REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

HEALTH WORKFORCE STUDY PURSUANT TO ITEM 12B, APPROPRIATION ACT

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 89

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

Preface

The 1999 General Assembly included language in the 1999 Appropriation Act directing the Joint Commission on Health Care (JCHC) to review the efficiency, effectiveness, and outcomes of the Commonwealth's health workforce initiatives.

Item 12(B) of the 1999 Appropriation Act directs the Joint Commission's ongoing review of these issues to include: (i) the Area Health Education Centers (AHEC) program, (ii) the various recruitment, scholarship and loan repayment programs; (iii) the activities of the Generalist Physician Initiative which relate to improving access to care in underserved areas; and (iv) the activities of other related private, nonprofit community-based organizations. The specific tasks outlined in the study language include:

- "monitoring and analyzing the efficiency, effectiveness and outcomes of existing programs designed to recruit and retain primary care providers in underserved areas;
- identifying new, innovative programs that can increase the number of primary care providers locating in underserved areas;
- identifying effective workforce programs in other states that could be implemented in Virginia;
- recommending appropriate modifications to Virginia's overall health workforce efforts; and
- recommending appropriate funding strategies."

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

- Virginia's workforce programs are designed to increase the number of providers practicing in underserved areas. In Virginia, there are three measures of determining underserved areas: health professional shortage areas (HPSAs), medically underserved areas (MUAs) and Virginia medically underserved areas (VMUAs). There are 56 HPSAs, 93 MUAs, and 43 VMUAs in Virginia. Thirty localities have a "dual designation" as a HPSA and VMUA.
- In addition to underserved "areas," there are also underserved "populations." Underserved populations exist in rural as well as urban and suburban areas.
- The Virginia Department of Health's (VDH's) Office of Health Policy and Center for Primary Care and Rural Health coordinates the Commonwealth's provider recruitment and retention efforts. However, there is no statutory mandate, direction, or accountability for this function.

- There is limited staffing at VDH assigned to health workforce functions which limits the Center's ability to actively recruit providers. Virginia's staff devoted to recruiting is less than other neighboring states. Some interested parties have suggested moving this function out of VDH to another entity where the function will have greater visibility and be a higher priority. Others have suggested providing statutory direction and accountability to VDH along with the necessary resources.
- The limited staffing and resources at VDH has resulted in little active recruitment of providers to Virginia's underserved areas. VDH does not routinely recruit providers/medical school residents from other states.
- Most health professions residents and medical school students are unfamiliar with the recruitment and retention programs available to them and also are unfamiliar with the workforce functions of VDH. Several residents indicated they are more familiar with the programs available in North Carolina than Virginia.
- Loan repayment programs are more effective than scholarships in recruiting providers. Consideration should be given to increasing the amount of funding appropriated for loan repayment. Consideration also should be given to consolidating all funding for incentives into one appropriation that authorizes use of the funds in the way that best suits the needs of the provider being recruited. This would eliminate the current restriction of pre-determined amounts. Consideration also should be given to authorizing additional incentives such as a "signing bonus," salary supplements, and travel expenses for providers visiting an underserved area.
- The Statewide AHEC Program is carried out by a Statewide AHEC Board and 8 local AHECs located throughout the Commonwealth. The four key areas of AHEC activities are: (i) health careers, (ii) student rotations, (iii) provider retention, and (iv) health promotion.
- As federal "core" funding has declined the past several years, state GF support for AHECs has increased. For FY 2000, $900,000 is appropriated for the local AHECs. AHECs also receive other sources of revenue. In FY 1999, in total, AHECs expended approximately the same amount of federal, state and local dollars.
- The AHEC program activity with the greatest expenditures was "health careers." Health careers was also the greatest area of state GF expenditures in FY 1999.
- As AHEC requests for additional state funding have increased, questions have been raised regarding what specific measurable results are being achieved. Much of the AHEC program data are "process-oriented" rather than "outcomes-oriented." A key question for the Commonwealth is whether to place the same importance on all AHEC activities. Health careers and health promotion activities do not appear to have a direct impact on increasing the number of providers locating in underserved areas. Consideration should be given to requiring AHECs to use state GF dollars

only for activities related to student rotations, and provider recruitment and retention activities. AHECs could use other funding sources for health careers and health promotion activities.

- Determining an appropriate amount of funding for AHECs depends on which activities the Commonwealth wants to support, and whether the same level of funding should be provided to each AHEC. The Statewide AHEC Program recommends a total of $200,000 is needed per AHEC.
- An alternative approach to providing the same level of funding to each AHEC would be to appropriate one amount to the Statewide AHEC Board and direct it to allocate the amount among the 8 local AHECs.
- Currently, the Statewide AHEC Board must submit an annual report to the Secretary of Health and Human Resources, the Board of Health, the Governor and General Assembly regarding program activities. However, the Statewide AHEC Board is not required to report on how state GF dollars are used to support the program. Consideration should be given to requiring the Board to include this information in its annual report.

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 49-52.

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 Virginia Department of Health, the Statewide AHEC Program, the Medical College of Virginia, the University of Virginia Medical School, Eastern Virginia Medical School, the Virginia Primary Care Association, the Virginia Association of Free Clinics and the Virginia Academy of Family Physicians for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

December, 1999

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I.
Background and Authority for Study/ Organization of Report

1998 Appropriation Act Directed The Joint Commission on Health Care To Study The Need For A Centralized Planning And Funding Mechanism For Health Workforce Activities

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 study conducted last year focused on establishing an ongoing process for reviewing the various health workforce initiatives in the Commonwealth to ensure that the individual programs and activities are coordinated and are achieving the intended goal of increasing the number of primary care providers in underserved areas. Last year's report, published as 1999 House Document 49, provided information on: (i) Virginia's underserved areas; (ii) the programs that have been implemented to recruit and retain providers in underserved areas; and (iii) various mechanisms that could be established to improve the coordination, planning, and funding of these programs. The report also identified several policy options for establishing a centralized health workforce planning and funding process.

Based on the information included in last year's report and the public comments received in response to the report, the Joint Commission on Health Care recommended to the 1999 General Assembly that it review health workforce programs, evaluate results, and make recommendations concerning program activities and funding. Included in the Joint Commission's recommendation was a request for an additional staff position and funding to assume this responsibility.

The 1999 General Assembly Included Language in the 1999 Appropriation Act Directing the Joint Commission to Review The Efficiency, Effectiveness, and Outcomes of the Commonwealth's Health Workforce Initiatives

As recommended by the Joint Commission, the 1999 General Assembly included language in the 1999 Appropriation Act directing the Joint Commission

to review the efficiency, effectiveness, and outcomes of the Commonwealth's health workforce initiatives related to improving access to care in underserved areas. However, no additional staff or funding was approved.

Item 12(B) of the 1999 Appropriation Act directs the Joint Commission's ongoing review of these issues to include: (i) the Area Health Education Centers (AHEC) program, (ii) the various recruitment, scholarship and loan repayment programs; (iii) the activities of the Generalist Physician Initiative which relate to improving access to care in underserved areas; and (iv) the activities of other related private, nonprofit community-based organizations. The specific tasks outlined in the study language include:

- "monitoring and analyzing the efficiency, effectiveness and outcomes of existing programs designed to recruit and retain primary care providers in underserved areas;
- identifying new, innovative programs that can increase the number of primary care providers locating in underserved areas;
- identifying effective workforce programs in other states that could be implemented in Virginia;
- recommending appropriate modifications to Virginia's overall health workforce efforts; and
- recommending appropriate funding strategies."

The 1999 Appropriation Act language requires the Joint Commission to complete its initial review of these issues by November 1, 1999, and to make its recommendations to the Governor and the 2000 Session of the General Assembly.

This Report Is Organized Into Six Sections

This section of the report provided background information on last year's health workforce study and the directive for this year's review. Section II provides an overview of the need for and objectives of health workforce initiatives. Also, information regarding the underserved areas of the Commonwealth is presented in Section II. Section III updates information presented last year on the various health workforce initiatives in Virginia. Section IV includes an assessment of Virginia's efforts to recruit and retain primary care providers for underserved areas and populations. Section V reviews the activities of the Commonwealth's AHEC program, and discusses the need to develop a funding strategy for this program. Lastly, Section VI presents a number of policy options for consideration by the Joint Commission in addressing these workforce issues.

II.
The Need To Recruit And Retain Primary Care Providers For Underserved Areas And Populations

Many Virginia Communities Do Not Have Adequate Access To Primary Care; In Certain Other Locations, Specific Populations Lack Adequate Access

In reviewing the issue of improving access to primary care, it is important to recognize that, in addition to underserved geographic areas, such as rural or remote localities, there often are underserved populations that exist within an otherwise appropriately served geographic area. For instance, in some urban areas of Virginia, the overall measure of access to care is appropriate (i.e., the number of providers for the total population is adequate); however, there may be specific segments of the population without appropriate access. Examples can include certain minority or ethnic populations, inner-city populations, or persons with specific medical conditions requiring sub-specialty care. Developing and administering programs to improve access to care must recognize and respond to both underserved areas and populations.

There Are Three Measures Or Processes For Designating Underserved Areas

In Virginia, there are three primary measures or processes for determining which localities have inadequate access to primary care. The federal government administers two designations: medically underserved areas (MUAs) and health professional shortage areas (HPSAs). In addition to the federal designations, the Virginia State Board of Health has responsibility for identifying medically underserved areas pursuant to §32.1-122.5 of the *Code of Virginia*. As discussed in Section III, these areas, known as Virginia medically underserved areas (VMUAs), are used in conjunction with the Virginia scholarship programs and loan repayment program. VMUAs identify those areas in which financial award recipients must practice for a given period of time to qualify for the respective scholarship or loan repayment.

The criteria for designating HPSAs, MUAs and VMUAs are illustrated in Figure 1. As seen in Figure 1, the criteria for the HPSA designation focus more directly on the availability of providers than the MUA or VMUA designations which are based on broader health care data. The MUA and VMUA criteria are nearly identical.

Figure 1

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

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.

MUA - Medically Underserved Areas (federal designation)
- Primary care physician to population ratio
- Percent of population with income below 100% of the federal poverty level
- Percent of population 65 years of age or older
- Five-year average infant mortality rate

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

Source: Virginia Department of Health, Office of Health Policy and the Center for Primary Care And Rural Health

Currently, There Are 56 HPSAs, 93 MUAs, and 43 VMUAs In Virginia

Entire counties or cities or portions of counties and cities can be designated as HPSAs, MUAs or VMUAs. Based on information provided by the Virginia Department of Health's (VDH) Office of Health Policy and Center for Primary Care and Rural Health, there are a total of:

- 56 HPSAs (31 whole counties/cities, 23 partial counties/cities, and 2 facilities);
- 93 MUAs (67 whole counties/cities, 26 partial counties/cities); and
- 43 VMUAs (all of which are whole counties/cities).

Currently, 30 counties/cities have "dual" designations as both a federal HPSA (includes HPSAs which are partial counties/cities) and a VMUA. Figure 2

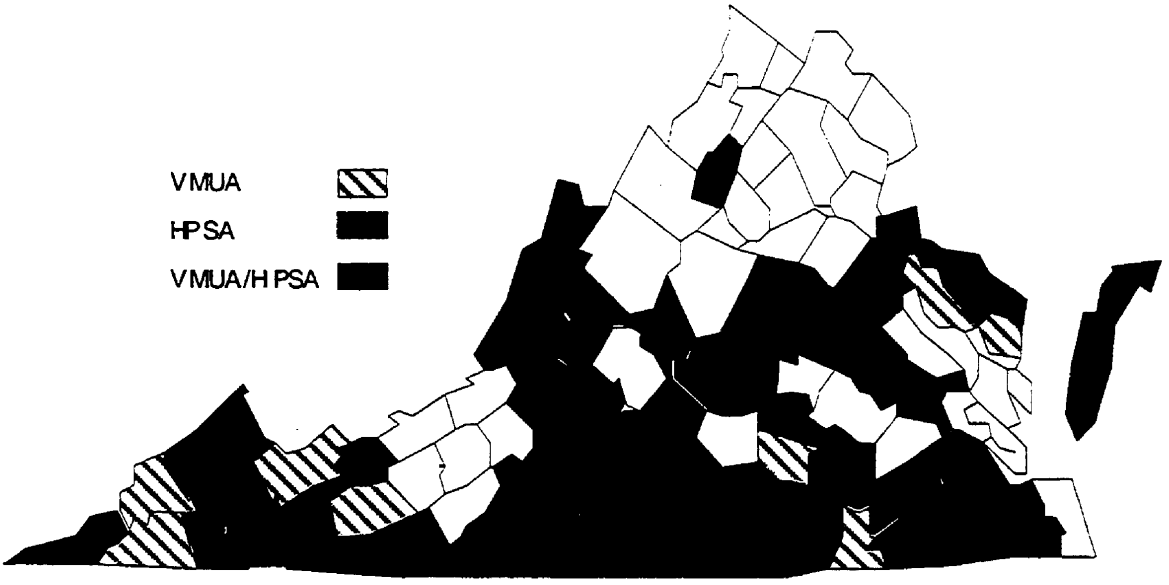
provides a geographical depiction of these underserved areas. As seen in Figure 2, a significant percentage of Virginia citizens live in these underserved and provider shortage areas.

Counties/Cities Also Can Be Designated As "Dental" and "Mental Health" HPSAs

In addition to being designated as a primary care HPSA, counties and cities also can be designated as a "dental" or "mental health" HPSA. While the primary care HPSA designations have been kept current by VDH, only 13 counties/cities have been designated as dental HPSAs. As reported in the JCHC's recent study on improving access to dental care, approximately 43 localities appear to meet the dentist:population criteria for designation as a dental HPSA. However, only 13 have been designated. VDH indicates that, as of August 5, 1999, 17 localities had been designated as "mental health" HPSAs. As with the dental HPSA designations, while it is anticipated that a number of additional localities qualify for designation as a mental health HPSA, few have been designated thus far.

