurse practitioner programs to meet residents and students and assist with their recruitment needs;
- attendance at state and national meetings by the Center's provider recruitment specialists; and
- advertisement in select journals.

Statewide Database Of Primary Care Physicians In Virginia: An accurate base of data regarding the number, location and type of primary care providers is essential to any efforts aimed at increasing the number of primary care providers in underserved areas. The lack of such a database severely limits the ability to accurately assess provider needs and evaluate the effectiveness of interventions/programs.

The Center currently is developing a statewide database of primary care physicians practicing in Virginia. The Center indicates that this project will be completed by December, 1998 and will be updated regularly.

The passage of Senate Bill 660 by the 1998 Session of the General Assembly should enhance the CPCRD's ability to collect information on primary care providers. SB 660 directs the Board of Medicine to require all physicians of medicine or osteopathy to report certain information, including specialty, location of practice settings and the percentage of the physician's time at each setting. This information should enhance the accuracy and usefulness of the CPCRD's database.

The Center Administers A Number Of Health Professions Scholarship Programs And A Physician Loan Repayment Program

Virginia Medical Scholarship Program: The purpose of the Virginia Medical Scholarship Program (VMSP) is to increase and improve primary health care access in medically underserved areas of Virginia. The program is designed to assist both medical students and medically underserved communities. The

program offers a $10,000 financial incentive to medical students and first-year residents (who are past recipients) pursuing primary care specialties. Scholarships are awarded annually in exchange for year for year commitments to practice in areas designated as medically underserved in Virginia.

Effective July 1, 1994, the Virginia medical schools were required to match state funds for new recipients entering the program ($5,000 general fund/$5,000 Virginia medical school). Beginning July 1, 1998, all scholarships for recipients attending Virginia medical schools will be match funded.

The Appropriation Act provides funding for 67 scholarships each year. Total state funding for FY 1997 and 1998 was $445,000. The 1998 Appropriation Act increases the Virginia medical scholarship program by $20,000 for a total appropriation of $465,000 in FY 1999 and FY 2000. The 1998 Appropriation Act designates four scholarships for Virginia residents who attend the School of Medicine at East Tennessee State University. Also, two scholarships are set aside for students who attend Pikeville College School of Osteopathic Medicine.

Twenty-six scholarship recipients have been placed in service in a Virginia Medically Underserved Area (VMUA) since FY 1991. Eleven have completed their obligation, 15 are currently practicing, and of the 15 practicing, 3 will be fulfilling their obligation this year. Five recipients will be starting practice in a VMUA this year.

In FY 98, $265,000 was awarded to 46 students. This amount represents 60% of the total amount appropriated for FY 98. According to CPCRD staff, the two key reasons for having unspent funds are: (i) the scholarship does not fully cover tuition cost; and (ii) the triple payback penalty that is imposed if the recipient does not practice primary care in a Virginia medically underserved area. A total of $180,000 was returned to the general fund as a result of the unused scholarships.

In response to the difficulty in awarding the entire scholarship amounts, language was included in the 1998 Appropriation Act directing any unexpended and repaid medical scholarship money to the physician loan repayment program.

Virginia Nurse Practitioner/Nurse Midwife Scholarship Program: The Mary Marshall Nurse Practitioner/Nurse Midwife Scholarship Program was established in 1993. The program provides $5,000 scholarships to Virginia nurse practitioner students and nearby midwifery students in return for a commitment of year for year service in a Virginia medically underserved area. Five

scholarships are funded each year for a total annual appropriation of $25,000. During the 1997-1998 academic year, all 5 scholarships were awarded.

Since 1993, there have been a total of 28 recipients. There are 11 recipients that are still in school, 7 recipients that are currently working in a Virginia medically underserved area and 8 recipients who have fulfilled their obligation. Two recipients have defaulted.

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 underserved dental area for each year of scholarship. Total state funding in each fiscal year is $25,000 or 10 scholarship awards.

Since 1976, there has been a total of 86 participants. Thirty-eight (38) graduates have worked or are working in a dental area of need, and 23 have chosen monetary payback. Eleven graduates continued with dental residency programs, 10 are still in dental school and 2 graduates are unaccounted for.