Figure 2

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



Source: Virginia Department of Health, Office of Health Policy and the Center for Primary Care And Rural Health

VDH Estimates That In Order To Eliminate All Primary Care HPSA Designations, Approximately 100 Additional Physicians Are Needed In These Underserved Areas

The VDH Office of Health Policy and the Center for Primary Care and Rural Health conducted an analysis of the number of physicians that would be needed to eliminate all HPSA designations in the Commonwealth. Based on the federal physician to population ratio of 1 physician to 3,000 population, VDH estimates that an additional 102 physicians would need to be recruited into Virginia's underserved areas to remove all HPSA designations. (The federal government normally uses a physician to population ratio of 1:3,500; however, areas can be designated as a HPSA with a 1:3,000 ratio if other measures of significant need exist. VDH used the 1:3,000 ratio in its analysis because its experience is that other measures of need typically can be documented.)

The VDH estimate is consistent with earlier analyses reported in a 1996 Joint Commission on Health Care (JCHC) study of health workforce initiatives which indicated 95 providers would be needed to eliminate all of the HPSA designations. Moreover, the 1996 JCHC report indicated that more than 800 new physicians would be needed to eliminate shortage areas in metropolitan areas, Northern Virginia, and metro-Richmond. Comparison of the 1996 and 1999 estimates indicates that approximately the same level of provider shortages exist today that existed three years ago.

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 aimed at increasing the number of providers locating in underserved areas, and provides an estimate of the funding of these initiatives.

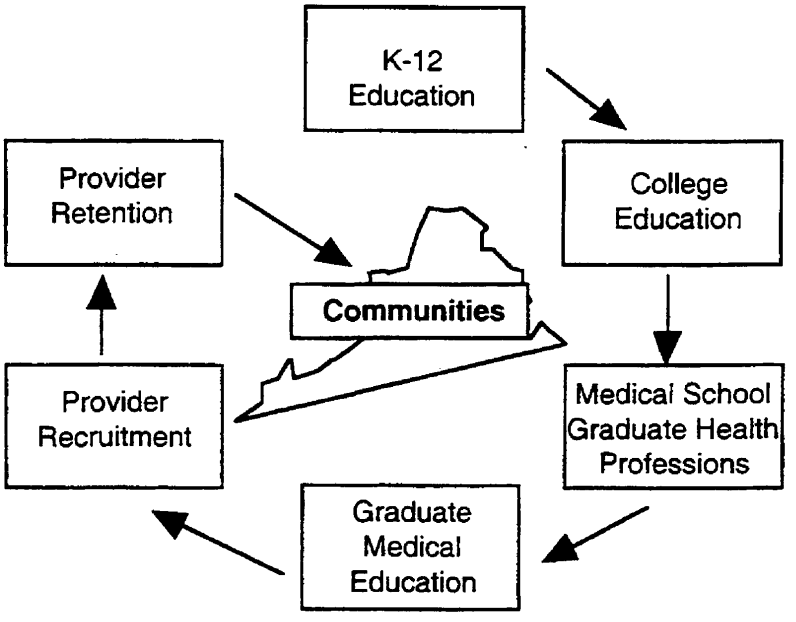
III.
Virginia's Health Workforce Initiatives

Virginia Has Implemented A Number Of Initiatives To Address The Need For Additional Primary Care Providers For Underserved Areas And Populations

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



Source: Joint Commission on Health Care Staff Analysis

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.

- **Office of Health Policy And Center for Primary Care And Rural Health.** Located within the Virginia Department of Health (VDH), this office administers several health workforce programs/initiatives.

    - **Recruitment/Retention:** the VDH coordinates the Commonwealth's efforts to recruit and retain primary care providers in underserved areas.
    - **Scholarship and Loan Repayment Programs:** the VDH 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.

- **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.

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 50 Community and Migrant Health Centers (CMHCs) across the Commonwealth including recruitment of providers to practice at the CMHCs. The Rural Health Association advocates on behalf of rural areas regarding various health issues, including access to primary care providers.

Last Year's Joint Commission Report On Health Workforce Issues Included A Description Of Each Program/Initiative; This Section Provides Updated Information Where Appropriate

Information regarding each of the Commonwealth's health workforce programs and initiatives was provided in the study conducted last year by the JCHC (1999 House Document 49). As such, rather than repeat all of the information contained in last year's report, this document provides updated information where appropriate. In addition, as noted earlier, Section IV provides a detailed discussion and analysis of VDH provider recruitment and retention efforts; Section V discusses the need to develop a funding strategy for the AHEC program.

The Commonwealth Will Invest Approximately $17.3 Million In General Funds (GF) On Related Health Workforce Initiatives In FY 2000

As seen in Figure 4, the Commonwealth will invest approximately $17.3 million GF in related health workforce initiatives in FY 2000. Total health workforce spending in FY 2000 will be approximately $3.5 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 has remained relatively constant.

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

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]	$ 240,000	$ 358,139	$ 358,139	$ 658,139	$ 1,008,139	$ 1,058,139
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	2,600,722	2,626,229
MCV/VCU	4,793,605	4,874,030	4,987,449	5,288,982	5,560,340	5,837,036
Subtotal	$ 8,292,159	$ 8,407,607	$ 8,631,927	$ 9,003,391	$ 9,259,725	$ 9,561,928
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 [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
DMHMRSAS[5]						$ 500,000
Va. Health Care Foundation**	$ 2,372,138	$ 2,229,810	$ 2,229,810	$ 2,229,810	$ 2,229,810	$ 2,229,810
Grand Total	**$13,859,402**	**$13,800,466**	**$14,539,895**	**$15,259,792**	**$16,362,084**	**$17,313,207**

NOTES: 1. For FY 96, 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 Commonwealth. Unexpended medical scholarship monies revert to loan repayment.

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.

5. Funding for program to recruit and retain graduate students in psychiatry for underserved areas.

* Estimates

** Some but not all of Virginia Health Care Foundation grants support provider recruitment and retention efforts.

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.

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 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, The 1998 And 1999 Appropriation Acts Include 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

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. Significant progress has been made in reaching the goal of 50% of medical school graduates intending to enter generalist practice. A database tracking the practice location of generalist physicians trained at the three medical schools has been completed. 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 were outlined in last year's report.

Language was included in the 1998 and 1999 Appropriation Acts indicating 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 Appropriation Act states that funding for the GPI will not be continued in the FY 2000-2002 biennium unless the GPI goals for FY 2000 are met.

There also is language in the 1998 and 1999 Appropriation Acts 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 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

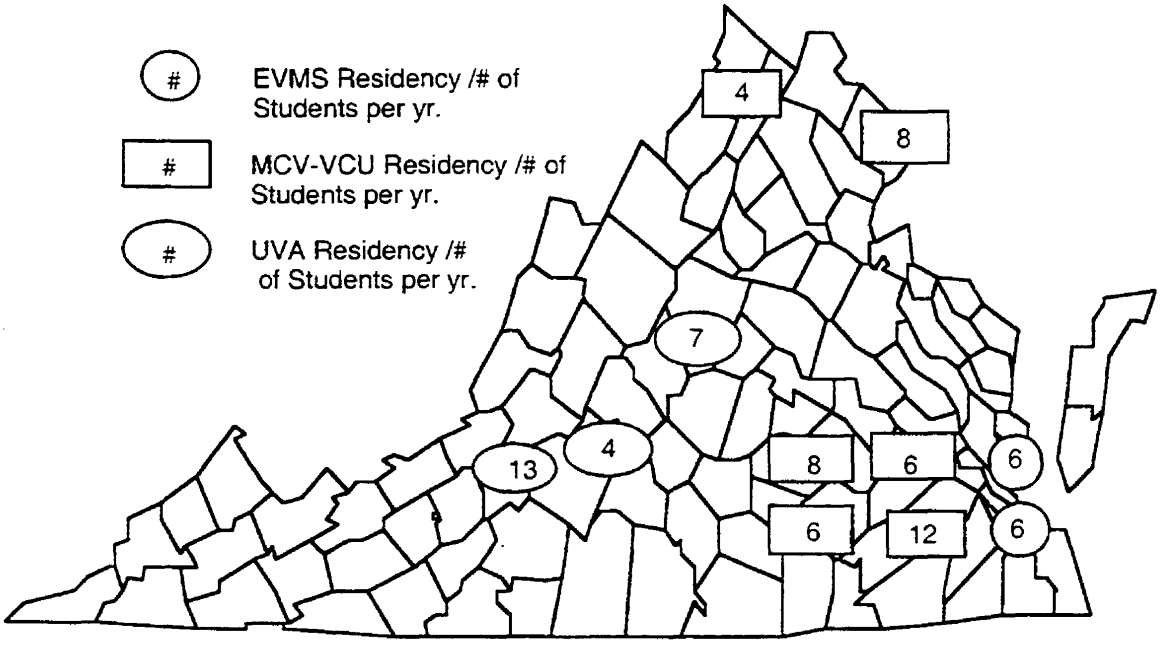
As seen in Figure 4, the Commonwealth will spend approximately $9.6 million in FY 2000 to support family practice residencies across the Commonwealth. Family practice residencies play a critical role in the training of

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, all three of the 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 per year. In addition to these programs, the 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

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

The Virginia Department of Health's (VDH) Office of Health Policy and Center for Primary Care and Rural Health coordinates a number of programs for recruiting and retaining providers in underserved areas, including the various scholarship and loan repayment programs. For the past several years, the core funding for the recruitment and retention activities of the Office was from a Robert Wood Johnson (RWJ) Foundation grant for the "Practice Sights Initiative." As a result of the grant ending last year, state GF dollars ($325,000) have been appropriated to support the recruitment and retention activities of the Office.

Section IV of this report provides more detailed information about VDH's activities and assesses the effectiveness of Virginia's recruitment and retention efforts.

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.

Section V of this report provides more detailed information about the activities of Virginia's AHEC program, and discusses the need to develop a funding policy for the program.

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 50 community and migrant health centers located throughout the Commonwealth. These health centers are not-for-profit corporations located in medically underserved areas. The centers provide primary health care 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 more than 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.

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 lifestyle. The Virginia Health Care Foundation provides funding to support the SCEPTER program. Since 1994, SCEPTER has placed more than 200 students in these rotations.

In recent months, the VPCA has embarked on a statewide campaign to assure every Virginian has access to affordable and regular primary health care services. The campaign, entitled "100 Percent Access, 0 Health Disparities," is an effort to bring together businesses, organizations, agencies and individuals to share whatever resources are available to identify and address the health care needs of each targeted community. The campaign has established an annual goal to build improved systems of access to care in 5-10 medically needy communities each year. The long-term goal is to provide affordable access to primary health care services for all Virginians and to track and reduce health disparities in Virginia.

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 1998, the Foundation supported 56 projects across the Commonwealth. Over one-half of these projects were 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 low interest rate loans to bring new primary care providers to Virginia's primary care and dental HPSAs. Each loan provides money to expand existing health clinics, start new ones, or recruit new practitioners.

- **Virginia Health Careers 2000:** This 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, a majority of the Foundation's projects also serve as a placement site for students to receive resident training or other clinical experiences.

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

The 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.

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.
Assessing Virginia's Primary Care Provider Recruitment And Retention Efforts

As previously noted, a primary focus of this report is to assess the Commonwealth's efforts to recruit and retain primary care providers for underserved areas and populations and to identify ways of enhancing these efforts. This section of the report addresses these two key issues.

VDH's Office Of Health Policy And Center For Primary Care And Rural Health Serves As The Coordinating Entity For Recruitment And Retention Of Primary Care Providers For Underserved Areas And Populations

While not statutorily required to coordinate Virginia's provider recruitment and retention efforts, VDH's Office of Health Policy and Center for Primary Care and Rural Health (the Center) has performed this function for several years. Recently, the functions of the Center were merged with the health policy section.

The Center Is Involved In Several Activities Related To Provider Recruitment

Recruitment Clearinghouse: The Center has developed a recruitment clearinghouse 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 then matched against a listing of primary care providers seeking employment. The Center has assisted in the placement of 38 providers since 1996. Thus far in 1999, 141 providers (physicians, nurse practitioners, and physician assistants) have contacted the Center seeking employment assistance.

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

- Advertisement in select journals and websites;
- Contact with primary care residents, nurse practitioner and physician assistant programs;
- Attendance at state, regional and national meetings; and
- Project Manager for the development of the Virginia Recruitment and Retention Network web page (through partnership with the Blue Ridge AHEC).

VDH Has Contracted With A Number Of Entities For Various Services Related To Recruitment/Retention Of Providers And Rural Health Care

As noted in Figure 4, VDH receives approximately $325,000 (GF) for the Center's activities in rural health and those related to implementing a Five-Year Plan For Improving Access To Primary Care in Underserved Areas and Populations. The Center has used nearly all of these funds to contract with various entities to perform certain services/functions. Listed below is a sampling of the contracts and the contracting entities:

- Development of a recruitment/retention web page; James Madison University and Blue Ridge AHEC;
- Publication of "AG-MED" a rural practitioner's guide to agromedicine; VPI&SU;
- Analysis of the model rural health program developed in Nelson County; James Madison University, Blue Ridge AHEC;
- Development of a HCFA-approved rural health plan to support the Medicare Rural Hospital Flexibility Program; VPI&SU;
- Development of an electronic information system to support multicultural health initiatives; Northern Virginia AHEC; and
- Development of a continuing medical education program for primary care physicians on behavioral and mental health and the primary care provider; Southwest AHEC.