Ten scholarships are available each year; however, for the last 2 years there has only been 1 scholarship recipient per year. There was also 1 recipient for FY 1998. The small number of recipients is primarily due to the scholarship amount being only $2,500 which is less than one quarter of the tuition cost of dental school. The triple-payback provision for default also makes the program less attractive to dental students.

Physician Loan Repayment Program: Three physician loan repayment programs have been established in Virginia:

- *National Health Service Corp (NHSC) – Virginia Loan Repayment Program (VLRP).* This program is match funded by federal and state dollars. This program offers loan repayment assistance of $25,000 a year in return for a minimum commitment of two-years of service in a health professional shortage area (HPSA). Total state funding for FY 1998 is $50,000 to match $50,000 in federal funding.

  There have been only 5 loan repayment recipients since its inception in 1993. There was one program participant for FY 1998 who is a nurse practitioner. Currently, there are 3 participants in the program. Of significance, there is 1 former recipient who is still practicing at the site where he completed his service obligation.

  Not all of the available funds have been used because the recipient's loan debts were less than the anticipated $50,000 that is allowed for the minimum

two-year commitment. Also, the fact that this program does not allow the loan repayment recipient to practice in a private for-profit entity disqualifies interested applicants. The federal National Health Service Corp Loan Repayment Program (NHSCLRP) (described below) is more attractive than this program because the NHSCLRP pays the recipient an additional 39% on the loan payoff amount to offset tax liabilities on top of the loan repayment funds. Also, the NHSCLRP has flexibility for allowing a physician to practice at a private for-profit entity.

- *National Health Service Corps Loan Repayment Program:* This federal program provides loan repayment assistance in return for service in federally designated underserved areas. This program offers loan repayment of $25,000 a year, plus an additional 39% of that amount to cover income taxes, for a minimum two-year commitment of two years of service. Nine program participants are practicing in Virginia as of May 1998. The state does not administer this program.

- *Virginia Physician Loan Repayment Program*: This program was established in 1994 with the intent of establishing a purely state funded loan repayment program; however, no money had been appropriated to implement it until the 1997 Session of the General Assembly. Beginning in FY 1998 and continuing through FY 2000, $50,000 is appropriated each year for medically underserved areas in Lee, Scott, and Wise Counties and the City of Norton. The Appropriation Act language provides that any unexpended amounts can be used in other medically underserved areas of the Commonwealth.

  As noted earlier, the 1998 Appropriation Act also provides that any unused and repaid medical scholarship money will revert to the Virginia Physician Loan Repayment Program. With the available funding, this program can be used as an incentive to recruit physicians to underserved areas of the State. The VDH is in the process of establishing regulations for this program.

The Center For Primary Care Resource Development Also Administers The Federal J-1 Visa Waiver Program

Federal law requires that international medical graduates who pursue graduate medical education training in the United States (U.S.) must obtain a J-1 exchange visitor visa. The J-1 visa allows physicians to remain in the U.S. until their studies are completed. Upon completion of their studies, the physicians must return to their home country for at least two years before they can return to the U.S. to practice. A physician is allowed to stay in the U.S. to practice medicine if an "interested" federal agency or a state requests a waiver of the home residency requirement on his/her behalf.

Through the CPCRD, Virginia has participated in the J-1 visa program. From 1990 until present, 76 physicians have received waivers to practice in federally designated health professional shortage areas (HPSAs) in Virginia. Fifty-three percent of those who have completed their two or more years of contractual service have remained in the respective HPSAs.

The Commissioner Of Health Has Adopted A Five-Year Action Plan For Improving Access To Primary Health Care Services In Medically Underserved Areas And Populations Of The Commonwealth

The Commissioner of Health has adopted a five-year action plan for improving access to primary health care services in medically underserved areas and populations of the Commonwealth. The plan encompasses years 1997-2002, and includes four major areas of activity: (i) public-private partnerships; (ii) primary care for the uninsured; (iii) data gathering, research and application; and (iv) primary care workforce initiatives. The 1998 Appropriation Act includes $325,000 in each year of the 1998-2000 biennium to implement the plan, including $150,000 in each year for the Office of Rural Health.

One of the accomplishments of the first year of the plan was a statewide Health Care Access Summit held last September in Richmond. The plan activities envisioned for primary care workforce initiatives in 1998-1999 include recommending legislative changes, as appropriate, for the scholarship and local repayment programs. The Commissioner is scheduled to brief the Joint Commission on these and other aspects of the five-year action plan later this year.

The Virginia Primary Care Association Recruits Primary Care Providers To Underserved Areas

The Virginia Primary Care Association (VPCA) is a private, not-for-profit organization which promotes community-based primary care for medically underserved and health professional shortage areas. VPCA also is the state association for the 42 community and migrant health centers located throughout the Commonwealth. These health centers provide health care services for insured and uninsured persons and charge for their services on a sliding fee scale. The health centers employ over 100 physicians, and annually provide services to approximately 140,000 patients statewide.

The VPCA provides ongoing recruitment for providers to practice in the health centers across the state and offers technical assistance to individual centers in their recruitment efforts. Because the health centers are in underserved areas,

the VPCA's recruitment function brings providers into these needy areas. The VPCA and the health centers do not receive any direct state funding; however, as noted below, the Virginia Health Care Foundation provides support for some activities.

In addition to its ongoing recruitment, the VPCA also administers the SCEPTER (Students & Communities Exchanging Professional Training, Experience & Resources) program. The purpose of the SCEPTER program is to increase the number of community-linked, multidisciplinary educational opportunities for primary care students in health professional shortage areas (HPSAs). Medical, dental, nurse practitioner, physician assistant and other students are matched with a preceptor in the community for a 2-6 week period. Each placement includes both clinical and community experiences. A distinguishing characteristic of the SCEPTER program is the emphasis on the community aspect of the placement. A community sponsor helps the student understand and adjust to the local life-style. The Virginia Health Care Foundation provides funding to support the SCEPTER program.

The Virginia Health Care Foundation Funds Local Public-Private Initiatives Which Increase Access To Primary Health Care For Virginia's Uninsured And Medically Underserved

The Virginia Health Care Foundation was established in 1992 to encourage public-private partnerships that provide access to primary care for underserved Virginians. The Foundation's focus is directed toward delivering care to those without access and increasing the number of physicians, nurses, dentists and other primary care providers in Virginia's medically underserved areas.

In 1997, the Foundation supported 42 projects across the Commonwealth. Many of these projects are geared toward increasing the number of primary care providers in underserved areas such as the following:

- **Healthy Communities Loan Fund:** A $4.2 million pool of funds is used to offer prime interest rate loans to bring new primary care providers to Virginia's HPSAs. Each loan provides up to $250,000 for such items as "bricks and mortar" to expand an existing health clinic, and recruitment incentives for primary care practitioners.
- **Virginia Health Careers Reference Manual:** The Virginia Health Careers Reference Manual provides information on dozens of health care careers and includes a complete job description, salary information, recommended high school coursework, and Virginia locations where students can receive the required education and training.

- **Support of the SCEPTER Program:** The Foundation has provided financial support to the SCEPTER program which is administered by the Virginia Primary Care Association.
- **Telemedicine Projects:** The Foundation has supported several telemedicine projects across the state which provide health professions training and clinical services to remote or underserved locations.

In addition to those projects specifically targeted to increasing the number of primary care providers, the Foundation's grant award process encourages all projects to also serve as a placement sight for students to receive resident training or other clinical experience.

The Free Clinics In Virginia And The Virginia Rural Health Association Also Have Interests In Recruiting Providers To Underserved Areas

The 30 Free Clinics across Virginia have a keen interest in having an adequate supply of primary care providers in their respective areas. The clinics provide free medical care to uninsured persons who cannot afford to pay for health care services. Some clinics also provide free dental care. The clinics do not directly receive any state funds; however, several clinics receive Virginia Health Care Foundation grant monies.

All of the clinics depend on providers who are willing to donate their time to deliver medical/dental care. As such, the clinics need an adequate base of providers from which to recruit physicians, dentists and others to care for their patients. While recruitment of providers is not a central focus of the Free Clinics, each of the clinics, as well as the Association of Free Clinics, supports recruitment and retention efforts wherever possible. As an example, many of the Free Clinics serve as preceptor and training sites for various health professions students.