A Statewide Database Of Primary Care Physicians In Virginia Has Not Been Fully Developed

The Center's activities previously were funded primarily through the "Practice Sights" grant from the Robert Wood Johnson (RWJ) Foundation. One of the key objectives of the Practice Sights grant was to develop a database that included the number, location, and type of primary care providers practicing throughout the Commonwealth. The database was to be used to accurately assess provider needs and assist in determining where recruitment and retention efforts were most needed. In addition, the database was to be used in the process of designating underserved areas (i.e., HPSAs, VMUAs, and MUAs) and for overall workforce planning.

Despite having the funds to develop and implement the database through the RWJ grant, the system has not been fully completed, and is not being used by the Center at this time. The grant period has since expired and the funds are no longer available. VDH staff indicate that they are uncertain as to the usefulness of the system as it exists today. Moreover, VDH staff indicate it is unclear whether the database would provide a more efficient means of assessing

provider capacity for designating underserved areas than the current method of making telephone inquiries with each community.

Consideration should be given to directing VDH to review the efficacy of the database in its current status and report on whether the system should be utilized and, if so, what resources if any are needed to improve the system and make it functional. If additional resources are necessary to upgrade the system, a potential source of revenue could be generated by redirecting a portion of the funds currently obligated to the contracts discussed above once they are completed.

The Center Administers a Number of Health Professions Scholarship Programs and Three Physician Loan Repayment Programs

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 (VMUAs).

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). As of July 1, 1998, all scholarships for recipients attending Virginia medical schools require match funding.

While the Appropriation Act indicates that funding is provided for 67 scholarships each year, VDH staff indicate that since the match requirement became effective, the actual total number of scholarships is 87. A total of $465,000 in state funding is provided in each year of the biennium (FYs 1999 and 2000). The Appropriation Act designates four scholarships for Virginia residents who attend the School of Medicine at East Tennessee State University. In addition, two scholarships are set aside for students who attend the School of Osteopathic Medicine at Pikeville College.

Fifty scholarship recipients have been placed in service in a VMUA since FY 1991. Thirty-one have completed their obligation, 19 are currently practicing, and of the 19 practicing, four will be fulfilling their obligation in FY 2000. The 19 practicing scholars are working in the following VMUAs: Accomack County (2), Essex/Richmond County, Galax, Giles County (2), Henry County, Lancaster County (2), Louisa County, Lunenburg County, Mecklenburg County,

Northampton County, Nottoway County, Page County, Southampton County, Washington County (2), and Wytheville.

In FY 1999, $235,000 was awarded to 38 students. This amount represents 51% of the total amount appropriated for FY 1999. According to Center staff, the reasons for having unspent funds are: (1) the scholarship does not fully cover tuition cost; and (2) the triple payback penalty that is imposed if the recipient does not practice primary care in a VMUA. In response to the difficulty in awarding the entire scholarship amounts, language was included in the 1998 Appropriation Act directing any unexpended scholarship money to the loan repayment program. As a result of this language, a total of $230,000 was carried forward for the Virginia Loan Repayment Program.

VDH Center staff indicates that one potential way to increase the number of recipients is to broaden the number of underserved areas that students can select as their practice location. Currently, Section 32.1-122.6 of the Code of Virginia requires recipients to agree to practice in an "underserved area." These underserved areas are VMUAs as established by the Board of Health pursuant to §32.1-122.5. Consideration should be given to amending the Code of Virginia to include HPSAs among the underserved areas where scholarship recipients could locate. This would add approximately 26 localities which would improve the likelihood that students would find an area in which they would be willing to locate upon completion of their training. The end result should be an increase in the number of students accepting the scholarships.

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 nurse practitioner students and midwifery students in return for a year for year service agreement in a VMUA. Five scholarships are funded each year for a total annual appropriation of $25,000. During the 1998-1999 academic year, all five scholarships were awarded.

Since 1993, there have been a total of 30 recipients. There are seven recipients that are still in school; 14 have fulfilled their obligation, three are in a pending status, two have defaulted, and four are currently working in the following areas: Charlotte County, Chase City, Smyth County, and the Piedmont Health District which includes the counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway and Prince Edward.

Virginia Dental Scholarship Program: This program provides scholarship money to students who agree to practice in underserved areas. Prior to 1999, ten scholarships of $2,500 each were available each year for Virginia

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.

The Center coordinates the Commonwealth's participation in the J-1 visa program. Currently, there are 54 physicians practicing in federally designated health professional shortage areas (HPSAs) in Virginia through the J-1 visa program.

Very Few Virginia Primary Care Residents Are Aware Of VDH's Activities And The Programs Administered By The Center

Despite the activities and efforts of VDH and the programs administered by the Center, very few of Virginia's primary care residents are aware of VDH or the opportunities and incentives for practicing in an underserved area. As part of this study, JCHC staff interviewed approximately 40 primary care residents from across the Commonwealth. When asked about their familiarity with VDH or any of the programs administered by the Center, the vast majority of the residents indicated that they were not familiar with VDH or the Center's activities. Very few residents stated they had any familiarity with Virginia's workforce activities or recruitment programs. Moreover, as a group, residents are not aware of the underserved areas (e.g., HPSAs, VMUAs) in the Commonwealth in which they could practice and become eligible for loan repayment or scholarship benefits. These findings were consistent among all of the residents interviewed across the state.

There Appears To Be Little "Active" Recruitment Of Residents And Other Providers Into Virginia's Underserved Areas; Virginia Residents Report Being Recruited Far More Aggressively By North Carolina And Other States

Based on interviews of primary care residents, information provided by VDH, and interviews of other individuals involved in and knowledgeable about health workforce efforts in Virginia, there appears to be little "active" recruitment of residents and other providers to practice in Virginia's underserved areas. Nearly all residents report they have not been recruited by Virginia to practice in an underserved area.

VDH administers a recruitment clearinghouse, has attended some resident meetings, and offers assistance to physicians who are looking for an area in which to practice. VDH also maintains a web site with information about

Virginia's financial incentive programs, medically underserved areas, and contacts for interested providers. At the conclusion of this study, VDH was sending a recruitment letter to Virginia primary care residents. While these efforts are helpful, the current recruitment approach appears to be more "passive" than the approach taken by some other states which regularly initiate contact with residents and other providers. Virginia's current approach to recruiting is reflected in a statement made by one of the residents who said "I guess if I looked hard enough, I could find this information."

When residents were asked to identify which states had been recruiting them, the state most often cited was North Carolina. Others identified states such as Texas, Oklahoma, and Tennessee. Several residents stated that they know more about opportunities available to physicians in North Carolina than in Virginia. While a few noted that some health systems in Virginia (e.g., Carilion) had recruited them, only a very small number indicated they had been recruited by the state of Virginia.

VDH Does Not Routinely Recruit Residents Or Providers In Other States

While Virginia primary care residents report being recruited by other states, VDH staff indicate that while the Center has worked with residents in other states on occasion, these residents are not actively recruited. Just as a significant number of Virginia residents are successfully recruited to North Carolina and other states, an active recruiting campaign by Virginia in other states, especially neighboring states, would increase the number of providers locating in Virginia.

In sum, recruiting physicians to underserved areas is a competitive enterprise. Virginia competes with North Carolina and other states for physicians willing to locate in these areas. In light of the more aggressive approach taken by North Carolina and others, Virginia needs to adopt a more proactive approach to physician recruiting, both within and outside of the Commonwealth.

Staffing At VDH Limits The Ability Of The Center To Actively Recruit Providers

Currently, there is a total of 3.5 FTEs assigned to VDH's Center for Primary Care and Rural Health. These staff perform a number of tasks and functions within the Center including: (i) designating localities as HPSAs, MUAs, and VMUAs; (ii) coordinating rural health activities; (iii) administering the scholarship and loan repayment programs; and (iv) recruiting providers. With respect to recruitment of providers to underserved areas, VDH indicates that,

dental students who agreed to provide one year of service in a Virginia underserved dental area for each year of scholarship award. The 1999 Appropriation Act increased the amount of the scholarships to $5,000 each, but reduced the number of scholarships to five.

VDH staff indicated that prior to 1994 when a number of changes in the terms of the scholarship were instituted, most, if not all, of the scholarships were awarded each year. However, since 1994, only 1 or 2 scholarships have been awarded each year. VDH indicates that the primary reasons why the number of recipients has declined are: (i) the small amount of the scholarship amount ($2,500 prior to 1999); the "triple-payback" provision for students who do not complete the service requirement; and (iii) the contract provision which requires the recipient to treat all patients regardless of ability to pay.

While the amount of the scholarship has increased to $5,000, this amount is still less than one-half the cost of a year's in-state tuition at VCU/MCV dental school. Moreover, the number of scholarships has been reduced to only five. These amounts are quite low compared to the medical scholarship program in which 87 scholarships of $10,000 ($5,000 general fund/$5,000 Virginia medical school) each are awarded each year.

(The dental scholarship program was discussed in greater detail in the Joint Commission's staff report on improving access to dental care in Virginia pursuant to HJR 644. The HJR 644 dental report included policy options for improving the effectiveness of this program.)

Physician Loan Repayment Programs: 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 1999 is $50,000 to match $50,000 in federal funding.

  There have been only 8 loan repayment recipients since its inception in 1993. There are two program participants for FY 1999 who are nurse practitioners. Currently, there are five participants in the program who are practicing in the following counties: Dickenson (2), Grayson, Nelson, and Westmoreland. All available funds were used in FY 1999.

Federal regulations do not allow the loan repayment recipient to practice in a private for-profit entity which discourages some interested persons from applying. Conversely, the federal National Health Service Corp Loan Repayment Program (NHSCLRP) (described below) has the flexibility for allowing a physician to practice at a private for-profit entity. Another attractive aspect of the federal program is that the NHSCLRP pays the recipient an additional 39% on the loan payoff amount to offset tax liabilities on top of the loan repayment funds.

- *National Health Service Corps Loan Repayment Program:* This federal program provides loan repayment assistance in return for service in federally designated underserved areas (HPSAs). 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 service commitment. Even though medical school graduates from across the country are eligible for this program and could choose a Virginia HPSA to fulfill their service requirement, since 1993, only 9 participants in this program have selected a Virginia HPSA. Five are currently working in a HPSA. As previously reported, there are 56 primary care HPSAs in Virginia.

- *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. In FY 1999, $32,075 was used for one recipient working in Nelson County. In FY 2000, $50,000 has already been used for a recipient working in Scott County.

  As noted earlier, the Appropriation Act provides that any unused scholarship funding reverts to the Virginia Physician Loan Repayment Program. In FY 1999, $235,000 reverted to the loan repayment program. With the available funding, this program can be used as an incentive to recruit physicians to underserved areas of the state. Because of staff turnover in the Center, the process of establishing regulations is not complete. VDH indicates that regulations will be promulgated later this Fall.

The Center 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

while the Center staff members assist each other in completing various tasks, the equivalent of .5 of a P-14 position (temporary employee) is devoted to recruitment functions. This substantially limits the ability of the Center to actively and effectively recruit providers.

The Number Of Recruitment Staff And The Organizational Location Of The Recruitment Function Vary In Other States; North Carolina Assigns The Most Staff To Provider Recruitment

A survey of several other states that are recognized as having effective provider recruitment programs was conducted to gather information regarding their staffing and incentive programs. Figure 6 summarizes the survey findings regarding staffing for provider recruitment, and illustrates the organizational location of the recruitment function.

As seen in Figure 6, each of the other states devotes at least 1 FTE to provider recruitment. North Carolina clearly devotes the greatest amount of staff to provider recruitment. North Carolina officials indicated that 3 of the 5 FTEs devoted to provider recruitment are full time recruiters, who continually contact and interact with both in-state and out-of-state residents and other providers. The other 2 FTEs are support staff. North Carolina's recruitment staff of 5 FTEs is 10 times greater than Virginia's half-time position, and clearly is one reason why Virginia residents report being recruited more aggressively by North Carolina.

Based on the limited survey conducted as part of this study, North Carolina, clearly, is an outlier with respect to the number of staff devoted to provider recruitment. Unfortunately, the impact of this commitment of resources is felt more in Virginia than in more distant states. In addition to its recruiting staff, North Carolina also has 8 field staff dedicated to providing technical assistance and practice support to 78 rural health centers and 35 community/migrant health centers.

Consideration Should Be Given To Increasing The Number Of Staff At VDH For Provider Recruitment And Retention

If the provider recruitment and retention program remains within VDH, consideration should be given to increasing the number of FTEs at VDH dedicated to provider recruitment and retention efforts. As noted above, to be effective, recruitment of providers must be active and continuous. The recruitment of providers needs to be far more aggressive than currently is the case. Moreover, Virginia's recruitment efforts need to be expanded to physician

residents in other states. To accomplish this, additional staff need to be assigned to this function.

Figure 6

Provider Recruitment Staff In Selected Other States

State	Number of Recruitment Staff (FTE)	Organizational Location of Recruitment Staff
New Mexico	1.5	Private Foundation contracting with N.M. Health Dept.
New York	1.0	N.Y. Dept. of Health
North Carolina	5.0	Office of Rural Health, Dept. of HHR (Cabinet Secretary's Office)
South Dakota	1	S.D. Health Dept.
Vermont	2.5	State Hospital Assoc., Recruitment Office has independent board
Wisconsin	1.75	Office of Rural Health; Univ. of Wisconsin School of Medicine

Source: JCHC Staff Survey

While VDH Serves As The Coordinating Entity For Provider Recruitment, There Are No Provisions In The Code Of Virginia To Direct These Activities; Consideration Should Be Given To Enacting Legislation Which Would Establish Provider Recruitment And Retention As A Responsibility Of VDH

The Code of Virginia includes provisions that establish the various scholarship and loan repayment programs administered by VDH; however, there are no provisions directing VDH, or any other entity, to perform provider recruitment and retention functions. VDH assumed the provider recruitment function as a result of the RWJ Practice Sights grant that began in 1994. While

the "Practice Sights" grant ended this year, VDH has continued to conduct these activities.