The Virginia Rural Health Association advocates for the health care needs of rural areas across the state, including access to primary care services. While the association currently does not receive any state funds to sponsor any specific programs, it provides assistance to other initiatives whenever possible.

IV.
Planning And Funding Virginia's Health Workforce Initiatives

The language in Item 12 of the 1998 Appropriation Act directs the Joint Commission on Health Care to study and develop a centralized planning and funding mechanism to ensure that the Commonwealth's health workforce activities and initiatives related to improving access to care in underserved areas are designed, administered, and funded in a coordinated manner that maximizes their efficiency and effectiveness. This section of the report focuses specifically on this issue and provides alternatives for establishing a centralized planning and funding mechanism.

The Joint Commission's 1995 Study Of Health Workforce Initiatives Identified A Number Of Concerns Regarding The Planning And Funding Of These Functions

In 1995, the Joint Commission conducted a study of the organization and effectiveness of state health workforce reform initiatives pursuant to Senate Joint Resolution 308 of the 1995 Session of the General Assembly. Some of the key findings and conclusions of the 1995 study, as published in 1996 Senate Document 5, were as follows:

- responsibility for health workforce reform is dispersed across two secretariats and multiple state agencies;
- effective workforce reform will require active oversight and coordination because of a rapidly changing policy environment and the need to coordinate activities across multiple secretariats and agencies;
- 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; and
- there has been little coordination between the secretariats in developing budget and policy proposals for health workforce reform.

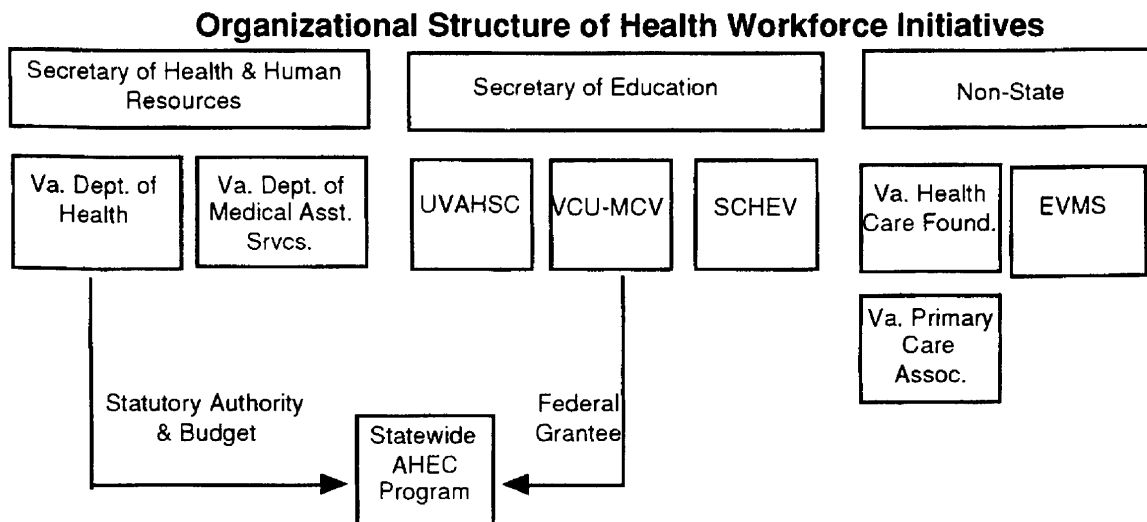
Inasmuch as there have been no significant revisions to health workforce planning and funding processes, the issues identified in the 1995 study still exist today. These ongoing concerns gave rise to the inclusion of the 1998 study language directing this review of health workforce initiatives.

Oversight Of Health Workforce Initiatives And Responsibility For Results Are Fragmented

As noted in the 1995 study, oversight of the health workforce initiatives and responsibility for achieving results are fragmented across two secretariats and multiple agencies and programs. Figure 8 illustrates the current organizational structure and oversight of health workforce initiatives.

Figure 8

Organizational Structure of Health Workforce Initiatives



As a result of the current organizational structure, no one entity has either the authority or responsibility for ensuring that all the various workforce initiatives are coordinated and working toward the same objectives and goals. Each individual program/initiative certainly functions within its own organizational structure and there is no clear evidence to suggest that the programs are working in conflict with each other. However, without a single locus of responsibility and accountability for the programs, the effectiveness of Virginia's overall health workforce initiative is diminished. The funding process also is fragmented with each individual program/initiative submitting budget amendment requests with little or no coordination among the various entities.

The programs do cooperate in many ways and support each other's activities; however, without one entity having responsibility and accountability for results, each initiative can claim that it can do only so much in achieving the

overall goal of increasing primary care providers in underserved areas because each controls only a part of the process.

Evaluating The Effectiveness Of The Workforce Initiatives Is Difficult

Evaluating the effectiveness of the workforce initiatives is difficult because results often are separated by several years from the intervention. For example, many of the educational programs sponsored by the AHECs are provided to elementary, middle, and high school students. It is extremely difficult to develop any outcome data that suggest these programs result or do not result in more students choosing a health professions career. As educational programs move to younger children (Greater Richmond AHEC offers programs to pre-schoolers), the link between the intervention and the desired result becomes even more difficult to measure. Moreover, some educational programs (e.g., wildlife, water quality, electricity, machines, etc.) have drifted away from health care related subjects. If there is any direct connection between these programs and students choosing to practice a health care profession in an underserved area, it will be virtually impossible to measure.

Some suggest that in the absence of outcome data, "process" information such as the number of students participating in a given educational program, preceptor experience or other initiatives at least provides decisionmakers with data on how many students, residents, providers, etc. are benefiting from the program. While this may be the case, such information still does not provide any evaluation of how the program is contributing to the goal of increasing the number of providers in underserved areas.

Programs Are Inter-Related: Measuring the effectiveness of the various workforce initiatives is also complicated by the fact that the programs are inter-related. One program or intervention alone generally does not result in a provider locating in an underserved area. It is the combined effect of different programs that produces the desired result (e.g. AHEC education, generalist training, and scholarship/loan repayment). The fact that the programs are so inextricably linked not only makes evaluation of each component difficult, it also speaks to the need for an entity that provides overall coordination of the various programs.

A meaningful measure of the effectiveness of Virginia's overall health workforce initiative can only be accomplished in a global sense rather than through separate evaluations of each individual program.

Medical Scholarship vs. Loan Repayment

One issue regarding the effectiveness of the various programs that was raised by many of those interviewed during this study is that medical scholarships have had only marginal success in attracting students to underserved areas and that loan repayment is a more effective approach. The reasons offered for this argument include: (i) at the time scholarships are offered, many students have not decided which area of medicine to pursue and are reluctant to take a scholarship with service commitments and triple pay back provisions; (ii) when students graduate from medical school, the average loan debt is $80,000 - $100,000 which they want to pay off, and loan repayment provides a means by which to reduce this debt; and (iii) loan repayment is offered after students have decided which specialty to pursue which makes it easier for them to accept the service commitment. These concerns are evidenced by the fact that, as reported earlier, not all of the medical scholarships have been awarded in past years.

As previously noted, the 1998 Appropriation Act includes language directing any unexpended or repaid medical scholarship monies to revert to the loan repayment program. However, in addition to this language, several persons involved in the various health workforce programs suggested redirecting at least a portion of the scholarship funding to the loan repayment program.

A General Accounting Office Evaluation of National Health Professions Education Programs Was Unable To Determine Their Effectiveness

The difficulty in measuring the effectiveness of health workforce programs is not isolated to Virginia. This is a difficult issue among all of the states as well as the federal government. In 1997, the General Accounting Office (GAO) conducted a study to determine whether national health professions education programs were effective in advancing three key objectives: (i)increasing the numbers of health professionals; (ii) improving their distribution in health professional shortage areas; and (iii) increasing the number of minorities.

The GAO reported that determining the effectiveness of these programs will remain difficult as long they are authorized to support a broad range of health care objectives without common goals, outcome measures and reporting requirements. The GAO also noted that evaluations of individual programs could not be generalized to determine the national impact of the programs in meeting the three objectives identified above. The absence of specific program outcome measures was cited as a key reason for not being able to evaluate the effectiveness of the programs.