It is generally believed that, within government agencies, functions mandated by law generally receive higher priority than other non-mandated functions. In addition, without enabling legislation and statutory authority, there is no clear direction as to which entity is responsible for a given program or function; nor is there any clear direction as to how a given program should be operating. With regard to provider recruitment efforts at VDH, this function is one of numerous programs that the agency has responsibility for administering. In order to raise the visibility and priority of this program, both within VDH and the Commonwealth in general, consideration should be given to enacting legislation which would: (i) identify this program as a responsibility of VDH; (ii) provide clear direction as to how the program should operate; (iii) establish program goals and objectives; and (iv) provide a level of accountability for increasing the number of providers locating in underserved areas.

Consideration Also Should Be Given To Enacting Legislation That Would Establish The Provider Recruitment And Retention Function Outside Of VDH

An alternative approach to housing the provider recruitment and retention program within the VDH would be to enact legislation establishing this function outside of VDH either as a separate entity or as part of another existing entity. A key advantage of locating this function outside of VDH is that it would be more visible and would not risk being "just one of many programs" at VDH.

Separate Entity: If established as a separate entity, a non-profit, public-private partnership could be created. Virginia Health Information (VHI), which contracts with VDH to administer the health care cost and quality data reporting activities in the Commonwealth, could serve as a model. The health care data collection and analysis function is outlined in the Code of Virginia. VHI conducts its activities through a contract with VDH. State funding for VHI activities is appropriated through VDH. VHI has an Executive Director and a small staff who conduct the day-to-day activities, and a Board of Directors composed of representatives of the various interested parties.

In this scenario, VDH would contract with an entity to perform recruitment and retention functions, and administer the various scholarship and loan repayment programs. The entity would be funded through state appropriations which pass through VDH. The legislation could require that the contracting entity have a Board of Directors composed of representatives from the appropriate entities such as VDH and/or other state agencies, the AHECs, the Virginia Primary Care Association, the academic health centers, and others.

Budget amendments would be needed to reflect the new structure of the health workforce program, and to make appropriate revisions in the various incentive programs currently administered by VDH.

Existing Entity: Rather than create a new entity, the recruitment and retention function could be located within an existing entity outside of VDH. During interviews conducted by JCHC staff, two potential sites were identified: the Virginia Primary Care Association (VPCA) and the Statewide AHEC Program. Under either scenario, responsibility for provider recruiting and retention along with the necessary funding would be transferred to the host organization. The VPCA already has experience in recruiting for the 50 Community and Migrant Health Centers (CMHCs) throughout the Commonwealth and has the type of administrative infrastructure to administer these types of programs. The VPCA has a Board of Directors, however, its purpose and structure are tied exclusively to the CMHCs. A separate Board would need to be formed with representatives of the parties identified above.

The Statewide AHEC Board has not been involved directly in recruiting providers, but the mission of the AHEC program lends itself to assuming responsibility for this type of activity. Currently, the Statewide AHEC Program does not have the kind of administrative infrastructure that exists at the VPCA. This likely would require more start-up expenses and administrative systems than would be necessary at VPCA. However, the composition of the Statewide AHEC Board is more suited to the oversight/advisory structure that would be needed as compared to VPCA's current Board. The Statewide AHEC Board includes representatives from state government, the academic health centers, the Community and Migrant Health Centers, and other health-related organizations.

In Addition To Providing Legislative Direction And Increasing The Visibility And Priority Of Virginia's Provider Recruitment And Retention Program, Consideration Should Be Given To Increasing The Amount Of Funding Appropriated For Provider Incentives, Particularly Loan Repayment

Another clear message from the residents interviewed as part of this study is that loan repayment is the single most effective incentive for a provider to locate in an underserved area. Currently, tuition at Virginia's three medical schools for four years ranges from $100,000 to $128,000 for in-state students, and from $148,000 to $184,000 for out-of-state students. National data suggest that the loan debt carried by medical students ranges from $80,000 – $100,000. Loan repayment is seen by residents as an excellent way to pay off their student loans.

Other States Rank Loan Repayment As Most Effective: A survey of all 50 states conducted by the National Council of State Legislatures (NCSL) in 1998

found that state/federal loan repayment is considered the most effective provider incentive.

Loan Repayment Appears To Result In Longer Provider Retention: Unfortunately, there is very little evaluation data available on the long-term impact of the various provider incentive programs. However, a study that has not yet been published evaluated the retention rate associated with various incentive programs and found that loan repayment had the highest rate. (Pathman, 1999.)

While loan repayment is considered to be the most effective provider incentive, currently, Virginia directly appropriates only $100,000 each year for this purpose. This equates to a year's medical school tuition for 4-5 students. Appropriation Act language directs unspent scholarship monies into loan repayment which increases the available amount for loan repayment. (In FY 1999, $230,000 reverted to loan repayment.) Given the consistently low number of persons accepting medical scholarships over the past several years, consideration should be given to reducing the amount designated for scholarships, perhaps by $230,000, and appropriating this amount directly for loan repayment. This would make the funding available throughout the entire year instead of having to wait until the next fiscal year to use it for loan repayment. In addition, consideration should be given to increasing the amount of funding for loan repayment beyond the amount that may be re-directed from the medical scholarship program.

Consideration Should Be Given To Authorizing Additional Types Of Provider Incentives And To Consolidating The Various Financial Incentives Into One Appropriation To Provide Greater Flexibility In Meeting The Individual Needs Of Each Provider

While loan repayment is considered to be the most effective provider incentive, not all medical students carry student loan debts. For students with minimal or no loan debts, loan repayment obviously presents little or no incentive to locate in an underserved area. Additionally, even for some students with student loan debts, loan repayment may not always be the most meaningful incentive. North Carolina and some other states also offer additional financial incentives such as "signing bonuses," and "salary supplements." A signing bonus provides a one-time monetary "bonus" for agreeing to practice in an underserved area. A "salary supplement" provides a pre-determined amount of additional payment over a period of time to enhance the physician's salary. North Carolina and some other states also will pay travel expenses for a resident or other provider (and their spouse) to visit an underserved area as part of the recruitment process.

Authorizing additional financial incentives would increase the number of "tools" available to the Commonwealth in recruiting providers to underserved areas. Even if no additional funds are appropriated for new incentives such as bonuses, salary supplements, or travel expenses, consideration should be given to authorizing the use of these incentives as a means of increasing the likelihood that providers being recruited will find at least one type of incentive that is attractive enough to them that they would practice in an underserved area.

One way to broaden the types of incentives and enhance the flexibility of what can be offered to a provider would be to consolidate the separate appropriations for the medical scholarships and loan repayment into one appropriation. Language could be included in the Appropriation Act stipulating which types of incentives can be offered (e.g., scholarship, loan repayment, bonuses, salary supplement, travel expenses, etc.). This would enable the entity managing the program to offer whatever incentive works best for each individual provider rather than being restricted to pre-determined amounts for each type of incentive that may or may not be meaningful to a given provider. With such flexibility, the entity managing the program would need to provide clear evidence that its use of the funds was effective in increasing the number of providers in underserved areas.

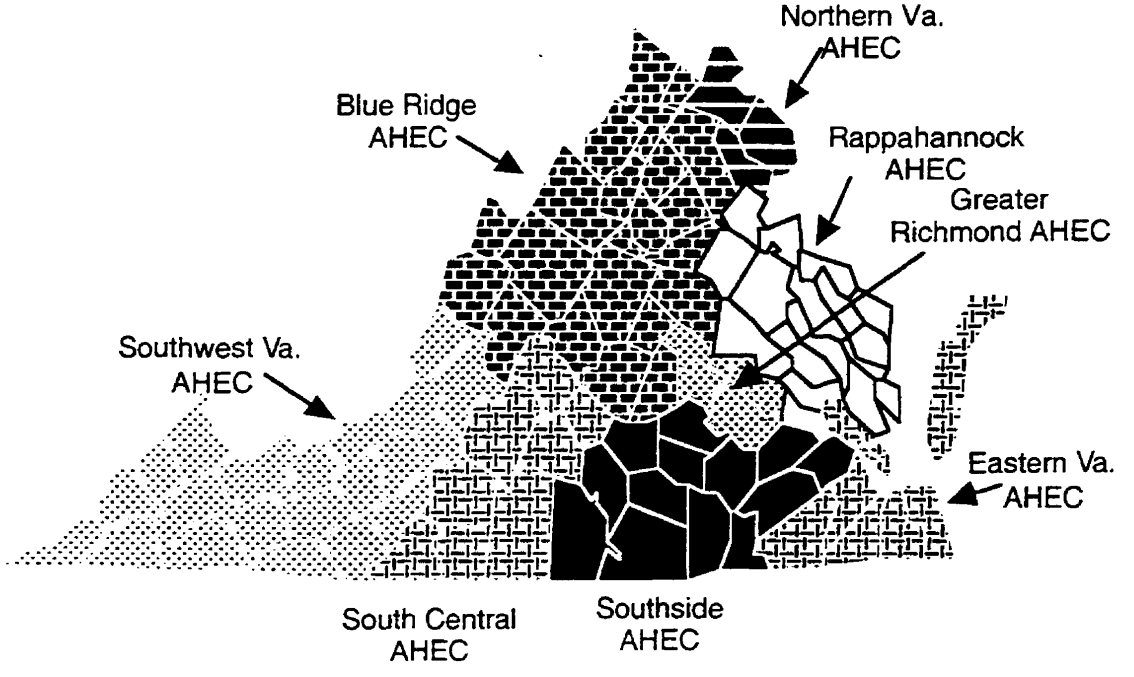
V.
Developing A Funding Strategy For Virginia's AHEC Program

As noted in Section III of this report, 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. Section 32.1-122.7 of the Code of Virginia identifies the mission of the AHEC program as promoting health careers and access to primary care for medically underserved populations through community-academic partnerships.

The Statewide AHEC program is administered through a statewide office and eight community AHECs located throughout the Commonwealth. Figure 7 illustrates the location and service areas of the eight local AHECs.

Figure 7

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



Source: Statewide AHEC Office

The Mission of the AHEC Program Is Accomplished Through Four Major Areas Of Program Activity

Each community AHEC has a governing or advisory board which works with the AHEC Executive Director to develop and implement programs that respond to local and regional needs. The services provided by the community AHECs can be categorized into four types of activities. These categories of program activities are included in §32.1-122.7 of the Code of Virginia. Figure 8 provides a general description of the four categories of AHEC programs and activities.

Figure 8

Description Of AHEC Program Activities

AHEC Program Category	Description
Health Careers	Activities targeted toward elementary through high school age students, particularly minority and disadvantaged youth, designed to increase interest in and/or ability to perform in a health care career
Rotations	Support of community-based student rotations; may include increasing the practice site's ability to accept students, curriculum development and/or coordination, or student stipends; includes various types of students, including medical, nursing, allied health, pharmacy, dental and certified nursing assistants
Retention	Programs and activities to support primary health care providers and encourage them to remain in practice in underserved areas; primarily continuing education programs and direct support for practice sites
Health Promotion	Programs and activities designed to promote health and wellness activities in the community

Source: Statewide AHEC Office

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. (Local/university match amounts include cash, faculty and administrators at affiliate health science centers, volunteer board and advisory members, in-kind contributions, grants, etc.) AHECs are eligible for up to six years of "core" federal funding, with year four being the peak year of funding. Virginia's community AHECs received an average of approximately $235,000 per year in federal funds during their program implementation years. The "core" federal funding required a 25% cash and/or in-kind match, which Virginia routinely exceeded.

In recent years, the federal funding has been phasing out as AHECs completed their six year "core" funding cycles. This has required the AHECs to rely increasingly on additional state funding and/or local/university match amounts to maintain the same level of activity.

Federal "Model" AHEC Funds Are Now Available: Effective October, 1999, all community AHECs will begin to receive federal "model" funding. These funds are available to AHEC programs and centers that have completed their "core" funding cycle. There are three major differences between "core" and "model" funding: (i) "model" funding is significantly lower than "core" funding, although recent legislation passed by Congress mandates an increasing percentage of all federal funding be directed into the "model" category; (ii) "model" funding can be obtained in perpetuity, although funds can only be requested in three-year increments; and (iii) "model" funds require a "dollar-for-dollar" cash match instead of the 25% cash and/or in-kind match required of "core" funding. Most of Virginia's AHECs will receive $25,000 in "model" federal funds in FY 2000. The amount per AHEC is projected to increase to approximately $50,000 per AHEC in the next two fiscal years.

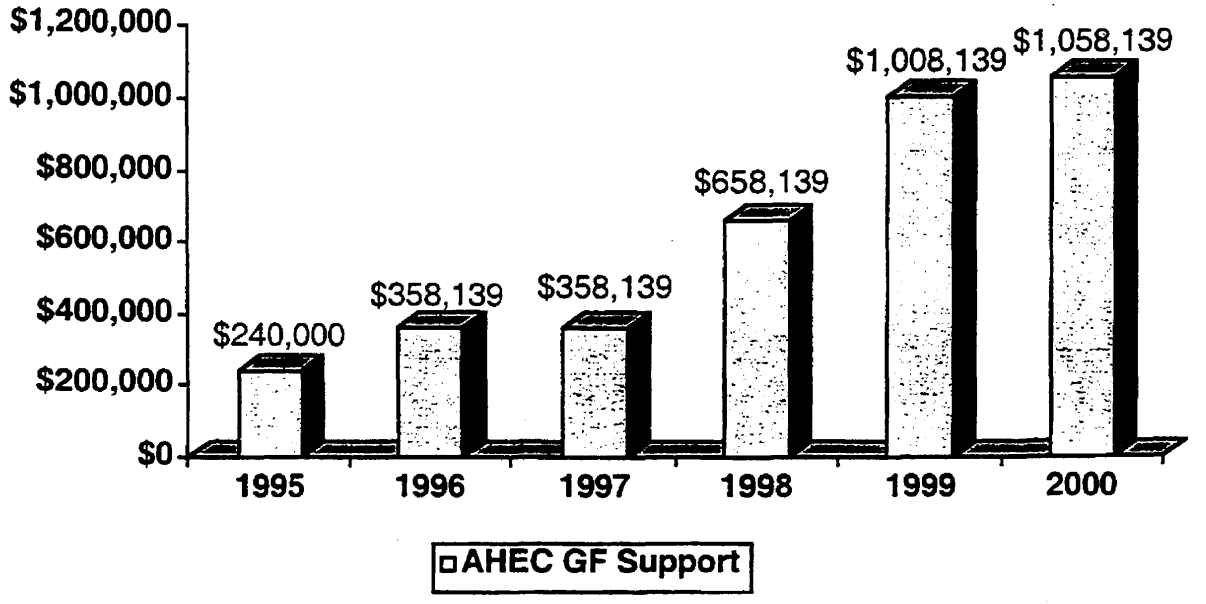
State General Fund (GF) Support For AHECs Has Increased Substantially From $150,000 In FY 1991 To $1,058,139 In FY 2000

State funding for AHEC began in July, 1991 with a total of $150,000 appropriated through the Virginia Department of Health (VDH). State GF support for AHEC has increased to $1,058,139 in FY 2000. (Of the $1,058,139 appropriated for AHEC in FY 2000, $158,139 was appropriated to the Statewide AHEC to support the Generalist Physician Initiative at the medical schools.) The entire increase in state GF support for AHEC has come from legislative budget amendments and most of the increase has been provided to the individual

AHECs as they complete their federal "core" funding cycle. Figure 9 illustrates state GF support for the AHEC program during the past several fiscal years.

Figure 9

State GF Support For AHEC: FY 1995-2000



Source: JCHC Staff Analysis of 1995-1999 Appropriation Acts

State GF Support Varies By Individual AHEC

As previously noted , GF support for the AHEC program has increased as individual AHECs completed their federal "core" funding and requested state dollars as a means of replacing decreasing federal funds. The GF support provided to each community AHEC varies. The variation in individual AHEC funding seems to be related, at least in part, to the chronological order in which each AHEC completed its federal "core" funding cycle.

As seen in Figure 10, the Eastern Virginia AHEC, which was the first AHEC to complete its federal "core" funding, receives $200,000 in state GF in FY 1999 and FY 2000. (Eastern Virginia AHEC has received this amount for several years.) Blue Ridge and Southside AHEC, which were the next AHECs to complete their federal "core" funding cycle, receive $150,000 each in FY 2000. Southwest, Greater Richmond, South Central, and Rappahannock, which were the most recent AHECs to complete their "core"

funding, receive $100,000. Northern Virginia does not currently receive state GF because it has not yet completed its federal "core" funding. In addition to the amounts appropriated for each AHEC, the 1999 Appropriation Act includes language directing the AHECs to develop a plan to increase funding from non-state sources and present the plan to the Governor and the Chairmen of the Senate Finance and House Appropriations Committees by October 1,1999.

Figure 10

State GF Support For Individual Community AHECs: FY 1999-2000

Community AHEC	FY 1999 GF Support	FY 2000 GF Support
Eastern Virginia	$200,000	$200,000
Blue Ridge	$150,000	$150,000
Southside	$150,000	$150,000
Southwest Virginia	$175,000	$100,000
Greater Richmond	$175,000	$100,000
South Central	$0	$100,000
Rappahannock	$0	$100,000
Northern Virginia	$0	$0
TOTAL	**$850,000**	**$900,000**

Note: Amounts shown do not include amount appropriated for support of Generalist Physician Initiative

Source: JCHC Staff Analysis of 1999 Appropriation Act

The Appropriation Act Provides Only General Guidance On The Expenditure of General Funds Supporting AHEC

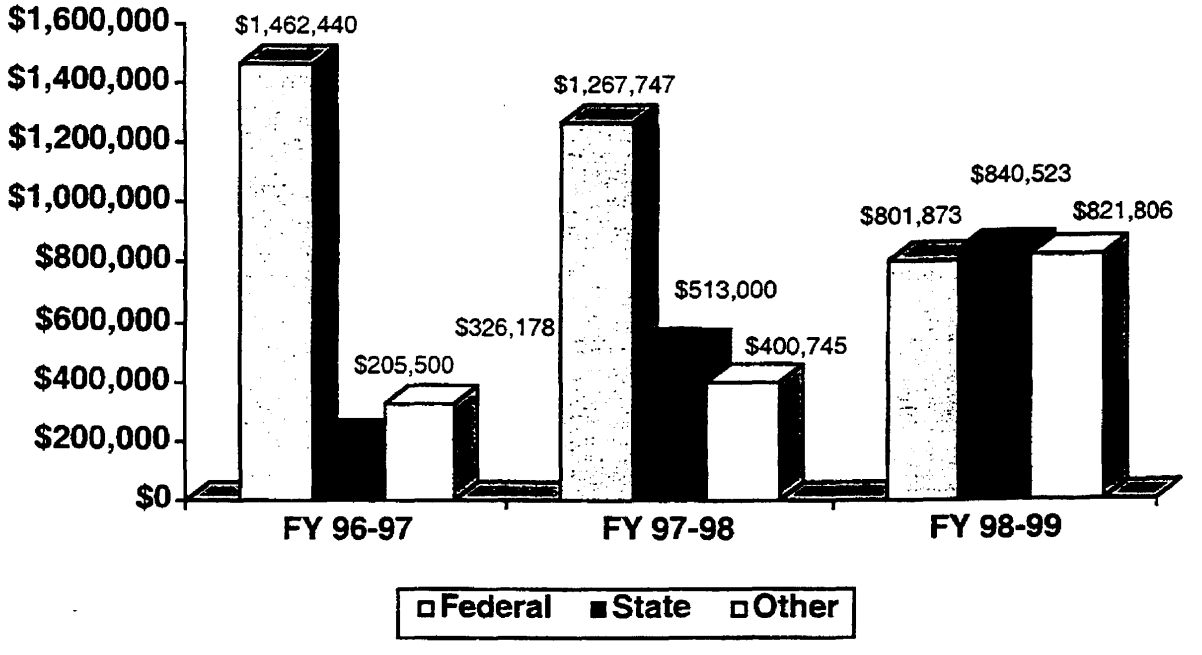
Language in the Appropriation Act provides only general guidance on the expenditure of state dollars supporting AHEC. The Appropriation Act states that the funding is to support the four areas of AHEC activities (i.e., health careers promotion, clinical training for health professions students, continuing

education and practice support for practitioners, and community health initiatives). The Appropriation Act also specifies that $158,139 is to be spent each year on the Virginia Generalist Physician Initiative.

Section 32.1-122.7 of the Code of Virginia requires the Statewide AHEC Board of Directors to annually report to the Secretary of Health and Human Resources, the State Board of Health, the Governor and the General Assembly on the status and progress of the implementation of the program's goals and objectives. However, there is no requirement in the Code of Virginia or the Appropriation Act for the AHEC program to report on the expenditure of state funds used to support AHEC activities.

Figure 11

AHEC Program Expenditures By Revenue Source: Fiscal Years 1996-97, 1997-98, 1998-99



Note: Amounts shown do not include amount appropriated for support of Generalist Physician Initiative

Source: Statewide AHEC Program

AHEC Program Expenditures Reflect Changing Revenue Streams

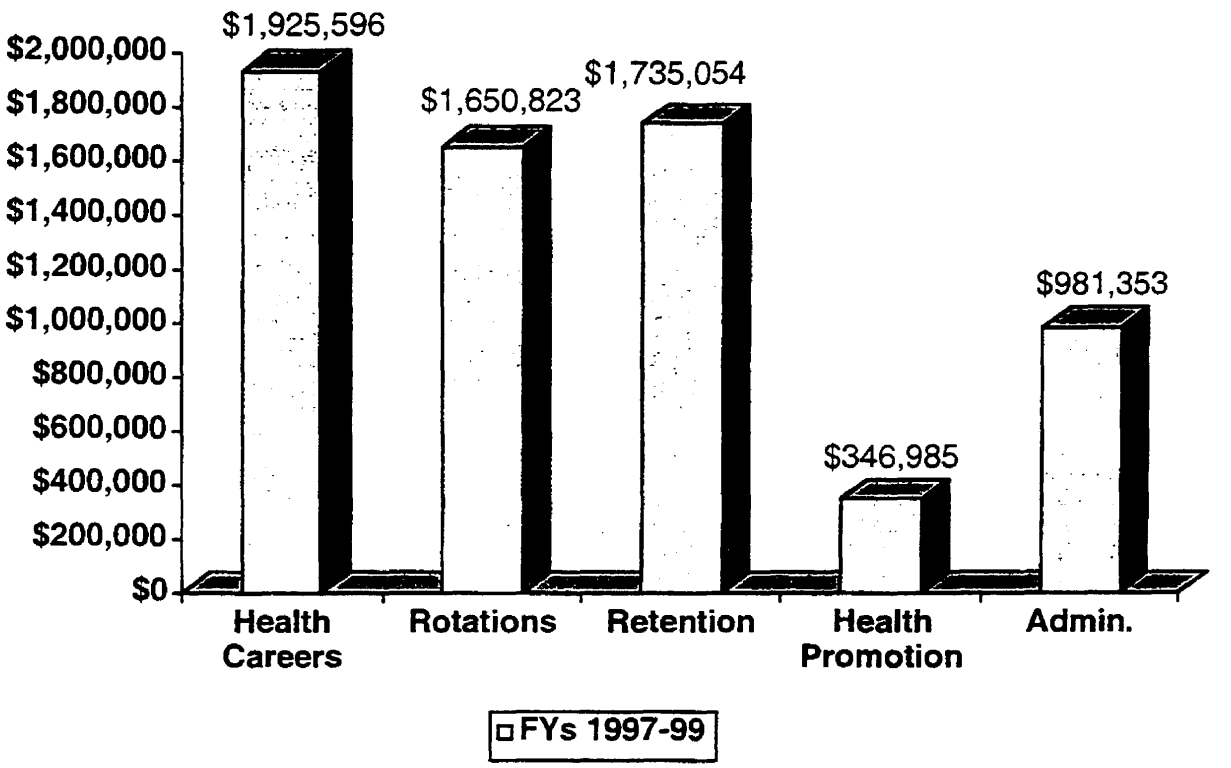
As part of the analysis conducted for this study, JCHC staff requested the AHEC Program to provide information on AHEC expenditures during the past several years. AHEC data was available for FYs 1996-97, 1997-98, and 1998-99.

(The amounts reported in the proceeding narrative and graphics depict AHEC expenditures, and do not include the amounts appropriated to AHEC in support of the Generalist Physician Initiative.)

Figure 11 illustrates the AHEC expenditures for FY 1997, 1998, 1999 by revenue source. As seen in Figure 11, expenditure of federal dollars has decreased due to AHECs completing their "core" funding, while expenditures of state GF and other sources of revenue have increased.

Figure 12

Total AHEC Program Expenditures By Category Of Activity: Totals For Fiscal Years 1997-1999



Note: Amounts shown do not include amount appropriated for support of Generalist Physician Initiative

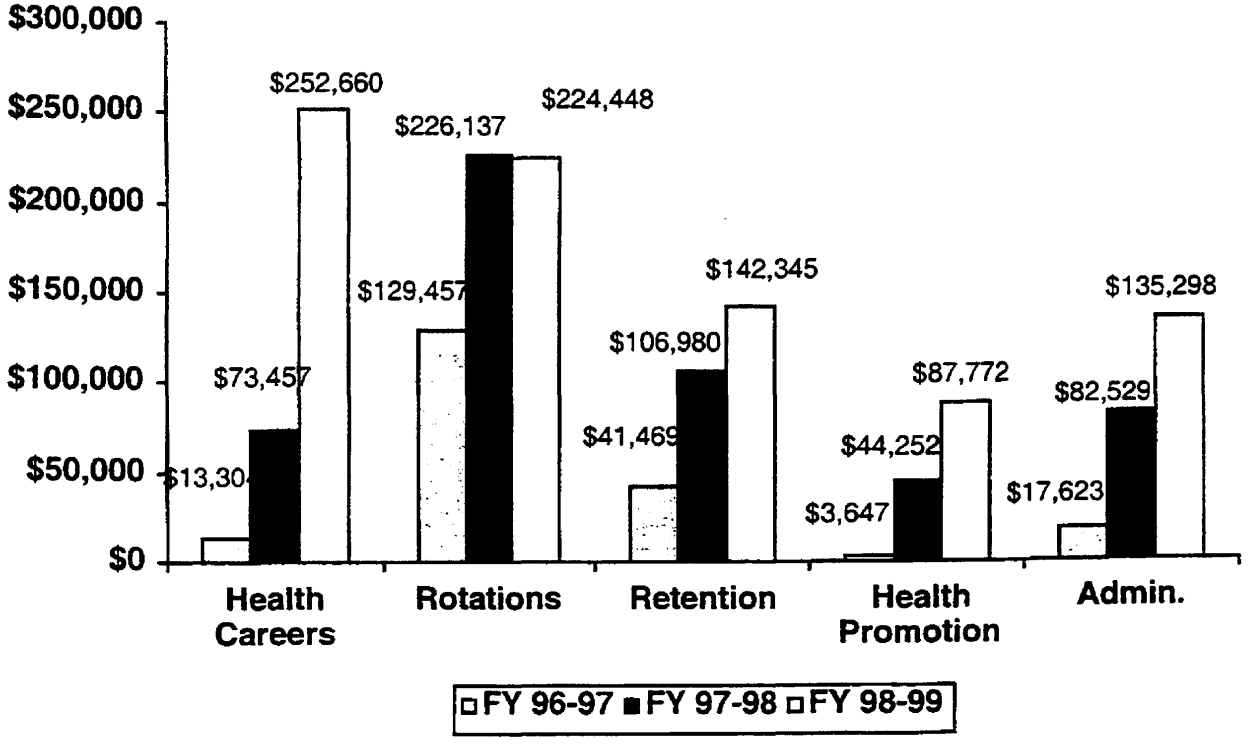
Source: Statewide AHEC Program

During Fiscal Years 1997–1999, The Single-Greatest Area Of AHEC Expenditures Has Been On "Health Careers"

AHEC expenditures are categorized by the four major areas of activity (health careers, rotations, retention, health promotion) and administrative expenses. As indicated in Figure 12, during fiscal years 1997 through 1999, the category of AHEC activity with the greatest level of expenditures was "health careers" ($1.9 million). The next highest category of AHEC expenditures was in the area of "retention" ($1.7 million), followed by "rotations" ($1.6 million), administrative costs ($.9 million), and "health promotions" ($347,000).