The Difficulty In Measuring The Effectiveness Of Health Workforce Programs Creates An Even Greater Need To Have A More Coordinated Planning And Funding Mechanism

The fact that clear outcome measures are not available for outside parties to evaluate the effectiveness of these programs makes it even more necessary to have greater coordination and oversight of their activities. Moreover, in the absence of outcome data, a centralized planning and funding mechanism which can provide policy and funding recommendations becomes even more valuable to those responsible for making budgetary decisions.

The Experiences Of Some Virginia Family Practice Residents Reflect Need For Better Coordination Of Virginia's Health Workforce Initiatives

Due to time constraints, a survey of medical students and family practice residents was not conducted. Interviews with a large number of students/residents also were not possible. However, interviews with two residents and a physician administering a family practice residency program who interacts with many residents indicate that a number of residents believe Virginia's efforts at recruiting them to practice in underserved areas need to be strengthened and given more emphasis.

Representatives Of The Various Health Workforce Programs Generally Agree There Is A Need For A More Coordinated Approach To Planning And Funding These Initiatives

Most of the representatives of the various health workforce programs interviewed during this study indicated that greater coordination is needed in planning and funding Virginia's health workforce initiatives. The reasons cited by these individuals are consistent with those identified earlier. Nearly all stated that while each program is contributing to the overall goal, there needs to be greater coordination of all components to ensure that the programs are as effective as possible and that the ultimate goal (i.e. increasing the number of providers in underserved areas), rather than individual program goals, is being achieved.

While there is general agreement that better coordination is needed, and that some type of planning/coordinating entity or process should be established, there is less agreement as to how this should be accomplished.

There Are Several Possible Approaches To Establishing A Centralized Planning And Funding Mechanism

There are several possible approaches to establishing a centralized planning and funding mechanism that would provide overall coordination of Virginia's health workforce initiatives. The alternatives range from what might be described as "fine-tuning" of existing systems/processes to establishing a separate entity with either an advisory/coordinating role or a policy setting and program authority function. While there are many ways to structure each of these alternatives, the following paragraphs briefly describe several possible approaches.

Modifications/"Fine-Tuning" Of Existing Processes: There are actions that could be taken to provide some additional coordination of health workforce planning and funding without a major restructuring of the current process. Possible actions include:

- directing the Secretaries of Education and Health and Human Resources to develop a formalized process for coordinating these activities and reviewing related budget requests; or
- allocating an additional staff position within the Joint Commission to monitor health workforce activities, evaluate effectiveness of programs, review health workforce budget submissions, and make budget recommendations to the money committees.

Separate Entity To Provide Centralized Planning/Funding Mechanism: As an alternative to modifying or "fine-tuning" existing processes, a separate entity could be established to provide a centralized planning and funding mechanism. Several critical decisions would need to be made regarding how a separate entity for centralized planning and funding of health workforce programs would function.

- Affected health workforce initiatives/programs: decisions would have to be made regarding which health workforce initiatives/programs, or components thereof, would fall within the purview of the entity (e.g., AHEC, Center for Primary Care Resource Development, components of the Generalist Initiative, etc.).
- Policy advisory or program authority role: a critical decision involves which of two different roles the entity would play: (i) a policy advisory and coordinating role which provides recommendations on programs and funding; or (ii) a policy setting and program authority role in which the entity would have authority over the programs and be accountable for results.

- Composition of entity/staff support: whatever decision is made regarding the appropriate role/function for the entity, decisions would have to be made about the type and composition of the Board as well as how staff support would be provided.
- Organizational location: there are several alternative organizational structures/locations for the entity, including: (i) housing the entity within an existing agency such as VDH, one of the medical schools or the State Council for Higher Education (§23-9.19:1 of the Code designates SCHEV as the coordinating agency for post-secondary educational programs for health professions); (ii) creating a new executive branch agency; (iii) creating an independent state agency; (iv) reconstituting the Virginia Health Planning Board (current Board has been inactive since 1991); or (v) establishing a private, not-for-profit authority.

Some Level Of Local Flexibility Should Be Retained

Under any scenario, a statewide coordinating entity would have to provide some flexibility at the local level to ensure that programs have the ability to respond to local needs.

V.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue. Also, in some instances, the policy options may not be mutually exclusive of one another; combinations of certain options can be implemented.