Figure 13

AHEC Program Expenditure Of State GF Dollars: Fiscal Years 1997-1999



Note: Amounts shown do not include amount appropriated for support of Generalist Physician Initiative

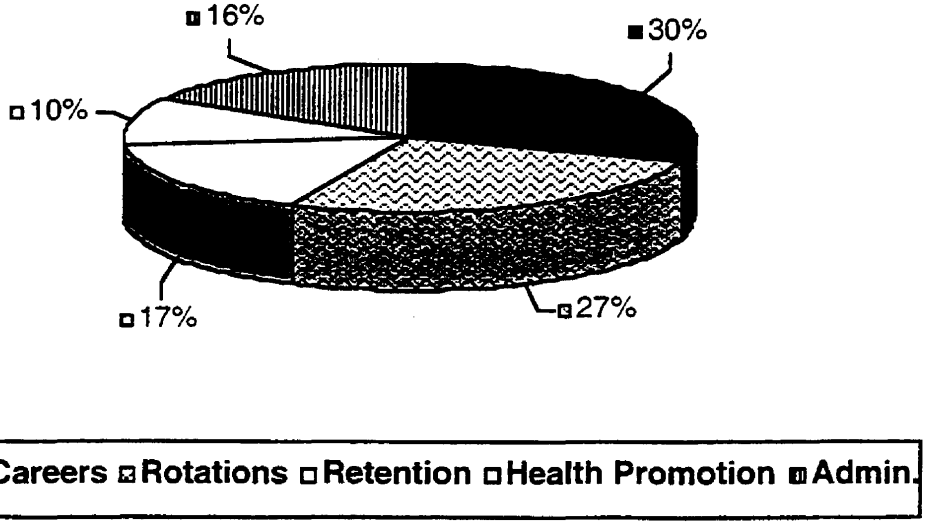
Source: Statewide AHEC Program

In Fiscal Year 1998-99, The Category Of AHEC Activity With The Highest Level Of State GF Expenditures Was "Health Careers"

Over the past three fiscal years, the amount of state GF dollars spent on "health careers" activities has increased from $13,304 in FY 1996-97 to $252,660 in FY 1998-99. As illustrated in Figure 13, the amount of GF dollars spent in each category of AHEC activity has increased substantially during the three-year period. In previous fiscal years (FY 1996-97 and FY 1997-98) the category with the greatest amount of state GF expenditures was "rotations," followed by "retention" and then "health careers." However, in FY 1998-99, the category with the greatest amount of state GF expenditures was "health careers," followed by "rotations," "retention," and then "health promotion."

Figure 14

FY 1998-99 AHEC Program Expenditure Of State GF Dollars: By Category



Note: Amounts shown do not include amount appropriated for support of Generalist Physician Initiative

Source: Statewide AHEC Program

Figure 14 illustrates the percentage that each category of expense comprised of the total state GF support for AHEC in FY 1998-99. As seen in Figure 14, "health careers" accounted for approximately 30% of total state GF

support of AHEC, followed by "rotations" (27%), "retention" (17%), administration (16%), and "health promotion" (10%).

While "health careers" is the largest single area of state GF expenditures, "rotations" and "retention" are both related to providing support to health care providers in the AHEC areas. When taken together, these areas represent 44% of the state GF dollars spent by the AHEC program in FY 1998-99.

Developing A Funding Strategy For The AHEC Program Is A Key Policy Issue For The Commonwealth

The key health workforce policy issue regarding the AHEC program is developing a funding strategy for the future of the program. In recent years, as the AHECs have completed their federal "core" funding and have looked to the Commonwealth for increasing support, similar GF amounts have been requested for each community AHEC to provide essentially equivalent funding for each program, and to fund the full range of AHEC programs.

As previously noted, all of the GF increases for AHEC have resulted from legislative budget amendments. However, as the amount of federal funding has decreased and the AHEC's GF requests have increased, questions have been raised regarding what specific, measurable results are being achieved by the AHECs. In response to these questions, the AHEC program has presented various data, including information on: (i) the number of students that have completed health careers training; (ii) the number of health professions students and residents participating in AHEC-supported training programs; and (iii) the number of health provider practice support services provided by AHEC.

The AHECs also have presented various information regarding different programs they have sponsored, including the following:

- *Southside AHEC's* community needs assessment programs which work with various community agencies in assessing needed health programs and services;

- *Blue Ridge AHEC's* lay health promoter program designed to increase access to care for a sizable Hispanic population;

- *Greater Richmond AHEC's* "exploring medical illustration" course that combines anatomy and art; the course reinforces several Standards of Learning (SOL) and includes field visits;

- *Rappahannock AHEC's* "Telehealth EduCare Connection" program that expands existing Internet/intranet for rural primary care providers, adds medical expert software, and enhances teleconferencing and telemedicine capabilities in the area;

- *Eastern Virginia AHEC's* development of the Portsmouth Health Center to provide primary care services for the medically underserved in Portsmouth;

- *Southwest Virginia AHEC's* involvement in the development of the Southwest Virginia Graduate Medical Education Consortium which is creating a network of high quality training sites for elective and required rotations by medical residents from Virginia and surrounding states;

- *Northern Virginia AHEC's* Cross Cultural Health Program which offers education in cross-cultural health issues/practices, and interpretation, translation, and consultation services to assist many foreign-born residents access health care services; and

- *South Central AHEC's* "Healthy Lifestyles" program which promotes good health at an early age; a pilot program was conducted for 6th graders focusing on heart disease.

AHEC data clearly show that many students and professionals are participating in AHEC-sponsored programs. Also, the AHEC programs described above indicate a wide range of health-related activities geared toward community needs. However, much of the data is "process-oriented" rather than "outcome-oriented." It is difficult to gauge what tangible results are being achieved with state GF dollars and what further results will be gained if additional dollars are appropriated to the program.

The Broad Spectrum Of AHEC Activities And The Limited Ability To Measure Specific Outcomes Makes It Difficult To Assess The Benefits Of Investing Additional GF Dollars In The Program; Consideration Should Be Given To Focusing State AHEC Funding On Recruitment And Retention Of Health Care Providers For Underserved Areas And Populations

One of the difficulties in determining the appropriate amount of state GF support for the AHEC program is the broad spectrum of activities which tend to diffuse what is being "purchased" with state dollars. All of the AHEC activities have value; however, a key question is whether the Commonwealth wants to

place the same value on all of the activities, or concentrate its resources in one or two specific areas which represent higher priorities.

The primary purpose of Virginia's health workforce programs is to increase the number of primary care providers for underserved areas and populations. AHEC activities in the areas of "rotation" and "retention" relate to this objective. While AHEC programs in the areas of "health careers" and "health promotion" provide useful services to those who are served by these activities, it is far more difficult to measure any direct effect that these programs would have on increasing the number of providers for underserved areas and populations.

Appropriating state GF dollars to support only those AHEC activities geared toward recruiting and retaining providers for underserved areas and populations would provide a more clearly defined scope of activities being funded by the Commonwealth. Such an approach also would enable state policymakers to develop more meaningful measures of program effectiveness by tracking the number of providers who are recruited to render services for these areas and populations and the retention rate of the providers. Under this approach, local AHECs could still develop programs specific to their respective needs; however, those supported with state dollars would need to be focused on recruiting and retaining primary care providers. AHECs could continue to use their other sources of revenue to fund health careers or health promotion programs.

Based on AHEC program expenditure of GF dollars in FY 1998-99, if state funds spent on health careers ($252,660) and health promotion ($87,772) were combined with the amounts spent on rotations ($224,448) and retention ($142,345), a total of $707,225 GF would be spent on recruiting and retaining providers. This would represent an increase of approximately 93% in expenditures for these programs. Combining these local AHEC resources with an enhanced statewide effort at VDH or other coordinating entity should result in substantial improvements in the area of recruiting and retaining primary care providers for underserved areas and populations.

Determining The Appropriate Amount Of State GF Support For The AHEC Program Requires Further Analysis And Policy Decisions Regarding Use Of State Dollars

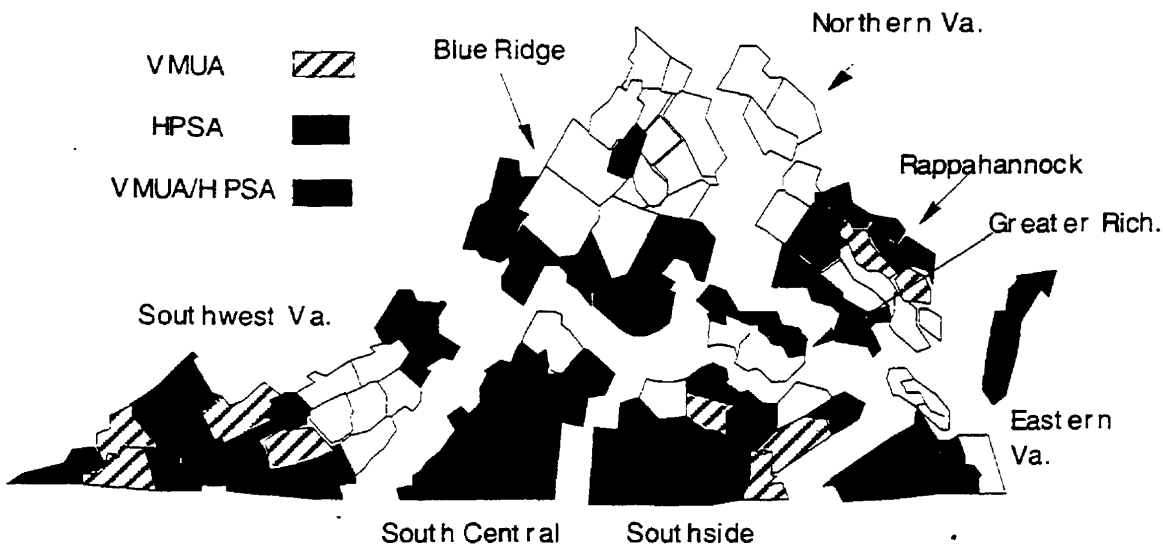
A reasonable estimate of the appropriate amount of state support for the AHEC program requires additional analysis and a policy decision as to what AHEC activities should be paid for with state GF dollars. If it is decided to continue funding all of the various types of AHEC activities as in the past, this

would, in effect, place the same level of priority on all four areas of AHEC programs. Because each AHEC would be able to identify enough community needs among the four types of program activities, providing an equal amount of funding for each AHEC may be the most appropriate course of action. However, developing a reasonable methodology for estimating what that amount is requires further analysis.

If it is decided to direct funding only to those activities aimed at recruiting and retaining providers for underserved areas and populations, it may be more appropriate to base the funding for each AHEC on the specific provider needs in each area. Figure 15 illustrates the number of health professional shortage areas (HPSAs), and Virginia medically underserved areas (VMUAs) by AHEC area. While this map illustrates some AHEC areas have a greater number of underserved areas than others, it does not take into account underserved *populations*, which are more difficult to define and measure. Moreover, additional factors would need to be taken into account beyond simply the number of HPSAs and/or VMUAs that exist in a given AHEC area. Developing an AHEC funding methodology based on the need to recruit and retain providers for underserved populations also would require more detailed analysis.

Figure 15

HPSAs And VMUAs By AHEC Area



Source: JCHC Staff Analysis

The Statewide AHEC Program Indicates That $200,000 Is Needed For Each Community AHEC To Reasonably Accomplish Its Mission

In interviews with JCHC staff, the Executive Director of the Statewide AHEC Program indicated that the question of what constitutes an appropriate amount of state funding for community AHECs depends on the degree to which the Commonwealth wants to address the community needs served by AHEC. A desire to meet a substantial amount of the needs served by AHEC would require significantly more funding than if the desire is to only meet minimal needs. (This issue applies whether state funding is appropriated for all AHEC types of activities or is targeted to provider recruitment and retention for underserved areas and populations.) Nonetheless, $200,000 was identified by the Statewide AHEC Executive Director as the amount of funds (in addition to "other" sources of revenue) that each community AHEC needs to have a sufficient financial base to reasonably accomplish its mission.

As previously noted, each AHEC is expected to receive approximately $50,000 in federal "model" AHEC funding in FY 2001. Factoring in $50,000 of federal money into the $200,000 amount recommended by the Statewide AHEC Program results in a net of $150,000 in GF dollars per AHEC. As seen in Figure 16, this would require appropriating an additional $350,000 in (GF) in FY 2001 and FY 2002.

Consideration Should Be Given To Requiring AHECs to Provide A Certain Level Of Locally Matched Dollars To Receive State Funding

Regardless of the amount of state funding that is approved for the AHEC program, consideration should be given to requiring the AHECs to provide a certain level of matching funds to receive state support. This would ensure that the AHECs are maximizing local support for their activities and would help to limit their reliance on state support. Based on FY 1998-99 data, the AHECs spent almost the same amount in "other" sources of revenue ($821,806) as state GF dollars ($840,523). Accordingly, while this requirement would not appear to be too burdensome on the AHECs, it would help ensure the same commitment of "other" dollars in future years.

An Alternative Approach To Funding The AHEC Program Would Be To Appropriate A Single Amount To The Statewide AHEC Board To Allocate Among The Local AHECs

An alternative approach to appropriating a separate amount for each AHEC would be to make a single appropriation to the Statewide AHEC Board and direct it to allocate the funds among the eight AHECs. The appropriation

could include language specifying whether the Commonwealth wants the funding to be spent on all AHEC programs, only those related to provider recruitment and retention for underserved areas and populations, or in some other manner. The language also could specify whether the funds should be allocated among the AHECs based on a methodology that measures the relative needs in each AHEC area.

Figure 16

Additional Appropriations Needed To Provide $150,000 GF To Each AHEC

Community AHEC	FY 2000 GF Support	Additional GF Needed To Reach $150,000 in FY 2001	Total GF Support In FY 2001 & 2002
Eastern Virginia	$200,000	$0	$ 200,000
Blue Ridge	$150,000	$0	$ 150,000
Southside	$150,000	$0	$ 150,000
Southwest Virginia	$100,000	$ 50,000	$ 150,000
Greater Richmond	$100,000	$ 50,000	$ 150,000
South Central	$100,000	$ 50,000	$ 150,000
Rappahannock	$100,000	$ 50,000	$ 150,000
Northern Virginia	$0	$150,000	$ 150,000
TOTAL	**$900,000**	**$350,000**	**$1,250,000***

Note: Amounts shown do not include amount appropriated for support of Generalist Physician Initiative

* Reflects total for AHEC program activities; the total amount including the Generalist Physician Initiative would be $1,408,139

Source: Statewide AHEC Program, JCHC Staff Analysis

Section 32.1-122.7 of the Code of Virginia provides that the Statewide AHEC Program is conducted under the auspices of the Statewide Board of Directors. Consistent with this statutory provision, such an alternative funding approach would give the Statewide AHEC Board the ability and responsibility

for developing and funding AHEC activities that respond to the priorities as established by the Commonwealth.

VI.
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.

Option I **Take no action**

Option II **Introduce Legislation Providing The Virginia Department Of Health With Responsibility For Designating Virginia Communities As Primary Care, Dental, And Mental Health Professional Shortage Areas, And For Maintaining These Designations.**

Option III **Introduce A Budget Amendment (Language Only) Directing The Virginia Department Of Health To: (I) Review The Efficacy Of The Provider Database Developed With "Practice Sights" Grant Funds; (II) Report On Whether The System Should Be Utilized, And, (III) Identify Any Resources That May Be Needed To Improve The System And Make It Functional.**

Option IV **Introduce Legislation Directing The Virginia Department Of Health To Coordinate The Commonwealth's Efforts In Recruiting And Retaining Providers For Underserved Areas And Populations; Legislation Would Identify Specific Functions And Activities To Be Conducted As Part Of This Responsibility.**

An accompanying budget amendment would be introduced to provide the necessary funding and positions (perhaps 3 FTEs). (Amount of budget amendment will be determined later.)

Option V **Introduce Legislation Directing The Virginia Department Of Health To Form A Public-Private Partnership By Contracting With A Private, Non-Profit Organization To Administer The Medical Scholarship And Loan Repayment Programs And Coordinate The Recruitment And Retention Of Providers For**

Underserved Areas And Populations. Legislation Would Require The Non-Profit Entity To Have A Board Of Directors Composed Of Representatives Of The Various Health Workforce-Related Entities, Including The Statewide AHEC Program, The Academic Health Centers, The Virginia Primary Care Association, The Commonwealth, And Other Appropriate Organizations.

Accompanying budget amendments would need to be introduced to reflect the new structure of the health workforce programs.

Option VI **Introduce Legislation Reassigning The Responsibility For Administering The Medical Scholarship And Loan Repayment Programs And For Coordinating The Recruitment And Retention Of Providers For Underserved Areas And Populations From The Virginia Department Of Health To The Statewide AHEC Board.**

Accompanying budget amendments would need to be introduced to reflect the new structure of the health workforce programs, including additional staff allocated to the Statewide AHEC Board.

Option VII **Introduce Legislation Directing The Virginia Department Of Health To Contract With The Virginia Primary Care Association (VPCA) To Administer The Medical Scholarship And Loan Repayment Programs And Coordinate The Recruitment And Retention Of Providers For Underserved Areas And Populations. Legislation Would Require The VPCA To Establish A Board Of Directors For This Purpose Which Would Be Composed Of Representatives Of The Various Health Workforce-Related Entities, Including The Statewide AHEC Program, The Academic Health Centers, the Commonwealth, and other appropriate organizations.**

Accompanying budget amendments would need to be introduced to reflect the new structure of the health workforce programs.

Option VIII **Introduce A Joint Resolution Or Budget Amendment (Language Only) Directing The Joint Commission On Health Care To Form A Subcommittee To Study And Recommend The**

Most Appropriate Organizational Structure For Coordinating The Commonwealth's Programs For Recruiting And Retaining Providers For Underserved Areas And Populations.

Option IX — Introduce Legislation Amending §§ 32.1-122.5:1, 32.1-122.6, 32.1-122.6:02, 32.1-122.6:03, 32.1-122.6:1, 32.1-122.9, And 32.1-122.10 Of The *Code Of Virginia* To Include Health Professional Shortage Areas (HPSAs) Among Those Underserved Areas In Which Scholarship And Loan Repayment Recipients Can Complete Their Service Requirement.

Option X — Introduce A Budget Amendment To Increase The Amount Of Funding Designated For The Virginia Physician Loan Repayment Program (Amount To Be Determined Later).

Option XI — Introduce A Budget Amendment Reducing The Amount Of Funds Appropriated For Medical Scholarships To $235,000, And Re-Allocating The Remaining $230,000 To The Virginia Physician Loan Repayment Program For Use Throughout The Commonwealth

Option XII — Introduce A Budget Amendment Consolidating All Appropriations For Provider Financial Incentives (Scholarships And Loan Repayment) Into A Single Appropriation Which Could Be Used For Scholarships, Loan Repayment, Signing Bonuses, Salary Supplements, And Other Appropriate Incentives. Language Would Be Included In The Amendment Requiring The Responsible Entity To Submit Annual Reports On How The Funds Were Used And The Number Of Providers Recruited To Underserved Areas And Populations.

Option XIII — Introduce Legislation Amending §32.1-122.7 Of The *Code Of Virginia* Requiring The Statewide AHEC Board To Include In Its Annual Reports To The Secretary Of Health And Human Resources, The Board Of Health, The Governor And General Assembly Information On How State GF Dollars Are Spent In Support Of The AHEC Program.

Option XIV — Introduce A Budget Amendment (Language Only) Requiring Local AHECs To Use State GF Dollars To Support Only Those Programs Designed To Recruit And Retain Providers For Underserved Areas And Populations.

Option XV Introduce A Budget Amendment For $350,000 (GF) In FY 2001 And FY 2002 To Provide $150,000 (GF) For Each AHEC.

Option XVI Introduce A Budget Amendment (Language Only) Requiring The Community AHECs To Provide A Certain Percentage Of Local Matching Dollars In Order To Receive State GF Support.

Option XVII Introduce A Budget Amendment (Language Only) Consolidating Individual AHEC Appropriations Into A Single Appropriation To The Statewide AHEC Board For Distribution Among The Individual AHECs. Language Could Be Included Requiring The Statewide AHEC Board To Develop And Implement A Funding Methodology For Allocating State GF Dollars Among Individual AHECs Based On Needs Established In Each AHEC Area.

Option XVIII Introduce A Budget Amendment (Language Only) Directing The Joint Commission On Health Care To Continue Its Review Of The Commonwealth's Health Workforce Programs.

APPENDIX A

Appropriation Act

As part of its ongoing responsibilities for making recommendations to the General Assembly regarding health care policy in the Commonwealth, the Joint Commission on Health Care shall review the efficiency, effectiveness, and outcomes of the Commonwealth's health workforce initiatives related to improving access to care in underserved areas. The Joint Commission's ongoing review shall include the Area Health Education Center program; the various recruitment, scholarship and loan repayment programs; the activities of the Generalist Physician Initiative which relate to improving access to care in underserved areas; and, the activities of other related private, nonprofit community-based organizations. The Joint Commission on Health Care's review of health workforce activities and initiatives shall include, but need not be limited to, (i) monitoring and analyzing the efficiency, effectiveness and outcomes of existing programs designed to recruit and retain primary care providers in underserved areas; (ii) identifying new, innovative programs that can increase the number of primary care providers locating in underserved areas; (iii) identifying effective workforce programs in other states that could be implemented in Virginia; (iv) recommending appropriate modifications to Virginia's overall health workforce efforts; and (v) recommending appropriate funding strategies. The Joint Commission shall conduct its review and analysis in cooperation with the House Appropriations Committee and the Senate Finance Committee. The Joint Commission also shall consult with and involve the Department of Health and the affected workforce programs and initiatives in its review activities. The Joint Commission shall complete its initial review by November 1, 1999, and shall report its findings and recommendations to the Governor and the 2000 Session of the General Assembly.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: HEALTH WORKFORCE STUDY (ITEM 12B, APPROPRIATION ACT)

Individuals/Organizations Submitting Comments

A total of 14 individuals and organizations submitted comments in response to the health workforce report.

- Blue Ridge Area Health Education Center
- Claudette Dalton, M.D.
- Roger A. Hofford, M.D.
- James Madison University – David E. Cockley, DrPH
- James Madison University – Vida S. Huber, EdD
- Southside Virginia Area Health Education Center
- Virginia Department of Health
- Virginia Health Workforce Committee
- Virginia Hospital and Healthcare Association
- Virginia Pharmacists Association
- Virginia Primary Care Association, Inc.
- Virginia Statewide Area Health Education Centers Program
- Hermes Kontos, MD, Ph.D., Vice President for Health Sciences, VCU
- Dr. Ronald Hunt, Dean, School of Dentistry, MCV

Policy Options Included in the Health Workforce Issue Brief

Option I **Take no action.**

Option II **Introduce Legislation Providing The Virginia Department Of Health With Responsibility For Designating Virginia Communities As Primary Care,**

Dental, And Mental Health Professional Shortage Areas, And For Maintaining These Designations.

Option III **Introduce A Budget Amendment (Language Only) Directing The Virginia Department Of Health To: (I) Review The Efficacy Of The Provider Database Developed With "Practice Sights" Grant Funds; (II) Report On Whether The System Should Be Utilized, And, (III) Identify Any Resources That May Be Needed To Improve The System And Make It Functional.**

Option IV **Introduce Legislation Directing The Virginia Department Of Health To Coordinate The Commonwealth's Efforts In Recruiting And Retaining Providers For Underserved Areas And Populations; Legislation Would Identify Specific Functions And Activities To Be Conducted As Part Of This Responsibility.**

An accompanying budget amendment would be introduced to provide the necessary funding and positions (perhaps 3 FTEs). (Amount of budget amendment will be determined later.)

Option V **Introduce Legislation Directing The Virginia Department Of Health To Form A Public-Private Partnership By Contracting With A Private, Non-Profit Organization To Administer The Medical Scholarship And Loan Repayment Programs And Coordinate The Recruitment And Retention Of Providers For Underserved Areas And Populations. Legislation Would Require The Non-Profit Entity To Have A Board Of Directors Composed Of Representatives Of The Various Health Workforce-Related Entities, Including The Statewide AHEC Program, The Academic Health Centers, The Virginia Primary Care Association, The Commonwealth, And Other Appropriate Organizations.**

Accompanying budget amendments would need to be introduced to reflect the new structure of the health workforce programs.

Option VI **Introduce Legislation Reassigning The Responsibility For Administering The Medical Scholarship And Loan Repayment Programs And For Coordinating The Recruitment And Retention Of Providers For Underserved Areas And Populations From The Virginia Department Of Health To The Statewide AHEC Board.**

Accompanying budget amendments would need to be introduced to reflect the new structure of the health workforce programs, including additional staff allocated to the Statewide AHEC Board.

Option VII **Introduce Legislation Directing The Virginia Department Of Health To Contract With The Virginia Primary Care Association (VPCA) To Administer The Medical Scholarship And Loan Repayment Programs And Coordinate The Recruitment And Retention Of Providers For Underserved Areas And Populations. Legislation Would Require The VPCA To Establish A Board Of Directors For This Purpose Which Would Be Composed Of Representatives Of The Various Health Workforce-Related Entities, Including The Statewide AHEC Program, The Academic Health Centers, the Commonwealth, and other appropriate organizations.**

Accompanying budget amendments would need to be introduced to reflect the new structure of the health workforce programs.

Option VIII **Introduce A Joint Resolution Or Budget Amendment (Language Only) Directing The Joint Commission On Health Care To Form A Subcommittee To Study And Recommend The Most Appropriate Organizational Structure For Coordinating The Commonwealth's**

Programs For Recruiting And Retaining Providers For Underserved Areas And Populations.