Option I. **Take no action**

Option II. **Introduce budget language directing the Secretaries of Education and Health and Human Resources, in cooperation with the Department of Planning and Budget and the State Council of Higher Education, to develop a formalized process for coordinating health workforce activities and related budget requests.**

Option III. **Introduce legislation or budget language directing the Joint Commission on Health Care, in cooperation with the Health and Human Resources and Higher Education Subcommittees of the Senate Finance and House Appropriations Committees, to develop a process for reviewing health workforce budget requests, monitoring program activities, and evaluating results.**

- This would require an additional staff position at the Joint Commission

Option IV. **Introduce legislation to establish a separate entity to provide a centralized planning and funding mechanism for the various health workforce initiatives.**

- There are several variations as to how the separate entity would be established and how it would function. Key decisions would have to be made regarding:
- The health workforce initiatives/programs, or components thereof, that would come under the purview of the entity;
- Whether the entity would have a policy advisory or program authority role;

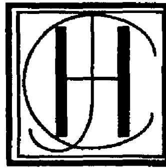
- The type and composition of the entity's Board and the provision of staff support; and
- The entity's organizational structure/location (i.e., within an existing agency, a new executive branch agency, a new independent state agency, reconstituting the Virginia Health Planning Board, or establishing a private, not-for-profit authority).

APPENDIX A

1998 Virginia Acts of Assembly
Chapter 464
Item 12

The Joint Commission on Health Care, in cooperation with the House Appropriations and Senate Finance Committees, shall study and develop a centralized planning and funding mechanism to ensure that the Commonwealth's health workforce activities and initiatives related to improving access to care in underserved areas are designed, administered, and funded in a coordinated manner that maximizes their efficiency and effectiveness. The Joint Commission's analysis shall include the Area Health Education Centers Program, the Department of Health's Center for Primary Care Resource Development including recruitment, scholarship and loan repayment programs; those activities of the Generalist Initiative which relate to improving access to care in underserved areas; and, the role of other related private non-profit community-based organizations. The Joint Commission shall complete its study by November 1, 1998, and shall report its findings and recommendation to the Governor and the 1999 Session of the General Assembly.

APPENDIX B



JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: HEALTH WORKFORCE STUDY (Item 12, 1998 Appropriations Act)

Individuals/Organizations Submitting Comments

A total of six individuals and organizations submitted comments in response to the draft issue brief on health workforce issues.

- Virginia Statewide AHEC Program
- Medical College of Virginia Campus of Virginia Commonwealth University
- Roger A. Hofford, M.D.
- "3-M Group" (Representatives of the Academic Health Centers: University of Virginia, Virginia Commonwealth University, and Eastern Virginia Medical School)
- Douglas R. Southard, Ph.D., College of Health Sciences' Physician Assistant Program
- Virginia Department of Health

Policy Options Included in the Health Workforce Issue Brief

Option I. **Take no action**

Option II. **Introduce budget language directing the Secretaries of Education and Health and Human Resources, in cooperation with the Department of Planning and Budget and the State Council of Higher Education, to develop a formalized process for coordinating health workforce activities and related budget requests.**

Option III. Introduce legislation or budget language directing the Joint Commission on Health Care, in cooperation with tl Health and Human Resources and Higher Education Subcommittees of the Senate Finance and House Appropriations Committees, to develop a process for reviewing health workforce budget requests, monitorin program activities, and evaluating results.

- This would require an additional staff position at the Joint Commission

Option IV. Introduce legislation to establish a separate entity to provide a centralized planning and funding mechanism for the various health workforce initiatives.

There are several variations as to how the separate entity woul be established and how it would function. Key decisions would have to be made regarding:

- the health workforce initiatives/programs, or components thereof, that would come under the purview of the entity;
- whether the entity would have a policy advisory or program authority role;
- the type and composition of the entity's Board and the provision of staff support; and
- the entity's organizational structure/location (i.e., within an existing agency, a new executive branch agency, a new independent state agency, reconstituting the Virginia Health Planning Board, or establishing a private, not-for-profit authority).

Overall Summary of Comments

Overall, the comments favored either Option II or III as a means of providing centralized funding and planning for health workforce initiatives. Four of the six commenters identified some variation or combination of the approaches outlined in Options II and III. Only one commenter suggested establishing a separate entity to coordinate workforce activities and make funding recommendations.