Option IX **Introduce Legislation Amending §§ 32.1-122.5:1, 32.1-122.6, 32.1-122.6:02, 32.1-122.6:03, 32.1-122.6:1, 32.1-122.9, And 32.1-122.10 Of The *Code Of Virginia* To Include Health Professional Shortage Areas (HPSAs) Among Those Underserved Areas In Which Scholarship And Loan Repayment Recipients Can Complete Their Service Requirement.**

Option X **Introduce A Budget Amendment To Increase The Amount Of Funding Designated For The Virginia Physician Loan Repayment Program (Amount To Be Determined Later).**

Option XI **Introduce A Budget Amendment Reducing The Amount Of Funds Appropriated For Medical Scholarships To $235,000, And Re-Allocating The Remaining $230,000 To The Virginia Physician Loan Repayment Program For Use Throughout The Commonwealth**

Option XII **Introduce A Budget Amendment Consolidating All Appropriations For Provider Financial Incentives (Scholarships And Loan Repayment) Into A Single Appropriation Which Could Be Used For Scholarships, Loan Repayment, Signing Bonuses, Salary Supplements, And Other Appropriate Incentives. Language Would Be Included In The Amendment Requiring The Responsible Entity To Submit Annual Reports On How The Funds Were Used And The Number Of Providers Recruited To Underserved Areas And Populations.**

Option XIII **Introduce Legislation Amending §32.1-122.7 Of The *Code Of Virginia* Requiring The Statewide AHEC Board To Include In Its Annual Reports To The Secretary Of Health And Human Resources, The Board Of Health, The Governor And General**

Assembly Information On How State GF Dollars Are Spent In Support Of The AHEC Program.

Option XIV **Introduce A Budget Amendment (Language Only) Requiring Local AHECs To Use State GF Dollars To Support Only Those Programs Designed To Recruit And Retain Providers For Underserved Areas And Populations.**

Option XV **Introduce A Budget Amendment For $350,000 (GF) In FY 2001 And FY 2002 To Provide $150,000 (GF) For Each AHEC.**

Option XVI **Introduce A Budget Amendment (Language Only) Requiring The Community AHECs To Provide A Certain Percentage Of Local Matching Dollars In Order To Receive State GF Support.**

Option XVII **Introduce A Budget Amendment (Language Only) Consolidating Individual AHEC Appropriations Into A Single Appropriation To The Statewide AHEC Board For Distribution Among The Individual AHECs. Language Could Be Included Requiring The Statewide AHEC Board To Develop And Implement A Funding Methodology For Allocating State GF Dollars Among Individual AHECs Based On Needs Established In Each AHEC Area.**

Option XVIII **Introduce A Budget Amendment (Language Only) Directing The Joint Commission On Health Care To Continue Its Review Of The Commonwealth's Health Workforce Programs.**

Overall Summary of Comments

There was a great deal of diversity in the comments that were received. The following table summarizes the comments that were received on each Policy Option. Only responses that specifically stated a position on the respective options are included in the table. As shown, none of the commenters supported Option I. Nine of the

18 options were supported by at least six commenters. Options II received the most widespread support with12 of the 14 commenters indicating support. Option XI was supported by 11 commenters. Option XIII was supported by ten commenters; Options III, IV, and XV by seven commenters; and Options XVI and XVIII by six commenters. Option XIV was opposed by five commenters while two commenters supported that Option. Four commenters indicated their opposition to Option XVII.

Policy Option	Number of Comments in Support	Number of Comments in Opposition
I		2
II	12	
III	7	
IV	7	
V	4	1
VI	2	2
VII	2	2
VIII	4	2
IX	11	
X	5	
XI	4	1
XII	9	
XIII	10	
XIV	2	5
XV	7	
XVI	6	
XVII		4
XVIII	6	

Summary of Individual Comments

Blue Ridge Area Health Education Center

Betty L. Newell, as Chair on behalf of the Board of Directors, expressed support of Options II through X, XII, XIII, XV, XVI and XVIII. Regarding support of Options V through VIII, Ms. Newell stated that "the Blue Ridge AHEC believes that the VDH is the most

appropriate agency to coordinate primary care provider recruitment and retention efforts as well as to administer scholarship and repayment programs. However, VDH should be directed to partner with the Virginia Statewide AHEC Program, the Virginia Primary Care Association, Virginia's Medical Schools, and other appropriate health professions education programs. We believe that this strategy would require the least amount of additional state dollars while drawing upon the considerable talents and expertise of staff and other resources within each of the respective agencies and organizations." In supporting Option XVI, which would require Community AHECs to provide local matching dollars, Ms Newell wrote that the term "local" needs to be defined "to include all sources of support outside of the base GF support as well as in-kind support (narrowly defined as rent, utilities, and other similar types of administrative or programmatic support)."

Ms. Newell reported opposition to Options I, XI, XIV, and XVII. Opposition to Option XIV included the explanation that "While the AHECs are and will continue to be involved in activities designed to recruit and retain providers, an important strength of the AHECs resides in their ability to promote access to care in various ways...There are many pressing health care needs that are not associated solely with the presence of a primary care provider. This option may better be stated by requiring AHECs to focus their state GF dollars on programs and activities that promote access to care and tying the reporting of how these dollars are spent to Option XIII."

Claudette Dalton, M.D.

Claudette Dalton, M.D. stated that her experience in the area leads her "to think that the current system needs an out-of-the-box fix rather than a band-aid on the current system." Dr. Dalton indicated her support for the various Options as follows: "Options II (to get the communities designated so they can be recruited to), V or VIII (as possible solutions to a new format for recruitment and retention activities in the absence of leadership by the AHECs), VI (as an interim solution for funding students), IX (to allow loan repayment in HPSAs), XII (a single fund to be USED AS NEEDED to recruit and retain), and XVIII (to continue this dialogue through the study). All of these will allow a new infusion of flexibility into the solution."

Regarding the AHECs, Dr. Dalton indicated her support for Options XIII through XVI and XVIII. She was neutral on Option XVII "if the AHECs continue to be a viable force."

Roger A. Hofford, M.D.

Roger A. Hofford, M.D., indicated support for Options II through IV, IX, and XII. Dr. Hofford stated that he would support legislation to accomplish Option II regarding VDH's designation of Primary Care, Dental, and Mental Health Professional Shortage Areas if it were needed. He noted that VDH actually provided the service in the past but that it is his "impression that VDH is understaffed for this important function." Dr. Hofford suggested tying the evaluation of the Provider Database in Option III with the Department of Health Professions' current project to collect physician demographics. Option IV was supported also with a suggestion to establish a VDH advisory board dealing with recruitment and retention and to allow VDH to contract with other organizations such as "AHEC and VPCA...to provide needed resources and skills in this endeavor."

James Madison University - David E. Cockley, DrPH

David E. Cockley, DrPH commented in support of Options II through IV, IX through XII, XV, XVI, and XVIII. Dr. Cockley indicated his strong endorsement of Options II and III noting that "Planning across the Commonwealth requires on-going monitoring of shortage areas. The Virginia Department of Health should be the monitoring agency for this as it falls squarely on its Assessment function as the state public health office." Option IV was supported because the "oversight role must be given to an organization viewed as neutral by both providers and communities." Dr. Cockley supported Option XVIII to continue review of health workforce programs as being "crucial for accumulating accurate data for future health policy planning."

Dr. Cockley opposed Options XIV and XVII because they would respectively, restrict local AHEC activities and "further centralize the AHEC system."

James Madison University – Vida S. Huber, EdD

Vida S. Huber, EdD commented in support of Option XIII noting she "appreciates the difficulty many health and human service programs have in evaluating programs" but also recognizes "the importance of accountability that programs such as the AHEC program have for detailing how state dollars are spent." Dr. Huber urges caution however, in placing restrictions on the activities that AHECs can support with state funds. She adds that "access to primary and other levels of health care will be improved when we (providers, educators, policy makers) improve our capacity to identify underserved and vulnerable populations and develop new and innovative ways of increasing access to health care for these groups." Dr. Huber indicated that she is therefore opposed to Option XIV.

Southside Virginia Area Health Education Center

Woody B. Hanes, Executive Director commented on behalf of the Board of Directors, in support of Options II through IV, IX, X, XIII, XV, XVI, and XVIII and in opposition to Options V through VIII, XIV, and XVII. In supporting Option XVI, however, Mr. Hanes states "The state needs to know the community commitment to our organization, but we have concerns as to the definition of local. Our local governments could not provide that local percentage. In determining the percentage, please take in consideration the different abilities and sources of funds in localities."

Virginia Department of Health

E. Anne Peterson, Acting State Health Commissioner indicated general support for Options II, IV, IX, XII, and XIII. Options VI, VII, and VIII generally were not favored.

In discussing Option II, Dr. Peterson indicated that "A legislative mandate to continue these activities will ensure that shortage designations are coordinated and that efforts of state agencies are not duplicated. In the absence of a state mandate, VDH will still have federal requirements to designate primary care shortage areas, but not dental or mental health HSPAs."

Dr. Peterson indicated support for Option IV in noting that VDH commits one-half FTE to the effort of recruiting and retaining providers for underserved areas. This is in contrast to North Carolina that has assigned five full-time staff. The Center for Primary Care and Rural Health "through partnerships with the AHECS, is funding the development of a recruitment web page and a health access newsletter and these activities are expected to improve recruitment. If this option [Option IV] is adopted, it would provide more manpower and resources necessary for Virginia to compete effectively with neighboring states. If this option is not adopted VDH will continue to play an important but limited role in recruitment and retention."

Dr. Peterson stated that Options X through XII have advantages but that "Option XII, if enacted, would allow the flexibility to allocated funding to the programs most desirable and marketable to health professionals. Option XII also preserves the role of the medical schools in awarding scholarships."

Virginia Health Workforce Committee

Lyn Hainge reported on behalf of representatives the Virginia Health Workforce Committee. The Virginia Health Workforce Committee is a voluntary association made up of "representatives of the three academic health centers, the Virginia Department of Health, the Virginia Primary Care Association (VPCA), the Statewide AHEC Program (AHEC), the Graduate Medical Education Center (GMEC), and other interested parties. Its purpose is to improve communication among members and, thereby, to maximize effectiveness (and minimize duplication) of healthcare workforce initiatives."

The Committee representatives indicated unanimous support for Options III, IX, XIII, and XV and unanimous opposition to Option I. Ms. Hainge also reported with regard to the other Options, "particularly Options IV – VIII (which address the manner in which workforce initiatives will be managed in Virginia), the group recognized that these are critical and complex issues requiring additional discussion before consensus was possible." She continues by saying that the Committee members are willing to continue discussions and to report back to JCHC by December 1, 1999.

Virginia Hospital and Healthcare Association

Barbara Brown, Vice President commented in support of Options II, VIII, XI, and XIII. In support of Option VIII, Dr. Brown noted that "adopting Option VIII would allow an analysis of what the structure for coordinating the Commonwealth's programs for recruiting and retaining providers should be. The study is needed to assure that tax dollars are spent efficiently and effectively and that duplicative activities among educational programs, VDH, AHEC, and the Primary Care Association are avoided."

Virginia Pharmacists Association

Rebecca P. Snead, Executive Director, VPhA, commented on behalf of the Virginia Pharmacists Association. Ms. Snead made the following observations about the draft: "Unfortunately, the draft does not adequately examine the potential and actual role of pharmacists providing health care in underserved areas of the Commonwealth. In many of these areas, Virginia pharmacists are not just the most accessible health care providers; they are often the only health care providers." Ms. Snead continues by stating that for many pharmacy students who have costly student loans to repay, salary is "a primary factor in determining prospective employers. One solution to this problem would be for the Commonwealth to create and fund pharmacist residency programs in under-served areas. Also, the state should implement a pharmacy scholarship and loan repayment program. For these reasons, the Virginia Pharmacists Association offers its support of Options II, IV, V, IX, and XII so long as pharmacy is included in these policy options."

Virginia Primary Care Association, Inc.

John B. Cafazza, Jr. Executive Director, commented on behalf of the VPCA membership in support of Options II, III, V, VII through XIII, XV, XVI, and XVIII. Regarding Option VII and VPCA's role, Mr. Cafazza included the following: "This is a complex issue with a solution requiring a much larger investment by the Commonwealth than previously has been experienced. As indicated by other states' successes, an effort of the magnitude needed to address the needs in

Virginia will require resources of staffing, marketing and systems development heretofore unavailable in the state. If given the responsibilities as outlined in this Option, and assuming the necessary state resources are made available over time, VPCA will develop the necessary capacity and structure to conduct the specified activities in a comprehensive and productive manner for the good of the Commonwealth."

Virginia Statewide Area Health Education Centers Program

Jeffrey A. Johnson, Executive Director, commented on behalf of the Virginia Statewide Area Health Education Center Program. Mr. Johnson indicated strong support for Options XIII, XV, XVI, and XVIII, and support for Options II through IV, and IX. In supporting Options II through IV, Mr. Johnson noted the "understanding that the community AHECs continue their efforts to partner with the Virginia Department of Health and others to recruit and train health professionals for underserved areas and populations." Reservations were reported regarding Options XIV and XVII related to AHECs desire to retain flexibility regarding the use of state funds and to retain "current appropriation language that provides specific funding levels to each community AHEC who, in turn, is responsible for making program decisions that reflect local needs and priorities."

Hermes A. Kontos, MD, Ph.D., Vice President for Health Sciences, Dean, School of Medicine, MCV

Dr. Kontos indicated support for Options II, IX, X, XII, XIII, and XIV. He stated that there are advantages and disadvantages to Options V, VI, and VII. Further, Option XI, with its specific funding recommendations, may not provide the flexibility needed for future program administration, but the flexibility to reassign funds between scholarships and loan repayment is desirable.

Dr. Ronald Hunt, Dean, School of Dentistry, MCV

Dr. Hunt indicated support for Options II, XI, and XII.

JOINT COMMISSION ON HEALTH CARE

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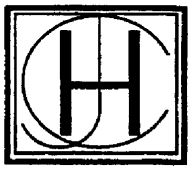

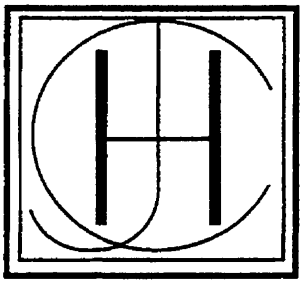

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