Summary of Individual Comments

Virginia Statewide AHEC Program

Betty Newell, Chair of the Statewide AHEC Board of Directors, commented in favor of Option III. Ms. Newell noted that this Option provides the most efficient mechanism to coordinate state budget requests and evaluate the effectiveness of these programs. Ms. Newell also commented that a specific policy regarding state funding for Virginia's eight community AHECs would be especially helpful.

Medical College of Virginia, Virginia Commonwealth University

Hermes A. Kontos, M.D., Ph.D., Vice President for Health Sciences and Dean of the School of Medicine, Medical College of Virginia Campus, Virginia Commonwealth University, commented that the Joint Commission on Health Care is the most logical locus for coordinating health workforce initiatives. Dr. Kontos stated that the coordinating entity proposed could be within or report to the Joint Commission on Health Care.

Roger A. Hofford, M.D.

Dr. Hofford, a physician educator and past President of the Virginia Academy of Family Physicians, commented as an individual citizen. Dr. Hofford commented that there needs to be better coordination of health workforce services and information and that the current structure limits Virginia's ability to compete with other states in recruiting and retaining health care providers.

Dr. Hofford did not express support for one of the Policy Options listed in the report; however, he commented that a commission of interested parties would best serve the state's health workforce interests. Dr. Hofford indicated that the commission would help coordinate the planning and funding of AHECs, the Generalist Initiative, the Virginia Health Care Foundation, and the Center for Primary Care Resource Development at the Virginia Department of Health. The commission would be headed by the State Health Commissioner and would be composed of the following members: VDH, the three state medical schools, Virginia Polytechnic Institute and State University, AHECs, Virginia Rural Health Association,

Joint Commission on Health Care, the Virginia Health Care Foundation and the Virginia Primary Care Association. Dr. Hofford commented that the commission could provide "one stop shopping" for communities, state agencies, and individual health care providers for critical information regarding the workforce needs and resources in Virginia.

3-M Group (Representatives of the Academic Health Centers: University of Virginia, Virginia Commonwealth University, and Eastern Virginia Medical School)

C. Donald Combs, Ph.D., Vice President for Planning and Program Development at Eastern Virginia Medical School and Chair of the 3-M Group, commented on behalf of the 3-M Group. Dr. Combs indicated that while the 3-M Group does not have a strong preference among the listed options, they tend to support Option II because it does not create a new bureaucratic entity. Dr. Combs commented that the 3-M Group would be pleased to work with the Joint Commission, representatives of the Secretaries of Education and Health and Human Resources, the Department of Planning and Budget and the State Council of Higher Education to discuss the more formal process envisioned in Option II and which programs and components of programs should be included in the definition of "health workforce."

Douglas R. Southard, Ph.D., College of Health Sciences' Physician Assistant Program

Dr. Southard, Director of the Physician Assistant Program at the College of Health Sciences, commented that information regarding the physician assistant scholarship program should be included in the report. (This information will be included in the final report.)

Virginia Department of Health (VDH)

Randolph L. Gordon, M.D., M.P.H., Commissioner of Health, commented that VDH agrees that a more centralized planning and funding mechanism is needed if the Commonwealth is to become more effective and efficient in its health workforce efforts. Dr. Gordon commented that Option IV would require further discussion and decisions concerning the organizational structure of a separate entity. Dr. Gordon commented that, without further study of Option IV, it appears that Option III may be the most viable at this time. Dr. Gordon also noted that as part of this process, the various

entities involved in health workforce initiatives should be required to meet on a regular basis so that each may stay abreast of each other's activities. Dr. Gordon noted that more collaborative and cooperative working relationships will lead to a more effective use of funds, staff and time.

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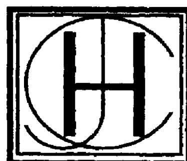

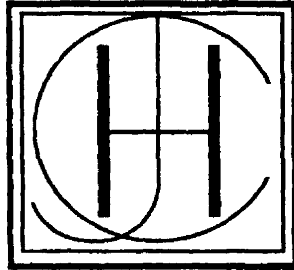

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